

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: NM

APPLICATION YEAR: 2005

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

The Assurances and Certifications are in pdf format in an attachment to the New Mexico Title V Grant Annual Report and Application. The central office of the New Mexico Title V MCH Program also maintains a reference copy.

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

***/2005/ Upon receiving final approval for the FY05 Application from the MCH Bureau/ HRSA/ DHHS the New Mexico Department of Health will publish a notice in the Albuquerque Journal, which has statewide distribution, inviting the public to comment on the current Title V Block Grant. It will be available to the public for review through contacts at each of the four district offices of the Public Health Division located in Santa Fe, Albuquerque, Las Cruces and Roswell, and the Title V State Office in Santa Fe. The Title V State Director will consider public comments on the Block Grant for a specified period of thirty days. The Title V State Office will acknowledge comments, and the Family Health Bureau (FHB) Management Team will review summary of comments and follow up on critical issues. The FHB Management Team will consider comments when evaluating program services and developing the subsequent year's Block Grant.***

***Public Input is an ongoing process. Input for DOH priorities was solicited through the revision of the DOH strategic plan process and the development of a comprehensive statewide health plan. Input from advisory groups was ongoing and is featured in this report and application document: the State's Early Childhood Comprehensive Systems (ECCS) working groups, the Children's Cabinet, the Children & Youth with Special Health Care Needs (CYSHCN) Transition Planning Council, the Youth Development Advisory Councils, the PRAMS Steering Committee, Family Health Bureau consultations with District Public Health teams, and other groups. //2005//***

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

Key Characteristics Related to MCH in New Mexico: New Mexico is a relatively young state whose history reflects the imprints of many cultures and sovereigns. Human presence in the area dates back to the "Clovis Man" circa 9,500 B.C. During the first few centuries A.D., most of the area population settled into villages located along the Rio Grande River. It was these pueblos and the nomadic tribes that the Spanish explorers encountered during their expeditions into what was then the northern frontier of New Spain, in 1540. Despite many outside influences, the pueblos and tribes (Navajo and Apache) still reside in this area and have retained much of their culture. Spanish rule of New Mexico began in 1598 and ended when Mexico gained its independence from Spain in 1821. A quarter century of Mexican rule ended in 1846 when the US declared war on Mexico. After many attempts to move from a territory to a state, New Mexico, the Land of Enchantment, was granted statehood on January 6, 1912, as the 47th state.

The state's history and cultural diversity are important backdrops to understand the challenges of delivering health care services in New Mexico.

//2002/ The population in 2000 of 1.8 million is culturally diverse with no single racial-ethnic group in the majority. The natural and cultural environments are richly endowed, yet the state ranks poorest in the nation based on 1997-99 census data. The territory is large, 121.3 thousand square miles, with an average 14.3-persons/square mile. Nearly a third of the population resides in the Albuquerque area; much of the state is classified as rural; and there are only six other cities with a population over 30,000. Key challenges to improving the health of the MCH population are economic and educational development, which require strategies beyond the purview of the Department of Health. Key factors impacting health care, and MCH specifically, are the rural nature of the state, several groups who speak other languages, literacy, poverty, a relatively poor distribution of health and health related services and health care providers in the more rural areas, large distances to reach health care facilities, immigration, and relatively high levels of uninsured or under-insured individuals. Statewide and local systems development and partnerships in health initiatives are of critical importance in this state. //2002//

Population Demographics: //2002/ New Mexico continues to be among the fastest growing states in the nation with an increase of 14% between 1990-97; and an estimated 4.9% between 2000-2001. The state's population of 1.8 million in 2001 is culturally diverse and younger than most states in the nation (NM at 30.5% age 18 and younger compared to 27% in the US). Nearly half of the children are Hispanic; 12% are Native American; and less than 3% are African American. .

//2003/ The U.S. Census reported for New Mexico a year 2000 total population of 1,819,046. Of this total, 29.51% were children age 0-18. The 2000 Census for New Mexico is a celebration of our diversity as seen in the table below. The most important change in the 2000 Census was the inclusion an option to self-report a multiple race category. While beneficial in many respects, the change is problematic because it is not comparable with many DOH data programs and it will make trend analysis of population-based estimates a challenge (for years prior to 2000). There may be an age bias in those who report other race or multiple races, as those who self-report in this category may be younger:

Race and Ethnicity, New Mexico 2000 Percent

Hispanic White 22%

Non-Hispanic White 44.7%

Black 1.9%

American Indian 9.6%

Asian 1.1%

Native Hawaiian & other Pacific Islander 0.1%

Hispanic, other race 16.9%

Non-Hispanic, other race 0.2%

Two or more races 3.6%

Of children age 0-18:

? 57.5% were white (including Hispanic white); and 50.79% of children 0-18 were Hispanic

- ? 21.19% were of some other race
- ? 12.71% were Native American, Alaska Native
- ? 5.51% were of two or more races
- ? 2.11% were Black
- ? 0.9% were Asian
- ? 0.1% were Native Hawaiian or Pacific Islander

The proportion of the total dependent population age 0-18 also varied by race-ethnicity, with non-white groups having the higher proportion of dependents age 0-18. This reflects slightly higher birth rates among traditional minority groups, as well as longer life span among white people. The proportion of the dependent age population 0-18 by race in 2000 was:

- ? 44.6% of people of two or more races were 0-18;
- ? 39.3% Native American, Alaska Native;
- ? 36.7% of other race;
- ? 35.6% of all Hispanics were 0-18 (includes white & other races);
- ? 34.1% of people Native Hawaiian or Pacific Islander were 0-18;
- ? 32.9% of Black; and
- ? 25.4% of White.

There were an estimated 391,364 women of reproductive age (15-44) in 2000, comprising 42% of the female population. In 2001 the NM population had increased by 0.6% (U.S. 1.2%) for a total population of 1,829,146.

/2004/ The 2001 intercensal estimate for New Mexico, prepared by demographers at the University of New Mexico's Bureau of Business and Economic Research (BBER) is summarized below:

There was an estimated population of 1,841,441 people, an estimated 1% increase since 2000.

The estimated population of children age 0-18 years was 515,645, an estimated 28% of the total. 132,236 were age 0-4; 142,909 were age 5-9.

There were an estimated 792,783 women, age 15-44, of reproductive age.

No significant changes in the distribution of race-ethnicity since 2000 census were reported. //2004//

Per Capita Income: /2002/ New Mexico fell from 47th in 1997 to 48th in 1999, with a personal income per capita of \$21,853 compared to the national figure of \$28,542.

**/2005/ In 2000, New Mexico remained 48th with a per capita income of \$21,931.00 compared to the national average of \$29,469.00. Nearly 28.2% of Native Americans and 23.3% of Hispanics in New Mexico were at or below the poverty level. //2005//**

Unemployment: /2002/ The state had the 5th highest unemployment rate in 1999 at 5.6% of the population or 33% greater than the national figure of 4.2%. The 1999 state ratio is an improvement from 6.2% in 1998.

Poverty: /2002/ In 1999 an estimated 26.4% of children and 20.7% of adults lived at or below the Federal Poverty Line. Compared to the US, these proportions are nearly two times higher for adults and 42% higher for children. The 1999 state estimate is a 21% improvement over the 1997 estimate of 32%. In an innovative approach to assessing poverty, the NM Advocates for Children assessed poverty using data from the NM Taxation and Revenue Dept. files. According to this study, in 1998 an estimated 30% of children lived at or below the poverty line; 26% at 101-185% of poverty (Medicaid-SALUD eligible); and 10% at 186-235% (S-CHIP level); and 34% over 235% of poverty. Between April 2000 and 2001 there was a general decline in use of TANF and Food Stamps for families in poverty while the state's population increased ~4.87% (from 1.734 million to 1.819 million). Notably there was a 5.8% overall increase in Medicaid eligibles between March 2000-2001. Medicaid eligibles comprised 17% of the 2001 population and only 13% in 1998, a 32% increase.

**/2005/ Using 2001 data, the 2004 national Kids Count reported that New Mexico ranked worst in the nation with greatest proportion of children living in poverty at 26%; the U.S. at 16%. For its composite measure of 10 indicators, NM ranked 48th in the nation. The state ranking was strongly influenced by poverty-related indicators: 34% of children lived in families where no parent has full-time, year-round employment at 50th rank; 36% of families are headed by a single parent, ranked 49th; live births to teen mothers at 15-17 at 38/100,000 population with 48th rank; 12% of NM teens age 16-19 dropped out of school at 43rd rank; 11% of teens were**

**not attending school or working at 41st rank. Among the measures that were health indicators NM fared better: 28th rank for low birth weight at 7.9% of live births; 20th rank for infant mortality at 6.4/1000 live births; 36th rank for child death rate of 25/100,000 children age 1-14; and 35th rank for teen age 15-19 fatal injury rate of 59/100,000. //2005//**

Food Stamps: /2002/ The Food Stamp program served 168,238 recipients in April 2000 (9.7% of population) and 162,343 in April 2001 (8.9% of state population). This represents a difference of -- 2.11% in absolute numbers who enrolled for food stamps and an --8.2% change in the proportion of the population on food stamps. Recipient ratios varied by county; the highest was McKinley County (22% in 2000 and 20% in 2001) and lowest Los Alamos (0.4% in 2000 and 2001).

/2003/ NM is unable to obtain unduplicated counts of food stamp recipients, but estimates are provided by the program. In April 2002, the Food Stamp Reciprocity Rate was 9.4%, based on 171,006 recipients. In April 2002 the food stamp caseload was 65,919, a 5.5% increase from April 2001.

**/2005/. In May 2003 the number of Food Stamp Recipients was 197,722 (10.9% of the population). This represented a slight increase in Reciprocity Rate of 1.5% over the April 2002 Food Stamp Reciprocity rate. The May 2003 Food Stamp caseload was 75,640, a 13.7% increase from May 2002. Using 2002 data, a summary analysis showed the following: The number of food stamps recipients (households w/ children) totaled 39,000 households (FY 2002). The number of food stamps recipients (children) totaled 87,000 children (FY 2002). Total spending on food stamps in New Mexico totaled (federal) \$154.4 million (FY 2002). Food Stamps spending per household averaged \$2,343/year (FY 2002). Households with children served on Food Stamps, as % of those at less than 130% of the Federal Poverty Level was 42% (FY 2002). In FY2004 the monthly maximum benefit for a family of 3 totaled \$371/month; the annual maximum benefit for a family of 3 was \$4,452.00/year. //2005//**

Temporary Assistance for Needy Families (TANF): The TANF program served 67,814 recipients in April 2000 (3.9% of state population) and 57,165 in April 2001 (3.1% of state population). The decline in TANF was greater than food stamps: -15.7% in absolute numbers who were on the program and -- 20% change in the proportion of the total population on TANF. Recipient ratios varied by county with Socorro the highest in both years (8.2% to 7.2%) and Los Alamos the lowest (0.2 to 0.1%). Children comprise nearly 50% of those on Food Stamps or in two-parent TANF families and over 63% of recipients in one-parent TANF families. Disparities are remarkable; the racial and ethnic distribution of parents and children on Food Stamps or TANF is disproportionately high compared to the general population for Hispanics and Native Americans; lower for white non-Hispanic or Asian. Even greater disparities are seen for one-parent than two who are not families on TANF.

/2003/In April 2002 the NM TANF program reported a total of 50,094 recipients, a TANF Reciprocity Rate of 2.8%. This is a decrease from data reported in 2000 (3.9%) and 2001 (3.1%). The implications for this decline will need to be examined. (Monthly Statistical Report, Human Services Department, State of NM issued in May 2001 for April 2001 data; and May 2002 for April 2002 data.)

/2004/ The number of TANF Program Recipients in May 2003 was 41,856 recipients (2.3% of state population) as compared to 57,165 in April 2001 (3.1% of state population). The decline in TANF was .8%. In May 2003, children still comprised nearly 51.9% of those on Food Stamps or 57.9% in two-parent TANF families and 64.6% of recipients in one-parent TANF families.

According to the HSD report for May 2003, only 72.8% (7,784/10,699) of those who applied for Food Stamps were approved; 50.7% (2036/4012) who applied for TANF were approved; and only 10.9% or 134 who applied for General Assistance were approved. The Education Works caseload, a program for supporting TANF recipients' efforts to work, has only grown from 103 in January 2001 to 455 persons in May 2003. From 1998 to 2000 over 15% of New Mexican households did not have adequate food for a healthy life and had to resort to extreme measures to get their food.

The lack of food with hunger was reported by nearly 5% of NM households. In 2000, PRAMS found an estimated 16% of new mothers did not have enough food to eat; the percentage was almost twice as high among those who were on public assistance programs or who had an unintended pregnancy . //2004//

**/2005/ The TANF Cash Assistance caseload was 17,377 in April 2004, a 7.9% increase from April 2003. //2005//**

Low Income Uninsured Children: In 1995-97, New Mexico was 50th ranked for percent children at less than 200% FPL and was 49th after Arizona for percent children at less than 200% FPL without health

insurance. In 1998 over 60% of NM children had health insurance through a parent's job and nearly 25% were covered by Medicaid. An estimated 66% of children lived below the combined Medicaid-SCHIP eligibility level of 235% of poverty and 42% were covered by Medicaid.

Poverty and Health: The health status of adults is directly related to poverty. In 1998, only 3.9% of adults reported themselves to be in poor health; yet this figure is three times higher at 12.9% for those at less than 100% of the FPL. Conversely, an estimated 45.6% of adults claimed to be in excellent health but of those less than 100% of the FPL, this estimate was only 26.7%.

***//2005/ Due to funding limitations, 1,500 low-income school-aged children who were not eligible for Medicaid or SCHIP lost the health insurance coverage they received under the Healthier Kids Fund (HKF). It's estimated that another 6,000 school-aged children would have been eligible for that Program had it not been closed to new enrollment as of January, 1999. The Healthier Kids Fund children are being carefully transferred to federal/state funded Rural Primary Health Care Agency (RPHCA) and other DOH-funded primary care clinics in New Mexico. Unfortunately, those sites will receive no additional funding to care for these children. Although most families will be able to access services at these clinics, transportation will be difficult for some children whose families are located in very rural areas in the State. The funding for HKF was cut in order to rescue the Children & Youth with Special Health Care Needs (CYSHCN) Program which had become more unstable due to rising medical and pharmaceutical costs and diminishing State and Federal funding. In addition to cutting costs, the CYSHCN Program had to eliminate some Ear, Nose & Throat (ENT) -related diagnoses that were previously covered. //2005//***

/2003/ In 2000 an estimated 49% of children age 0-18 lived ?200% of FPL; 13.3% did not have any form of health insurance. An estimated 23.8% of all NM at this poverty level were uninsured .

/2002/ Low Income Children without Health Insurance, 2000-01: Based on surveys by the NM Health Policy Commission, many low-income children do not have health insurance. At each level of the Federal Poverty Level (FPL) the estimate for number and percent of uninsured children:

Below 100% FPL: 23,171 or 20.1% 185-235% 12,801 or 15.9%  
100-185% FPL 29,457 or 21.5% Over 235% 11,976 or 5.6%

Trends in Health Insurance Coverage: 21% of New Mexico's population is uninsured compared to a national rate of 16.3%. The percent of the total population of New Mexico receiving Medicaid and Medicare is 13.3% and 14.4% respectively with Medicaid decreasing 2.5% and Medicare increasing 2.2% since 1997. Children less than 18 years old in the state have an uninsured rate of 17.1% compared to 15.4% nationally. Non-elderly adults between the ages of 19-64 have an uninsured rate of 27.8% compared to a national rate of 19.6%; of this age group, 58.5% have employment-based insurance.

/2002/ The 1999 CPS estimate of NM uninsured was 25.8%; children under 18 had an uninsured rate of 27.7% (an estimated 150,000 children). The 1999 figure for NM children was nearly twice the US estimate of 13.9%. CPS estimates for the period 1990-1999 have ranged from 17% children uninsured to 27.7%; an average of 21.5. These estimates have a high margin of error due to the methodology. The US estimates are more stable. Areas in NM with the highest proportion of children not covered at all in 1998 include the Northwest counties at 16.6%; Northeast counties at 14%; and Southeast counties at 13.7% (excluding Dona Ana).

/2003/ Estimates for insurance coverage for children age 0-17 were obtained from the NM Behavioral Risk Factor Surveillance Survey. NM BRFSS asked the respondent to the call about payor of health care for children in the house who were age 0-17 years of age. Up to three different sources of health coverage were allowed per respondent. These findings do not appear to be remarkably different from 1998-99 data from other sources. As children grow older, the data suggest a shift from Medicaid to an Employer's health plan. The findings also suggest that <2.5% of children under age 12 have no source of payment and 4.3% of teens age 13-17 have no source. Findings for 2000 are summarized here:

Source of Health Insurance Coverage	Age 0-4	Age 5-12	Age 13-17
An Employer's health plan (adult in family)	38.9	46.6	59.9
Medicaid	34.6	25.9	23.4
Cash, check or credit card	13.0	14.8	18.7

Indian Health Service 4.5 4.3 4.6  
Bought their own health plan 3.4 3.6 7.0  
Some other source or no source at all 2.5 2.7 4.3  
Total Number of Respondents 536 756 571  
Source of data: NM BRFSS 2000

Similar findings were reported in 1999, but with less detail available. Of children 0-4 years, 90.7% had some kind of coverage; 88% of children 5-12 had some coverage; and 89.5% of youth age 13-17 had some coverage.

Accessibility of Needed Health Services by Geographic Area: In a 1999 New Mexico Health Policy Commission Household Survey, respondents in north central New Mexico noted the highest percentage of households unable to access primary care all or part of the time (19.1%), preventative services (16.7%), eye care (21.2%) or dental care (32%). Southwestern and south central New Mexico had the highest percentage of respondents (14.7%) unable to access an emergency room all or part of the time. Average travel time and average mileage to a primary care provider was 14.5 minutes/6.6 miles in urban Bernalillo County in contrast to 29.9 minutes/25.2 miles in rural Sierra and Socorro County.

Health Care Professionals per 100,000 Population: /2002 / Although the population continues to grow in size, the number of licensed health care professionals is decreasing. The state has 75% of the national ratio for nurses; and 86% of the national ratio for doctors. In 2000 there were 723 Nurses/100,000 population; 217 physicians; and 43 licensed midlevels. All but 5/33 counties are designated as partial or full health professional shortage areas for primary care; 13/33 for dental health professionals; and all counties are designated full or partial for mental health.

/2003/ Recruitment and retention of nurses, nutritionists, social workers and information technology (IT) staff have become a growing concern to the Department of Health and other state agencies. The salaries of nurses and IT staff have been addressed through special appropriations and other personnel actions. Although salaries for nurses have been increased this past year, they remain below the private sector. State Personnel has adopted a more flexible salary system in NM and all staff were transitioned this past year. Some salaries were increased as a result of this new capability, but inequity remains, and there was not adequate budget to increase all positions that were deserving.

Medicaid in New Mexico: Medicaid is a major contributor of health care in New Mexico with 13.3% of population receiving coverage in 1998. Between 1998 and 1999, monthly enrollees increased an average of 7.8% and total Medicaid expenditures increased 3.8% during the same period. Children represent 63.8% of the total Medicaid enrollees.

Annual Medicaid expenditures have more than quadrupled since 1989 due to several factors including: expansion of coverage for pregnant women and children under the age of 19, a 25% increase in the state's population, and an increase in cost per enrollee. Expenditures in rank order in 1997 were

33% Blind and disabled 12% Elderly  
29% Children 7% other and unknown categories  
17% Adults 2% Foster care children

Medicaid is one alternative to the lack of universal health care in New Mexico.

/2003/ The Medicaid Managed Care Organizations (MCOs) began to acknowledge the value in prevention programs initiated by the Public Health Division, but are having difficulty with budget restrictions. Title V funding is a valuable supplement to the direct and limited preventative services provided to eligible populations by the Medicaid program particularly in a state which also has much work to be done to combat the effects of poverty. The state has made a commitment to increase enrollment of eligible children for Medicaid services.

/2004/ The FHB continues to work directly with HSD/Medicaid and the MCOs to promote MCH. Initiatives include Families FIRST Case Management (described elsewhere) and the Alphabet Soup Group. The latter is a working group of Medicaid MCO executives, HSD, CYFD and DOH leadership. Issues explored have included prenatal care access; status, trend, gaps and disparities found in health indicators from NM PRAMS data specific to the Medicaid population. //2004//

State Child Health Insurance Program (S-CHIP), Title XIX /2002/ Two components of SCHIP Phase II

were re-submitted to HCFA as a demonstration waiver, Behavioral Health Respite and Home Visiting. MCH Title V staff from the Family Health Bureau contributed to all phases of this new program. Collaborative partnerships formed during the work on SCHIP Phase II continue to be strengths in efforts to improve maternal and child health in a new initiative to address the urgent need for a statewide strategic plan to improve infant mental health. County Maternal and Child Health Councils continue to strengthen their capacity for community health improvement.

/2003/ The SCHIP Phase II waiver was denied by what was HCFA, and is now CMS and consequently the full package that included Home Visiting and Behavioral Health Respite will not be funded. In its stead, New Mexico took the option of expanding eligibility for Medicaid from 185% to 235% of poverty rather than developing a separate program under the Title XXI State Children Health Insurance Program (SCHIP). A 12-month continuous Medicaid eligibility guaranteeing coverage for an enrolled child independent of changes in family income became effective on July 1, 1998. An intense marketing effort of SCHIP Phase 1, "New MexiKids" began in October 1998 targeting uninsured children. SCHIP Phase I began implementation in March 1999 and is estimated to eventually reach an estimated 5,500 children.

Lacking proposed resources of the S-CHIP waiver proposal, collaborative work continues to address infant mental health through a work group developing a strategic plan. One County MCH Council, Santa Fe, has developed a county-wide "Zero to Three" strategic plan, based on its County MCH Plan, to focus on the urgent needs of young children and their families.

In FY2003 the Human Services Department, Medical Assistance Division developed another Medicaid Waiver application proposing a cost savings strategy of providing Medicaid as an employer benefit, and eliminating SCHIP. Although this strategy seemed appealing because the entire family could be covered (there is currently no coverage for men or low income women who do not have children), employers in NM do not have to provide health care benefits and many do not. There would also be a co-pay. This proposal met with criticism from the advocates. The Medicaid Program was increased during the Special Session in June 2002 by \$40 million, still \$18 million less than requested.

The Public Health Division (including Title V staff) worked diligently with others in the Department of Health and a broad range of community providers to provide input into the request for proposal process (RFP) for the Medicaid managed care contracts being awarded this past year. The Department of Health funded a \$3 million dollar substance abuse prevention initiative this past year from new appropriations and existing budgets. This initiative is intended to fund communities that wish to implement evidence-based interventions. The Public Health Division contributed one million dollars in state general funds. This "Improving Health Initiative" has hired staff both in the Public Health Division, including the State Office and Districts, and the Behavioral Services Division to implement this program. Grants were awarded to communities and several communities received small capacity building grants so that they could compete for larger grants more successfully in the future.

/2004/ Presumptive Eligibility-Medicaid On-Site Application Assistance (PE-MOSAA) The Balanced Budget Act of 1997 gave the states the option to establish a presumptive eligibility procedure to facilitate the enrollment of children in Medicaid. As part of this effort, the New Mexico Human Services Department (HSD) implemented the Medicaid On-Site Application Assistance (MOSAA) program on July 1, 1998. Local health offices of the Department of Health carry a very large part of the burden for on-site application of the program. Programs such as Families FIRST, Children's Medical Services, WIC and other Public Health Division employees in the local health offices have been trained to provide Presumptive Eligibility and MOSAA, and have educated themselves in the Medicaid Managed Care (SALUD!) enrollment process. In 2001 the New Mexico Human Services Department (NMHSD) sent out proposed regulations dated March 27, 2001 for implementation July 1, 2001, to carry out additional provisions of the Balanced Budget Act of 1997: Changes in its SCHIP coverage to allow families who voluntarily cancel their children's health insurance to enroll in SCHIP without penalty or a waiting period; and to remove the requirements for a face-to-face interview for Medicaid applications. In FY2002-2003 work continued to obtain reimbursement for MOSAA and Presumptive Eligibility. In FY2004 the NM Human Services Department agreed to reimburse PE-MOSAA services provided by the Families FIRST Program in the DOH.//2004//

**/2005/ Medicaid Update: Two factors will merit close monitoring of eligible children's access to and use of Medicaid-paid service. In FY2005, the state Medicaid agency announced a 1.5% cut in the operational budget. This will affect services statewide. In addition, families on Medicaid will now be required to do a recertification of eligibility every 6 months. This places a burden**

**on both field workers and the families. Medicaid is no longer contracting for outreach services. //2005//**

/2004/ Native Americans and Tribal Health Collaboration Tribal, Indian Health Services (IHS) and Bureau of Indian Affairs (BIA) provide health and social services to Indian children and families. The FHB and other members of PHD programs have joined in an initiative to create a statewide network to promote cooperation and collaboration among the many public health entities serving Indian children and non-Indian children. It includes initiatives to promote data sharing, access to population-based and program-specific data, and collaboration to better integrate services to all. The creation of this network flows out of successful initiatives taken in FY1996-2000 including Tribal and IHS participation in the development of NM Pregnancy Risk Assessment Monitoring System (PRAMS); FY1999-2001, the Tribal Consultation process used to develop New Mexico's State Child Health Insurance Program (S-CHIP). Within the Office of Epidemiology there are two staff devoted to DOH-Tribal epidemiology and facilitating use of data in public health initiatives for tribal communities.

**//2005/ The tribal epidemiologist, Dawn McCusker, MPH, maintains the Native American Department of Health Data Advisory Group (NADHWAG) which convenes quarterly; participants share data and discuss how it can be used. The community epidemiologist, Corazan Halasan, MPH, is working on a statewide training initiative to promote use of data for community needs assessment; tribal epidemiology works on this initiative as well.//2005//**

Maternal and Child Health: The state ranks last in the nation for the percent of women receiving the recommended level of prenatal care. In 1997, only 52.7% of all women in New Mexico received such care and at least 11.1% or 1 in every 9 births received no prenatal care. In McKinley County, in the western part of the state, only 30% of women received high levels of prenatal care. The state also ranks among the highest in the nation for teen pregnancy rates with birth rates averaging 39% higher than the national average. Nationally, 12.9% of all births in 1996 were to teen mothers compared to 17.8% in New Mexico.

2004/ Births to teens age 15-17 showed a five year sustained decrease; in 1999 the rate was 40.8; in 2000 the rate was 39.1; in 2001 the rate was 37.5; the 2002 rate was not published by June 30, 2003 but is thought to show a continued decline.//2004//

/2004/ MCH in New Mexico with respect to National Rankings. Overall, New Mexico is paradoxical when one considers health indicators used in creating indices and ranking states. In spite of the fact that the state ranks 40-50th for access or SES measures, the state is among the top 10 best for long term outcomes such as heart disease, cancer cases and total mortality; and for healthy behaviors such as breastfeeding initiation. New Mexico is among the 10 worst states for violent crime, high school graduation, unemployment, adequacy of prenatal care (modified Kessner), first trimester prenatal care, lack of health insurance, support for public health care and infectious disease. Overall poverty rates, in particular childhood poverty rates, show a strong negative correlation with health care quality. This report observes that states with high poverty levels tend to rank significantly lower in overall health care quality that shows the profound influence economic conditions have on health. It will be very difficult for such states to improve health care quality without improving the economic conditions. Childhood health deficiencies exacerbated by poverty are likely to impact overall health care quality for a state well into the future if not caught and corrected early.

The Healthy Birth Index, which comprises all births with a birthweight >5.5 pounds, Apgar of 9-10, gestation of >37 weeks and mothers who had first trimester prenatal care: Albuquerque ranked 26th of 36 cities ranked in the nation at 57.7 (the top city average was 61.6). Within the state index, New Mexico ranked 48th in the nation at 55.5; the National Index average was 66.8 .

Educational Status and Literacy: An estimated 21-23% of US youth and adults function at the lowest Level 1 literacy rate; in New Mexico this proportion is 20% (See full data in the Appendices submitted in FY02). The county specific proportions for Level 1 literacy range from 5% in Los Alamos to 35% in Luna County. Although many Level 1 adults can perform many tasks involving simple texts and documents, all adults at Level 1 displayed difficulty using certain reading, writing and computational skills considered necessary for functioning in everyday life.

Quality FIRST Index: New Mexico ranked 44th with health care costs of \$223/ per capita; the state ranks in the bottom 5 states for childhood poverty. Strengths in New Mexico include the state's mortality ranking as better than the national average due to low lung cancer and heart disease deaths. Weaknesses include economic issues such as unemployment, lack of health insurance, overall poverty, childhood poverty, births to teens, suicide rate, dentist shortages, low prenatal care

levels, incidence of immunizable diseases and days lost to illness. The New Mexico health care system is characterized by having a low usage of procedures, high penetration of managed care and health maintenance organizations in urban areas, low hospitalization days, and a low ratio of specialists to primary care physicians.

/2002/ State and local health planners benefit from several composite reports of socio-economic and health indicators depicting point estimates for each county and in rank order. These include NM Rates of Unemployment by County and by Health Planning District, Composite Scores for Hospitalization, Mortality, Traffic Crash and Youth Risks by County and by Health Planning Districts. An Index of MCH Vulnerability, statewide and by county, was developed under SSDI funds and will be released for use in summer 2002. This index is in development for NM Youth. A copy of the general index is found in the Appendix.

/2003/Given all of the challenges New Mexico faces to improve the health of the MCH population with limited funds, the Title V MCH Program continues to maximize resources, demonstrate creativity, and employ evidence-based strategies to impact health outcomes. Although the impact of September 11th was not as destructive financially for New Mexico as other more industrialized states, the effects were felt in the halting of progressive policies and procedures that were being proposed, and in the thinking about the immigrant population. The sentiment around the incident and the national initiatives to develop Homeland Security took precedent over the MCH population. Any discretionary funding for positions was redistributed to the cause. With funds to prevent bioterrorism, the infrastructure to deal with an incident was developed, communications technology was improved, and there was an increased awareness regarding the needs for public health infrastructure. Fortunately this infrastructure and technological improvement will benefit NM in any kind of disaster or outbreak situation.

In regards to racial and ethnic disparities, NM continues to develop and analyze data with ethnicity and race in mind. The Public Health Division and the Department have increased awareness of the need for cultural competence in services and linguistic access, and are working to improve existing operations. An Office of Workforce Development and Health Equity has been created under the Division Director. A task force with representation from Title V CMS worked on recommendations for assuring linguistic access for clients and presented them to the Division Leadership.

/2004/ NM continues to rank amongst the poorest of states; an estimated 18% of the population total lived =100% poverty 1999-2001 CPS. NM Kids Count 2003 summarizes key issues: 34% of families with children are headed by a single parent; 26% of children lived =100% FPL (nearly twice the national figure of 17%); 30% lived with parents who do not have full-time, year round employment; 45% of children lived in neighborhoods with a poverty rate greater than 18.5% (nearly twice the national figure of 23%); 11% of teens are high school drop outs; and 10% of teens age 16-19 were neither in school or working. More details about New Mexico's socio-economic status and its children are available at [www.aecf.org](http://www.aecf.org). NM ranked among the 4 states having the greatest food insecurity. //2004//

***/2005/Strategic Plan: The Strategic Plan for 2004 remains incomplete. Senior management redesigned the format of the DOH Strategic Plan. They plan to devise strategies and measures for five themes: Access, Health status, Quality, Workplace, and Emergency Preparedness & Environmental Health. The new administration has added a new introductory section of the department's Strategic Plan. This section includes information on the department's vision, mission, principles, core functions, a discussion on safety net and health disparities in New Mexico. This information reflected the new direction the department prioritized. /2005/***

***/2004/ The Department of Health Strategic Plan, 2000-2003 In the spring of 2000 the Department of Health undertook a department-wide strategic planning process that embraces all Divisions of the Department with processes for input by key partners and stakeholders. The Strategic Plan began with two parts: 1) a description of the mission of the Department, philosophy and guidelines for public health practice and quality improvement; and 2) detailed statements of goals, objectives, performance measures and health indicators. As it evolved, the DOH strategic plan developed five program areas: I. Prevention, Health Promotion and Early Intervention; II. Health Systems Improvement and Public Health Support Systems (includes epidemiology and surveillance); III. Behavioral Health Systems; IV. Long Term Care; and V. Administration. MCH issues are centered in program area I, but are found throughout the strategic plan. It has become a policy document: all RFPs, contracts, and Program Expansion***

**Requests must show a relationship to the Goals and Objectives of the Strategic Plan. Selected performance measures are now reported, by law, to the legislature on a quarterly basis. These include but are not limited to teen births and the proportion of DOH female clients who are screened for Violence, Alcohol, Substance abuse and Tobacco (the VAST initiative). It is a living document, with revisions made each year. The FHB and its Title V MCH, Title X Family Planning, Families FIRST and WIC programs was represented in each year's working groups: 2000-2002, Penny Jimerson and Susan Nalder; 2003 to present, Victoria Parrill. Susan Nalder was re-assigned to Program Area II that addresses public health surveillance, epidemiology and evaluation. A copy of the most current edition is easily accessed at [www.health.state.nm.us](http://www.health.state.nm.us).**

**It is expected that with strategic planning the Department will be in a better position to adequately utilize performance based budgeting, which is required by the NM State Legislature. In 2003 an office of strategic planning and performance budgeting was created. Staff include Penny Jimerson and Vicky Howell, PhD, an epidemiologist who is highly experienced with MCH health indicators and data systems.**

**//2005/Children's Cabinet**

**The Title V Director has represented the Department of Health on the Governor's Children's Cabinet this year. The New Mexico Children's Cabinet was created to oversee and coordinate cross-departmental efforts that:**

- ? Promote and establish comprehensive policies impacting children and youth**
- ? Assess and maximize resource allocation**
- ? Remove administrative barriers to obtaining departmental services and assistance**
- ? Track NM indicators concerning child and youth well-being**
- ? Encourage partnerships that elevate the conversations, expertise, research, and action regarding New Mexico's children and Youth**

**Principles: New Mexico's Children's Cabinet operates under a youth development framework, to ensure a comprehensive approach to the varying needs and realities of children and youth as they transition and develop through ages 0-24. This includes such principles as:**

- ? Balancing efforts to intervene in crisis situations with efforts to prevent problems before they occur, promote positive growth and development, and engage young people in constructive roles to better their communities**
- ? Ensuring that children and families are able to access all services the first time requested and within a "one stop" model**
- ? Addressing the needs of children and youth by focusing on the whole child, within their family and community context**
- ? Fostering government collaborations with families and communities**
- ? Giving young people a voice in all major decisions which affect their lives and communities.**

**Outcomes and Indicators: In addressing its vision, mission, and principles, the Children's Cabinet has articulated 5 specific outcome areas, to ensure a comprehensive approach to the full range of ways young people grown and develop. Additionally, the Children's Cabinet has begun a process of defining indicators for each outcome area. As this work advances, the indicators will be balanced across all areas of development, from avoiding crises to promoting community engagement, in line with the Children's Cabinet principles. A legislative agenda for SFY2005 will target the needs of children ages 0-5. //2005//**

**//2003/ Vision of Health In the period 2000-2003 the New Mexico Department of Health engaged a process of developing the Vision of Health for New Mexico. The Vision of Health document focuses on key health status indicators in areas where improvement in health outcomes is most needed. As a statewide vision, it is hoped the document will promote alignment and coordinate stakeholder input and engage private and public partners across all sectors in developing strategies to impact these health indicators. In January 2002 the NM DOH released its Vision of Health document. It is being used extensively to invite private and public health sector entities to participate in making NM a healthy state in which to live. Three priority areas are identified: Promoting healthy families (a focus on reducing births to teens, unintended pregnancy, and family violence); Breaking the Cycle of Substance Abuse (focus on reducing youth's use of alcohol, tobacco and substances); and Improving**

the quality of life (focus on health in disabled & elders, reducing chronic diseases and reducing intentional & unintentional injuries). Title V and other MCH activities are clearly aligned and incorporated into this document. It is also clear that the Department of Health cannot do this alone. /2004/ Quality Improvement: In an effort to make New Mexico a healthy place to live and grow, the Secretary of the Department of Health has appointed a Council to focus on Quality Improvement. The Department employees over 3,800 individuals located in every county of the state. The Council will use Quality Improvement Teams to focus on: Employee relations/satisfaction; processing financial documents; processing personnel actions; and the development of an ethics committee. The advantage of the Title V Block Grant funds is its flexibility for use in maintaining a safety net for some prevention and primary care services for populations that would otherwise not receive services. The funds also allows families to access existing services which may be categorical in nature, programs to assess the maternal and child population, population based screening efforts to be implemented, and to work toward developing a comprehensive service delivery system that meets the diverse needs of all individuals. Processes to determine importance, magnitude, value & priority of competing factors for assuring access to health services for the MCH population include collaboration to ensure access to and use of primary preventive health care services: Medicaid, S-CHIP, DOH and CYFD; and initiatives to Promote Collaboration between DOH and entities serving the Native American Populations. DOH Priorities in July 2004, The top priorities of the new administration and the Department of Health were announced: immunization, obesity, teen pregnancy and youth suicide. They include a focus on: 1) Immunizations to improve immunization coverage among children, including an immunization registry; 2) Behavioral health services to address high rates of alcohol and substance abuse and their associated co-morbidities and social disparities; and 3) a Statewide comprehensive health plan. //2004//

## B. AGENCY CAPACITY

***//2005//The Family Health Bureau assumed management responsibility for the Abstinence Education Program this year. The program was transferred from another division. This abstinence education grant will be administered by one person under the direction of the Bureau Chief. It currently administers 7 local contracts for abstinence education as well as one major evaluation contract and one large media contract. In addition, the County MCH Councils were transferred from the Family Health Bureau to the Office of Health Promotion and Improvement in the PHD Director's Office. This will change the nature of the MCH County Councils from focusing primarily on MCH issues to focusing upon health across all ages. Although, the Legislature had passed the Maternal and Child Health Plan Act, which states the Department may fund Councils to conduct assessment, planning, coordination and evaluation. It is the Department's interpretation that in aligning with the statute, the Department should not fund direct services out of the funds for County MCH Councils. There seems to be nothing in the Act that requires DOH to contract with Councils for direct services, only that the Department contract for necessary services that the Council identifies in an approved plan.//2005//***

***//2005//The Maternal, Child, Adolescent and Family (MCAF) Section: Maternal Health continues to oversee direct prenatal care services in ten to thirteen local public health offices, while maintaining partnerships with private providers to ensure availability of prenatal care to medically indigent women where possible. For high-risk medically indigent prenatal clients, the program administers a fee-for -service fund for qualified private care providers. The Maternal Health program regulates and licenses the practice of licensed midwives and certified nurse midwives (CNMs). There is also a partnership with UNM Hospital to bring prenatal care to urban medical indigents through the Maternal and Infant Care Project. In 2002, 30% of births in New Mexico were attended by CNMs. This percentage has risen steadily since 1983, and is expected to continue. A current barrier to CNMs' practices is the lack of CNM admitting and discharging privileges at almost all hospitals. This is exacerbated by JAHCO's recent policy statement that if a woman appears at a hospital in false labor, a physician must assess her before she can be discharged.//2005//***  
The Child and Adolescent/Youth Development Program /2004/The Adolescent/Youth Development

Program concentrates on primary prevention related to assets building and increasing protective factors that will reduce high-risk behavior and the inclusion of youth in planning, implementing, and evaluation of programs/activities serving youth. //2004//

Health and Health Related Services to Children: Affordable and quality childcare is an identified need in every county in New Mexico. County MCH Councils work locally to improve access to providers and to provider training, and staff of the MCH Unit work with the Department of Children Youth and Families to provide technical assistance for health and health related issues in childcare. New Mexico's Title V MCH staff provides intensive technical assistance.

Childhood Injury Prevention: Program staff worked on use of seatbelts, infant car seats and use of helmets for cyclists. Staff is also involved in environmental issues affecting children such as pesticides, radon, and childhood asthma triggers.

***/2005/ Environmental health, as well as safety, has become a much larger priority for program staff because of the dramatic increase in the incidence of asthma, allergies, and learning disabilities. Collaboration with the American Lung Association and other community agencies on a grant from the EPA produced a new prevention curriculum entitled "Healthy Environments and Living Places", with different protocols for homes, commercial daycares, and schools. Collaboration with other state departments and agencies on the Healthy Child Care grant initiative from the MCH Bureau produced another curriculum specifically for home daycares entitled "Improving the Safety of Child Care Environments." //2005//***

Children's Medical Services (CMS) serving Children and Youth with Special Health Care Needs (CYSHCN):

The Healthier Kids Fund (HKF) is funded by the state general fund and administered by CMS since 1995, and provides primary care coverage for all children ages 3-19 years with no other payment source. Due to limited funding, new enrollment was curtailed in January 1999; income eligibility guidelines of 300% of poverty have been implemented and the program operates on 50% of its budget. There was a 55% decrease in the size of the HKF Program as SCHIP was implemented, but there are still many children who are not eligible for New MexiKids and would be eligible for HKF if that program were accepting new enrollments.

***/2005/The Children's Medical Services Program, under which the Title V CYSHCN Program is located found it necessary to close the Healthier Kids Fund Program in order to sustain CYSHCN Program. The HKF Program was a primary care program for low-income school-aged children who are Medicaid & SCHIP ineligible. The CYSHCN Program is no longer able to cover certain ENT diagnoses because of increased medical and pharmaceutical costs and diminishing Federal and State funding. The State continues to experience funding shortages due to the increasing costs of the Medicaid Program .***

***In FY04 the CYSHCN Program was being reimbursed by Medicaid for care coordination services for CYSHCN fee-for-service clients. The HKF Confidential Services funding was being administered by Family Planning. The SALUD! MCOs reimburse the CMS Program at a modest rate for specialty clinic services for enrollees.***

***The work of the Enchanted Rainbow Children's Care Collaborative continues even though it is unfunded. The Collaborative meets quarterly to address issues of care coordination for CYSHCN. The focus is on children birth to age 6 with an emphasis on behavioral health and early referral for developmental screenings for newborns. The collaborative consists of State agencies, parents, Salud HMO's, UNM and early intervention providers.***

***The Infant Mental Health Collaborative Committee has met monthly to develop a statewide strategic plan for Infant Mental Health in New Mexico. The Plan was disseminated widely throughout the state. An RFP was initiated by CYFD to begin implementation of the plan. The collaborative consists of mental health professionals, parents, state agencies, early intervention providers, Medicaid and Salud HMO's, and UNM all of whom are concerned and interested in the promotion of Infant Mental Health in NM. //2005//***

Double Rainbow As a Part C case management provider in several counties CMS participated in the Double Rainbow Project in Sandoval County to develop a responsive system of health care with Medicaid MCOs for children eligible for IDEA, Part C. ***/2005/ Due to funding limitations, CMS was unable to hold its annual Statewide Meeting. //2005//***

Medical Home including Youth in Transition /2002/ CMS collaborates with Human Service Department/Medical Assistance Division partners to address quality of care issues such as care

coordination, adolescent transition, Medical Home and partners with HSD/MAD and Lovelace SALUD! a managed care organization serving Medicaid clients. The partnerships generate participation in the MCH Collaborative addressing statewide efforts to bring families into medical homes and to educate providers/families about the medical home concept.

***//2005/ Medical home update: In 2002 CMS and its partners planned and delivered a Medical Home Training for Providers. Two major statewide training events were delivered to the staff of the CYSHCN program and parents of CYSHCN attending the Parents Reaching Out Conference. The Medical Home survey of family practice physicians and pediatricians was included in the Epidemiology Newsletter reaching 4,000 organizations and individuals in New Mexico. Steps have been taken to include medical home in the residency-training program for the UNM School of Medicine for pediatrics and family practice. The Medical Home partnership continued to be strong. The Title V CYSHCN Director for CMS serves on the UNM advisory board. In 2004 the Medical Home project was in five sites in New Mexico. CMS provided the social work component of the medical home team in clinics that are receiving training. In 2005, while these Medical Home activities continued, the UNM Medical Home Grant is coming to a close. //2005//***

Youth in Transition with Special Health Care Needs The CMS program continues its efforts to raise awareness of Adolescent Transition with client families and local communities.

//2002/ Healthy Transition New Mexico is coordinated through the Healthy Transition Community Council and CMS, Title V CYSHCN program.

***//2005/ The Healthy Transition New Mexico coordinating committee (HTNMCC) held a second "Tools for Transition" conference in the Fall of 2003. The Council is strategizing activities for the upcoming year. CMS is currently applying for additional incentive funding from the Champions for Progress Center which is intended to fund an additional series of annual and regional Transition trainings Statewide. //2005//***

National Leadership and NM CYSHCN Program The Title V CYSHCN Director will serve on the Institute for Child Health Policy Advisory Board and the National Center for Cultural Competence Advisory Committee in the development of a monograph for services. She will also serve on the committee planning the MCH Leadership Conference. She currently serves on the DOH -ICDS team, and the Quality Human Resources Team. //2004//

Supplemental Security Income (SSI) and CYSHCN in NM CMS participated in the SSI Coalition to ensure that children with SSI benefits and those denied services have sufficient resources to navigate the system. This team made a decision to close this coalition as it had met its' original charge.

//2004/ CMS continued to receive lists of children in New Mexico who were denied SSI until the New Mexico social security administration's new computer program lost capacity to create the report. Once corrected, CMS will receive the report of children who were denied SSI. //2004//

Newborn Genetic Screening The newborn genetic screening and prevention section was transferred to CMS. Work continues to integrate the program with traditional CMS activities.

***//2005/ Metabolic Outreach clinics continue with an expansion statewide. Most of the CMS funded PKU clients were transitioned to private insurance after the passage of legislation that required insurance coverage for special foods and formula for in-born errors of metabolism. The SLD short-term follow-up nurse position was filled and is now vacant. For FY '05, funding for Newborn Intensive Care Unit (NICU) and the Sudden Infant Death Syndrome (SIDS) Program was eliminated. The safety net is still in existence through UNM funding. In addition the Sickle Cell Council funding, which provided counseling, education and screening services has been lowered.***

***Genetics Screening trainings were held throughout the state to upgrade compliance of screening activities. A UNM pathology residents training was developed, and courses were presented. //2005//***

//2003/ CMS developed statewide Metabolic Outreach clinics to treat children with metabolic conditions, particularly for the management of phenylketonuria (PKU). A multidisciplinary team provided clinical and follow-up services throughout the state. The clinics operate in partnership with UNM's School of Medicine, Department of Pediatrics, Genetics and Dysmorphology and CMS staff. An additional nurse position is being created to provide short-term follow-up and surveillance activities.

//2004/ HB 289 was passed in the 2003 State Legislation that requires health insurance coverage for medical diets to control genetic inborn errors of metabolism. The law assists insured individuals with

PKU obtain metabolic foods and formula through their health insurance. A PKU Food Fund was initiated providing various metabolic foods to 14 PKU clients in the state. Metabolic Outreach Clinics continue with services statewide. The CMS nurse consultant focuses on long-term follow up and statewide education to birthing hospitals. A newborn screening follow-up and tracking form was developed and is used by Family Infant Toddler (FIT) program's social workers to provide comprehensive, coordinated, continuous and family-centered health care.

A partnership between the New Mexico Sickle Cell Council, the University of New Mexico, Office of the Medical Investigator and SIDS Information and Counseling Program was initiated to collaborate on educational outreach efforts targeting the African American population. The 2003 State Legislation awarded the New Mexico Sickle Cell Council an additional \$15,000 to provide education, screening and counseling to individuals identified with sickle cell traits and other hemoglobinopathies. //2004// Follow Up of NICU Infants UNM's Newborn Intensive Care (NICU) Developmental Care Program continues to maintain coordination of follow-up, referral tracking and communication between NICU staff and families in need of service. Infants with a high environmental risk are referred to CMS for prevention and tracking for developmental delay.

/2004/ A new follow-up and tracking form was implemented. The average response rate by CMS improved to 50%, although a three-month period showed an increase to 85%. //2004//

Newborn Hearing Screening:

***/2005/ The Newborn Hearing Screening Program underwent a MCH/CDC audit recently. The report will be forthcoming. The program continues to work toward the refining of data collection and follow-up activities. NM hospitals have a 4-variable section on newborn hearing screening that is completed with electronic birth certificate (EBC) registration. Significant progress was made in 2003 from 30%--80% of hospital births having this information on the EBC file. The program will set up an electronic file for referrals made from hospitals and that go to CMS social workers in the field; 2003 data will be entered. An evaluation of program performance using 2003 data (including evaluation of the data itself) will be done by Tierney Murphy, MD, MPH, a CSTE-CDC MCH fellow assigned to the MCH Epidemiology program in FHB. //2005//***

Other CMS Needs Until recently, chronic orthopedic and rehabilitation service needs of children in New Mexico were provided for children with insurance, Medicaid, or no payor source through Carrie Tingley Hospital (CTH). When CTH merged with the UNM Medical Center few children without a payor source were able to receive services. CMS's resource limitations prevent program expansion to meet this need. /2004/ The lack of services to address the chronic orthopedic and rehabilitation needs of children continues to be a major concern especially for immigrant children in New Mexico. //2004//

***/2005/ The lack of services for chronic orthopedic and rehabilitative needs for children without a payor source continues to be a challenge. The challenge is met by careful and astute care coordination and resource identification. Some of the patients who can travel are receiving their services at Shriner's Hospitals out of state. Carrie Tingley does provide services and attempts to work out payment arrangements with these families. //2005//***

MCH Epidemiology carries out processes to determine the importance and magnitude of problems including the Title V health status assessment and updates of historical assessments, and specific surveillance initiatives of PRAMS, BDPASS, MMR, CFR, analysis of linked birth infant death files for 1987-1998, and the 1996 report for Linked Medicaid-Live Birth analysis to monitor maternal and infant health. Indicators were established using the Healthy People 2000 and 2010 document and collaborative assessment and planning between the state and local health offices.

***/2005/ The MCH Epidemiology Program is slated to include epidemiology and data services related to 1) the Title V MCH Block Grant for evaluation of child health, a focus on nutrition and obesity, and WIC data, as well as the upcoming comprehensive assessment; and 2) children with special health care needs that would include BDPASS, 3CR, newborn hearing and newborn genetic screening, and analysis of the CYSHCN/SLAITS data for the state. The FHB team is working to assemble funding, staffing and an organizational plan for the unit and how it relates to FHB in its expanded functions.***

***The CMS Program will fund an epidemiology position within the MCH Epidemiological Program. The program was stretched beyond capacity to meet the additional CMS data requirements. The position is based on a study of CMS program data collection, analysis and interpretation needs; it will be submitted for creation in July 2004. //2005//***

The WIC, Commodity Supplemental Food, and Farmers Market Nutrition Programs are now located in the Family Health Bureau, affording closer coordination of services to mothers, infants and children, including CYSHCN. The new information system is one of the top five in the country. The WIC Program is piloting a WIC Smartcard Chip on the food stamps electronic benefits card, which will allow greater flexibility for both clients and grocers. The new information system will provide increased data on health status of the MCH population. The many WIC sites have been extremely helpful in distributing components of the "From Day One" and "Day Two" parent education materials.

***//2005/ The WIC Program was the first in the nation to pilot a hybrid electronic benefits transfer card for WIC recipients using a cost effective model. This bare bones approach to WIC EBT was piloted in 7 local stores in TorC, Hatch, and Arrey New Mexico. Soon thereafter, the Texas WIC Program started their joint pilot in the El Paso area.***

***The Family Planning Program's emphasis continues to be on: Direct medical services including physical exams; breast, cervical and testicular cancer screening; hypertension screening; anemia screening; sexually transmitted disease (STD) testing and treatment; pregnancy testing; and offering contraceptive methods. Health education and counseling services include reproductive health, contraceptive methods, STD and HIV risk reduction; infertility counseling. Community services include data collection and monitoring for trends; identifying strengths and gaps in services; participating in community committees and councils; and educating communities on reproductive health.***

***to design a prototype for the nation.//2005//***

Family Planning Program efforts are directed at unplanned and untimely pregnancies which comprise an estimated 50% of live births, sexually transmitted infections and other reproductive health risks in the New Mexico population with a particular emphasis on teen pregnancy and male involvement in its prevention efforts. Local public health offices and providers who have contracts/agreements with the state provide family planning services throughout the state. Family planning activities are collaborative between federal, regional, state, local, profit, and non-profit organizations/agencies. Special focus projects include the Family Planning 1115 Medicaid Waiver; male involvement; the identification, assessment and referral for: violence, both domestic and sexual, alcohol, substance abuse, tobacco use (V.A.S.T.); sexual coercion; sterilization; quality assurance; adolescents; clinic management; and data management/fee collection. In July 1998, the Family Planning 1115 Medicaid Waiver extended services for five years uninterrupted to all women at 185% of poverty. In July 2003, HSD/Medicaid applied for continuation of the waiver with input from Title X FP program and data from NM PRAMS. The 1115 Medicaid Waiver is a fee-based service, allowing basic monitoring of program outcomes despite the rapid implementation of SALUD!

***//2005/The Family Planning Program's emphasis continues to be on: Direct medical services including physical exams; breast, cervical and testicular cancer screening; hypertension screening; anemia screening; sexually transmitted disease (STD) testing and treatment; pregnancy testing; and offering contraceptive methods. Health education and counseling services include reproductive health, contraceptive methods, STD and HIV risk reduction; infertility counseling. Community services include data collection and monitoring for trends; identifying strengths and gaps in services; participating in community committees and councils; and educating communities on reproductive health.//2005//***

***//2005/ The New Mexico Abstinence Education Program seeks to reduce the percentage of out-of-wedlock births and the incidence of sexually transmitted diseases with the help of community-based organizations, throughout the state, that teach programs promoting abstinence. Since 1998, the Department of Health has contracted with hospitals, educational institutions, crisis pregnancy centers, faith-based organizations and community partnerships. The contractors provide a variety of abstinence-based educational programs and services to adolescents, parents and youth workers in their local communities. In addition to classroom instruction for students and parents, their projects include mentoring programs, teen panels, community presentations, and train the trainer workshops. To complete the program, a multimedia campaign and an evaluation team have been secured. The abstinence program seeks to address the facts that New Mexico's teen birth rates are third highest in the nation (National Campaign to Prevent Teen Pregnancy); and according to the U.S. Census Bureau, in 2002, the teen birth rate for females age 15-19 in New Mexico was 62, compared to the U.S. average of 43. The goal for New Mexico is to reduce the teen birth rate to 54.1 by the end of***

**2005. Of a related nature, in 2004 New Mexico ranked 5th highest nationally for chlamydia, and primary and secondary syphilis case rates. The Abstinence Education Program will contribute to the decrease in teen births and incidences of sexually transmitted diseases (STD). Program reports show that approximately 8,000 students and parents have been served each year through the Abstinence Education Program.//2005//**

**/2005/ During state fiscal year 2003 the Family Planning program utilized Title V funds for eight adolescent pregnancy prevention contracts in Dona Ana, Rio Arriba, Taos, San Miguel, Rio Arriba, and Colfax counties. TA and evaluation contractor Judith Seltzer works with New Mexico Teen Pregnancy Coalition. has a technical assistance contract and Judith Seltzer is contracted to provide professional evaluation. The adolescent pregnancy prevention coordinator worked closely with each site, specifically those who had never contracted with the state of New Mexico in previous years. The program funded The Economic Impact of Teenage Childbearing in New Mexico by Phillip Ganderton, PhD from the University of New Mexico, Department of Economics. The study is cited in many presentations since its inception. In addition, the program is contributing to work on teen pregnancy, one of the state priority health issues. In spring 2005 a white paper was developed, with input from various medical personnel as well as members of the community who work to prevent teen pregnancy. The white paper will go on to an advisory committee; a final draft will then be presented to Governor Richardson on July 1, 2004. The Challenge 2005, 2004 update was presented on May 5, 2005, the National Day to Prevent Teen Pregnancy at the New Mexico Teen Pregnancy Coalition Conference. Ten counties are on target for reducing their teen birth rate in New Mexico. The ten counties are: Cibola, Colfax, Eddy, Grant, Guadalupe, Lea, Los Alamos, Luna, Sierra and Torrance. The Department of Health was recognized for its achievements in reducing teen pregnancy in New Mexico. //2005//**

Families FIRST is a perinatal case management program to assist appropriate individuals in gaining access to needed medical, social, educational and other services to Medicaid eligible pregnant women and children ages 0-3. Case management services include coordination with providers of medical and non-medical services such as nutrition programs or education agencies, when these services have been identified as necessary to foster positive pregnancy outcomes and promote healthier infants and children. Families FIRST Program successfully negotiated contracts with the three Medicaid Managed Care Organizations (Cimarron, Lovelace and Presbyterian)

**/2005/ Families FIRST has a provider network of 39 sites statewide. They cover 25 out of 33 counties in the state and consist of 23 Local Public Health Offices and 16 Private Contractors. Between July 1, 2002 and June 30, 2003 Families FIRST provided case management services to 2,550 Pregnant Women and 2,530 children. This program receives no Title V funds at this time. The Program continues to work on a system of receiving referrals with the HSD/MCOs and WIC, and with various community agencies. Families FIRST continues to collaborate with the MCOs to assist pregnant women with the Medicaid application process to improve the state's performance on early entry into prenatal care.//2005//**

**/2005/Family Violence, Prevention and Policy Work**

**The 2003 report Let Peace Begin With Us: The Problem Of Violence In New Mexico, which outlines violence statistics by county, and includes resources and highlights of programs that work, continues to be disseminated and used widely throughout the state by both policy makers and non-profits. The Network Coalition against domestic and sexual violence continues to expand its influence and function well. The award winning video entitled "Stolen Childhood" has continued to be distributed widely. There has been increasing attention to the issue of children who are exposed to violence in the state. The Medical Director helped craft the final report on this issue for the newly formed Governor's Task Force on domestic violence. He also supports a wide variety of men's wellness activities continue to occur through the state, addressing issues of male violence prevention, healthy fathering and outreach to young men.//2005/**

**The Dental Program.**

**/2005/ The Family Health Bureau and the Dental Health Program collaborated on the submission of a HRSA grant for dental services. The grant will afford the Department the chance to hire a Medical and Public Health Social Worker (One FTE base salary for 5 months) to serve as a case manager. The dental program case manager shall coordinate intake,**

**assessment of oral health needs, financial eligibility determination and referral services to women, children and their families who are eligible or presumptively eligible for Medicaid or SCHIP or who may qualify for oral health treatment services on a sliding fee scale. The case manager shall also actively participate in oral health surveillance activities with the project.//2005//**

**/2005/Public Health Division Integrated Information System (INPHORM): The INPHORM system's integrated client data system has serious limitations that need to be addressed. Data reports are known to have gaps. The Title X Family Planning Program, under Lynn Mundt's leadership, worked to rectify data quality. A new software called SNAP features hard copy forms that can be scanned directly into a SNAP database, and then uploaded into INPHORM. From July-December 2005, all client encounter records (in hard copy) will be done in SNAP format. This will bypass data entry needs and hopefully improve quality. SNAP also has a survey function that is being used by Family Planning to obtain essential quality assurance information from the client and provider populations.//2005//**

**/2005/HIPAA Update, the DOH is a covered entity; all staff are required to complete web-based training; new staff have 10 working days to complete it. The status of public health surveillance, exempted from federal HIPAA rules, continues to be explored.//2005//**

**/2005/Collaboration with Community, Provider and Consumer Groups:**

**The Title V Director participated in activities of the Rocky Mountain Public Health Education Coalition, the Governor's Children's Cabinet, 4 Early Childhood Comprehensive Systems Grant committees, the EPSDT Taskforce, Action for Healthy Kids, the Governor's Council on Physical Fitness, and the Immunization Coalition.//2005//**

**IHS and Tribal Health: The IHS Albuquerque Area and Navajo areas, tribal health entities such as the Health Services Division of the Navajo Nation and the WIC Program of the Navajo Nation, and tribal WIC Programs, provide MCH Services for Native Americans entity status of DOH.//2005//**

**/2005/ The Family Health Bureau Title V Director and the Adolescent Health Coordinator took part in American Indian Day at the Capitol Roundhouse providing health fair information to all of the tribes in New Mexico. This is a major gathering of all the tribes in New Mexico and an opportune time to interact with them. The Youth Development Action Council played an active role and Spirit Awards were given to youth in attendance for leadership.//2005//**

**/2005/Action for Healthy Kids (AFHK), a nationwide initiative dedicated to creating health-promoting schools that support sound nutrition and physical activity, is composed of 51 state teams and a national coordinating and resource group. It is an out growth of the 2002 Healthy School Summit and was formed in response to our nation's epidemic of overweight, sedentary, and undernourished children and adolescents. AFHK operates under the umbrella of "Healthy Schools, Inc.," a non-profit, non-member organization established to further the goals of the Healthy School Summit. In New Mexico, the state's AFHK program's mission is to improve children's nutrition and physical activity in the state's schools by collaborating with stakeholders in advocating, educating, promoting, and implementing state initiatives to enhance the school health environment, so children can learn and participate in positive lifestyle factors, including good nutrition and regular physical activity. In Spring 2004 the NM AKHD forum, including the School Health Unit in the NM Public Education Department and the DOH's Office of School Health, gathered key stakeholders to identify strategies to support New Mexico schools in collaborating with families and communities to help students build and maintain healthy, lifelong nutrition and fitness habits. The Title V Director and the Title V Child Safety Coordinator participated. //2005//**

## **C. ORGANIZATIONAL STRUCTURE**

C. Organizational Structure

Note: (Org Chart attached)

**/2002/ In June the Family Health Bureau (including the Dental Program) moved into the Colgate Building at 2040 South Pacheco, about six blocks from the main DOH building. This is the first time the entire Bureau has been in one building in the last decade. Organizational charts for the Family Health Bureau and the Public Health Division of the Department of Health are in the Appendices.//2002//**

/2004/ The Title V MCH programs are located within the Family Health Bureau of the Public Health Division (PHD), in the New Mexico Department of Health (DOH). The new Secretary of the DOH, Patricia Montoya is a Cabinet Secretary and reports directly to the Governor. There are two deputy secretaries, Fred Sandoval for programs and Gary Giron for administration. 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.

A new analyst at the Department of Finance Administration (DFA) has been assigned to the DOH; the FHB Chief and her team will be providing an orientation to Title V MCH and other FHB programs, a critical presentation for continued progress in the policy and financial domains. Other department-wide organizational changes include a new team responsible for the DOH Strategic Plan.

Joyce Naseyowma-Chalan was named Public Health Division Director in January 2003. The PHD Director's Office includes two Deputy Directors: Toby Rosenblatt and Patsy Nelson, both of who provide guidance and support to the FHB. Mr. Rosenblatt oversees financial functions for the PHD; Ms. Nelson is responsible for programmatic oversight and support for the FHB.

Jane Peacock was named Family Health Bureau Chief in December 2003. Dr. Victor La Cerva, pediatrician, remains the Medical Director for the Bureau. The Bureau administrative staff consists of a part time Medical Director, an Administrator, a Systems Analyst, and a Clerk Specialist position that was filled in summer of 2000.

Many system changes have occurred this year. The most significant, of course is the election of Governor Bill Richardson. Consequently, there has been considerable change in the operational portion of the program. Additional changes are expected and are in process. The contracting process for DOH has slowed down considerably due to a panel review process created by the Office of the Governor. Also, new to New Mexico, the Cabinet Secretaries from the Department of Health, Human Services Department, Children, Youth & Families, and the Aging and Long Term Care Departments have scheduled a series of meetings Statewide to address State Health and Human Services Initiatives. These four initiatives include Statewide Comprehensive Health Plan, Behavioral Health Plan for Children, Long Term Care Plan for Seniors & Individuals with Disabilities and Medicaid System Redesign. //2004//

***/2005/ The PHD Deputy Director Toby Rosenblatt retired; he was replaced by Dorothy Danfelser. Ms. Danfelser has extensive state government experience, and participated in the team that developed the Families FIRST case management program pilot.***

***/2005/ Family Health Bureau and Public Health Division Organizational Changes  
The Family Health Bureau has gained one program and another has been transferred to the Director's Office. In July 2003, the Abstinence Education Program was transferred into the FHB from the Behavioral Health Services Division. The Bureau initially placed the Abstinence Program within the Family Planning Section of the Bureau, however, it has since been moved directly under the supervision of the Family Health Bureau Chief. This is due to its controversial nature and the oversight required by the Department Cabinet Secretary. That program consists of one Health Educator who administers contracts within local communities that deliver abstinence education to prevent pregnancy.***

***The other program transferred to the Public Health Division Director's Office was the Maternal Child Health County Councils Program. This critical network of county councils serves 28 counties in New Mexico. The Cabinet Secretary chose to combine these councils with other Comprehensive Health Councils to streamline services within communities. Those councils will now report to the Office of Health Promotion and Community Health Improvement in the PHD Director's Office. //2005//***

***/2005/ Departmental Reorganization***

***Department of Health FY05 Program Structure: The DOH has reorganized its Program Areas from 4 divisions to 9 program areas that reflect budgetary funding sources. This reorganization does affect Title V services and other Family Health Bureau services. In order to deliver services in local districts, which are in a separate program area, service level agreements will be necessary. Service level agreements will have to be in place July 1, 2004.***

***The nine program areas follow:***

***The program area entitled Prevention and Health Promotion houses the Family Health Bureau Programs, Infectious Disease Prevention and Treatment, Fetal Alcohol Prevention, Improving Health Initiative, and Chronic Disease Prevention and Control. Remaining in the same division,***

**yet moved to a different program area, are all the Public Health District Offices and other local offices. Also moved to that new program area are Office of Border Health Clinical Services, Rural Health Care / Primary Care Health Systems, the Office of School Health, and Dental Services. //2005//**

**/2005/ Information Technology Consolidation:**

**The Governor signed an Executive order to consolidate all information technology (IT) operations in State Government. The terms include consolidation of all IT functions and staff within cabinet and executive agencies, who then reported into the agency CIO or IT leaders of that agency. The order gives the Governor's Chief Information Officer control and management of all IT expenses within the agency, either by the establishment of an independent IT organizational budget or by the establishment of administrative financial controls of IT expenses within existing agency budgets, subject to the approval of the cabinet secretary. The cabinet or executive agency CIO has approval authority over all agency IT-related spending, subject to the approval of the cabinet secretary. The cabinet or executive agency submits a complete inventory of agency IT hardware, software and licenses in a standardized electronic format, to the Office of the CIO no later than June 1st, 2004. The order froze purchase of any IT equipment until the submitted Plan was approved by the Governor's Chief of Staff, including all purchasing of IT equipment, services and software (for example: network equipment, personal computers, servers, e-mail software and hardware, etc.). Telecommunication equipment and personnel were expressly exempted from this section and this Order. Exceptions were made for purchases that are critical to DOH. All hiring of IT infrastructure staff was frozen until the Plan was approved by the Governor's Chief of Staff. Exceptions were made for IT infrastructure staff that are critical to DOH operations and projects. The freeze did not apply to application/database development and support staff. The impact of this order on services and operations remains to be seen. //2005//**

/2003/ The Dental Program was moved to the Health Systems Bureau in September 2001, although they physically continue to reside in the same building as the Family Health Bureau, allowing for easy access for collaboration. /2004/ Ronald Romero, DDS, MPH, is the Dental Program Chief; David Hanson, DDS, is the deputy program chief. The Dental Program continues to be in the Health Systems Bureau, with easy access to the FHB/Title V MCH Agency for consultations on oral health in mothers and children. //2004//

Laws, Policies and Regulations

/2003/ Regulations were developed jointly by DOH/CMS and the Commission for the Deaf and Hard of Hearing. The CMS program has adopted the title "Newborn Hearing Screening Program" to replace the former "Hear Early Program" designation. The deaf and hard of hearing community members made their suggestions for a change of title because "Hear Early" implies that all children should or will hear. CMS.

/2004/ The Hear Early program was renamed as the Newborn Hearing Screening Program at the request of the deaf community to better reflect the intent and to honor cultural sensitive issues. The Newborn Hearing Screening Coordinator, Suzanne Pope has been providing training and technical assistance to all birthing hospitals statewide on quality screening and referral procedures for infants who receive a referral on their screening test. The hospital follow-up form was revised and distributed as well as other educational materials. The Screening Coordinator conducted trainings for CMS Family Infant Toddler staff on follow-up procedures for infants who refer and implemented a revised tracking form to determine if all infants referred receive the appropriate audiological evaluation and early intervention services. CMS in partnership with NM Vital Statistics implemented a newborn hearing screening checkbox on the electronic birth certificate. The newborn hearing screening data is matched to the birth file to determine if all newborns received a hearing screening.

Specific bills in this past legislative session that will impact operations at the Department of Health during the next fiscal year included HB 289 which was passed in the Legislative Session 2003. It requires health insurance companies to provide coverage for medical diets required to control genetic inborn errors of metabolism. Those with PKU, who are insured, will be able to use their insurance to obtain their formula, special medical foods, and to be treated by licensed health care professionals. Currently, CMS has 7 clients on the PKU Formula Program and 14 on the PKU Food Fund who are insured. The passage of this legislation will help CMS with budgetary restrictions, and will ultimately

be a cost savings to the state. We anticipate by Fall 2003, that many PKU clients will be able to use their insurance companies for formula and food coverage. CMS PKU Formula and PKU Food Fund may see a saving of \$50,000. House Bill (HB) 315 passed which requires the Department of Health (DOH) to develop and implement a public and provider education plan to increase both awareness about and accessibility to emergency contraception (ECP) in New Mexico. Fifty thousand dollars (\$50,000) was appropriated from the general fund to the DOH. House Bill HB 119 passed, requiring hospitals that provide emergency care to sexual assault survivors, include information about ECP (includes drugs and devices approved by the FDA that prevent pregnancy after sexual intercourse). Amendments required only administration of emergency contraceptive pills at the hospital to each sexual assault survivor who requests it. Problems may be anticipated with the lack of trained professionals who know about the various types of ECP and are experienced in the educating, prescribing, referring or performing procedures. During FY03 the Healthier Kids Fund maintained limited enrollment. No legislative effort was made to expand this fund. House Memorials affecting the Public Health Division included: 1) initiatives to align early childhood programs, with the lead assigned being an Interagency Coordinating Group, 2) address under-use of Food Stamps Program, with the lead agency assigned as HSD, and finally 3) development of defense against "Agro-terrorism," with the lead agency being Homeland Security. At the federal level, Senator Bingaman secured \$200,000 in federal funds to study whether to establish a dental school at the University of New Mexico (UNM). The funding will be used to perform a feasibility study on whether to open a school of dentistry by 2010. . This will help address the shortage and mal-distribution of oral health professionals and auxiliaries.

***/2005/ III. C Laws Policies & Regulations:***

***In response to proposals by the Department of Health to shift priorities and cut funding to the \$2.5M available for implementation of away from the County Maternal and Child Health Plan Act (passed in 1990 to enhance community based services for childbearing women and their families), community partners organized local advocacy statewide. The 2004 Legislative Session successfully evidenced bi-partisan support by earmarking \$1.85 to implement the Act in the Department's FY05 budget that earmarked . However, the Department proceeded to eliminate funding for direct services identified as priorities in an effort to strengthen health councils in every county for their roles in assessment, coordination, planning and evaluation.//2005//***

## **D. OTHER MCH CAPACITY**

### **III. STATE OVERVIEW**

#### **D. Other MCH Capacity**

Office of the Family Health Bureau Chief

*/2004/ Jane Peacock, FHB Chief; Victor La Cerva, Title V Medical Director (.5FTE); Monica Montoya, Administrator; Andy Gonzales, Clerk Specialist; and Susan Guthrie, Information Systems.*

***/2005/ In 2005, in an effort to streamline and optimize operations, the Department will centralize management of all IT positions, thus Ms. Guthrie will no longer report directly to the Title V Director.//2005//***

Maternal, Child, Adolescent and Family Program (MCAF)

***/2005/ Due to space limitations, only 2005 information is presented.MCAF Section: 11 staff, Victoria Parrill, Section Manager, Edna Campos, Clerk Specialist, Rima Varela, Administrator 2, Roberta Moore, Maternal Health Manager, Rick Vigil, Child and Adolescent Health Manager, Karen White, Public Health Educator, Helen Montano, Clerk Specialist, BJ Butler, County MCH Manager, Viola Romero, Financial Specialist, John McPhee, Child Violence and Injury Prevention Coordinator. Vacancies included two public health educator positions; one supported position for a Vital Records and Health Statistics Analyst. Statewide initiatives continue to strengthen community partnerships to improve access to and proper utilization of weight appropriate child restraint seats in vehicles, car seat technicians trained in the National***

**Health and Transportation Safety Association (NHTSA) curriculum, and expansion of the Safe Kids network. Additional activities include legislative proposals to requires helmets for children on for bicycles, skateboards, scooters and in-line skates, continued support for implementation of the Child Restraint Law and the new All Positions seat belt law, and finding additional funding to meet demand for free car seats for distribution to low income families.//2005//**

Children's Medical Services:

/2002/ There are 120 staff in 32 field offices along with the state department. The Management Analyst position that was frozen last FY was cut due to PHD budget constraints. Fortunately, the FIT Clerk Specialist was filled and a CMS Family Infant Toddler Program Coordinator position was created by the FIT Program in the Long Term Services Division -- an early effort in expanding this program within CMS statewide. The Staff Development Specialist was opened to be filled after a long freezing of this vacancy. The CMS FIT Coordinator and the Staff Development Specialist have recently been hired. The CMS program continues to work closely with Family Voices and presently maintains a \$20,000 annual contract with Parents Reaching Out (PRO), a statewide parent organization for parents of CYSHCN. Family advocates (parents or individuals with disabilities) participate in pediatric specialty clinics and receive an honorarium for this participation. Many staff are also parents of CYSHCN. District II CMS is fully staffed for the first time in 5 years. Hiring of social workers continues to be difficult and is becoming more so with recent legislation that compensates Child Protective Service social workers with Human Services Division at a higher rate than CMS social workers are paid. The PHD Director is addressing the issue. However, it is making it more difficult for CMS to hire the position of Social Worker Consultant created through the funding of an MCH Newborn Hearing Screening grant. This position remains open until filled.

/2003/ The CMS Manager 5 position was filled August 2001 by Sandra Baxter, LMSW, who spent many years in Long Term Service in the Department of Health. Sue Brown, the Screening and Prevention Nurse Manager retired the end of September after 26.8 years of Public Health service. The position was filled by Sherry Bowers, RN, a nurse with over 30 years of public health experience, especially in the area of working with children with special health care needs. Clerical support continues to be quite limited. The Clerk Specialist Supervisor was promoted in July; we filled the Family, Infant, Toddler (FIT) Clerk Specialist position. With such a small state office staff and so many challenges, the workload has been quite difficult. During this fiscal year, we had to renew all Provider Agreements -- over 1000 due to policy changes in PHD. Shortages in the districts, especially District IV and I have made the CMS CYSHCN program services difficult as well.

The Social Work Consultant position was relinquished during FY02 beginning year budget review and turned into a contract. The Request for Proposals was released in September to be awarded in November. After a lengthy contracting process a coordinator was selected and has begun to examine the statewide newborn hearing-screening program. Currently, there are 112 CMS staff positions in 32 field offices along with the CMS program and the Department of Health. The CMS program continues to work closely with Family Voices and presently maintains a \$40,000 annual contract with Parents Reaching Out (PRO) (a \$20,000 increase from FY01), a statewide parent organization for parents of CYSHCN. Additions and changes in the contract were targeted to increase family involvement throughout the program, thus better addressing the Family Involvement performance measure.//2003//

/2004/ (CMS) will work to have great input into each of the four initiatives of the Cabinet Secretary's cited above. In addition, the state office staff has received cross-training to assume additional knowledge and responsibility since the Administrator position was vacated. This has been a positive change in the program. During 2003, CMS filled 3 vacant clerical positions in the State Office, including the Financial Specialist, Clerk Specialist Supervisor and FIT Clerk. The Planner position, vacated by Elisa Martin, remained unfilled for approximately 14 months. The position was filled by Bruce Blair who comes to CMS with a diversity of experience in both the private and public sector. The Manager V position was also vacated during 2002, and has recently been filled by Jean Higgins. The Clinic Coordinator position was vacated in December of 2001, and was just filled by Yolanda Sisneros. Two additional State Office positions -- Administrative Assistant and half-time Medical Director -- have been recently vacated. Paperwork is being processed to fill the Administrative Assistant position and the Medical Director position is being advertised. Three of the four Districts have promoted one Social Worker to Social Work Supervisor so that they each have one Program

Manager and 2 Social Worker Supervisors (the 4th District was already operating under this model). Currently, there are 120 CMS staff positions in 32 field offices along with the CMS program and the Department of Health. The CMS program continues to work closely with Family Voices and presently maintains a contract with EPICS-CMS was unable to complete the contracting process with PRO because of a lengthy state contracting process. The contract continues to target increased family involvement throughout the program, as well as statewide efforts regarding transition for Youth with Special Health Care Needs. //2004//

**//2005//The CMS state office is fully staffed, however it is anticipating the retirement of the Screening and Prevention Nurse consultant. The CMS Manager position was filled by Jean Higgins. Ms. Higgins has considerable fiscal knowledge and experience and has been an excellent addition to the staff. //2005//**

MCH Epidemiology Program:

**//2005// Due to limited text for this section, previous listing of MCH Epi staff was deleted. The 2005 information is presented. MCH Epidemiology Program: Title V MCH Funded staff: Susan Nalder, EdD, MPH, Program Manager; Ssu Weng, MD, MPH, medical epidemiology, major assignment is PRAMS at .75FTE; Dorin Sisneros, NM PRAMS survey operations manager at .80FTE; Anne Worthington, MPH, epidemiologist for MMR and CFR at 1.0FTE. We were without a clerk for period August 2003 to end January 2004; Philip Stultz began 1/26/2004 at .25FTE Title V and .75FTE CDC PRAMS Cooperative Agreement. A PRAMS Coordinator position was created and filled in May 2004: Eirian Coronado, bilingual English-Spanish, MA Anthropology and public health surveillance experience. Contracted services funded by Title V MCH include Georgia Brand, program assistant to NM MMR and CFR .80 FTE through October 2003; replaced by Laura Crawford in January 2004; Eloise Serna, PRAMS contractor, assembles packets for survey operations at 20 hours per week.**

**The FHB team is working to consolidate epidemiology and evaluation functions within the MCH Epidemiology Unit, making modifications in Spring 2004 to better serve the data and information needs of the FHB and its many partners. It is proposed to incorporate the resources that support data, surveillance and epidemiology for the Birth Defects surveillance program, the Children's Chronic Conditions Registry (3CR), newborn genetic and hearing screening. Analysis of CYSHCN survey will also be performed within this group. Resources are being sought to create and fill positions that are essential to these functions, however with funding cuts there will inevitably be cuts in epidemiology services.**

**MCH Epi applied for and was assigned a two year CSTE-CDC MCH epidemiology fellow for period March 2004-2006; Tierney Murphy, MD, MPH to work on birth defects, newborn hearing screening. In addition, a one-year CDC assigned Preventive Medicine Resident (PMR) from CDC will work in the MCH Epidemiology unit: Ann Do, MD, MPH. Dr. Do will assist with selected dimensions of the comprehensive Title V assessment and other assignments. Positions still to be created and filled: epidemiologist/data manager for CMS related projects using federal birth defects funds; and epidemiologist for Title V MCH block grant with SSDI funds. //2005//**

Family Planning

**//2005// due to lack of space, 2005 listings are presented.**

**//2005// Family Planning currently has 15 state office staff: Lynn Mundt, Program Manager; Wanicha Coggins, MD, Medical Director; Margie Montoya, Nurse Practitioner Consultant; Barbara Hickok, Nurse Consultant; Vacant, Nurse Consultant; Dick Young, Staff Manager; BJ Thomas, Management Analyst; Saroj Baxter, Training Manager; Susan Lovett, Male Involvement and Community Education Coordinator; Carmella Salazar, Adolescent Pregnancy Prevention Coordinator; Cynthia Wittenburg, VAST Coordinator; Phil Sweeney, IT Systems Analyst; Monica Narvaiz, Planner; Genevieve Lujan, Planner; Ferminia Najera, Administrator; Roland Valdez, Financial Specialist; Lucille Duran, Fee Collection Liaison; Vacant, Clerk; //2005//**

**Families FIRST:**

**//2005// due to lack of space, only 2005 listings are presented. The Families FIRST Program has 11 positions; two are vacant: Emelda Martinez, Program Manager; Julie Colton-Nash, Social Worker Consultant; vacant= Nurse Consultant; Milee Rotunno, Management Analyst 4, Jessica Marquez, Medical secretary; Lorraine de Vargas, financial specialist; and Ruth Gonzales, Clerk Specialist. District FF Coordinators: District 1 Kathy Casaus, District 2 Brenda Romero, District 3 Jeri Tarlton, and District 4 is vacant.**

***WIC and Nutrition The new Title V Director, Jane Peacock, transferred from the WIC Program where she worked for 15 years prior to accepting the Title V position. Sid Golden, MBA replaces her in the capacity as WIC Director. Mr. Golden has 26 years of public health experience, 15 of that has been in the WIC Program.//2004//  
/2005/ Deanna Torres, MPA, was named Assistant WIC Director; she has 17 years of WIC experience. WIC currently has 208 FTE; 32 are located in the state office and the rest in the 110 sites throughout the state. //2005//  
/2005/ The Abstinence Education Program Manager Gloria Bonner assumed her position May 10th, 2004. Ms. Bonner has a BA in Education. She is a licensed teacher. Her experience as a teacher and educator will be a valuable asset in the development of this education program. She has 7 years of experience teaching in public schools and 4.5 years as a health educator in the Abstinence Program in Arizona. //2005//***

## **E. STATE AGENCY COORDINATION**

### **E. State Agency Coordination**

//2004//The Title V agency's capacity to promote and protect the health of all mothers and children, including CYSHCN is extensive, yet there remain serious challenges to that objective due to the level of poverty of the State and the lack of additional General Fund monies to meet those challenges. Therefore, the NM Title V programs rely heavily on an extensive network of federal, state and local partners who are essential to implementation of services and programs. The Title V Agency of New Mexico continues to work closely with other state agencies. Several initiatives are central to this collaboration.

Title V coordinates heavily with the WIC Program, meeting with the WIC Director weekly in Family Health Bureau Management Team meetings. At these meetings, priorities for the Title V grant are discussed at length. The WIC Director and WIC Nutrition Education Coordinator collaborated with CMS's Medical Director on a Folic Acid Study involving the use of training for WIC staff and vitamin supplements in WIC clinics. The WIC Director attended the MCH Nutrition Leadership Institute at UCLA this year and discussed the continuing activity with the LEND representatives for the state. Families First and the WIC Program signed a written agreement for sharing data to improve participation in both programs. MCH Epidemiology worked with WIC to write programming to support data linkages between WIC and NM PRAMS, NM birth files and possibly the linked birth-death files of the NMOVRHS.

The CMS program collaborates with multiple state agencies and private organizations including County MCH Councils, the MCH Collaborative, and providers, and family members/organizations who receive Title V services. The Healthy Transition New Mexico Council continues to provide for providers, family members, and youth with education about transition for adolescents with special health care needs. This funding is not limited to organizations funded by Title V. It is truly a statewide community effort. The Title V Program continues to work with the University of New Mexico and other partners to institute medical home model clinics in ten sites throughout the state. This project is intended to provide an integrated care model with specially trained personnel for children with special health care and developmental issues. CMS continues to be part of the Enchanted Rainbow Group, an interagency group of Early Intervention providers, CMS, UNM, the Managed Care Organizations, and Medicaid. This statewide work group consists of consumers, providers, managed care organizations and state agency staff working to integrate early childhood and health care programs and achieve collaborative delivery of medical, behavioral and developmental services to families of children with special health care needs, ages birth through first grade, with focus on the under-served, children with autism, Native Americans, and the uninsured. In addition, the CYHCN Program and HSD continue to assure that the purchasing specifications remain in the Medicaid MCO contract design.

CMS works collaboratively with HSD and SALUD MCOs to provide a request for Block authorization of services for CYSHCN clients who have a diagnosis of cleft lip and palate. This is a promising collaborative effort with all players demonstrating commitment to clients. This effort is near

completion. The WIC Program is co-located in eleven Primary Care sites in New Mexico. The Family Planning Program coordinates with 43 federally qualified health center sites providing on site family planning services using Title X protocols. Services are offered on a sliding fee scale from zero to 250 % of poverty. Primary Care sites entering into agreements with Family Planning follow the Title X federal guidelines and cannot charge clients a records fee for services. In return the sites are given supplies, contraceptive methods as well as lab supplies and services. The Families FIRST Program also uses 4 federally qualified health centers as private providers of perinatal care.

In NM both the Healthier Kids Fund (HKF) and Federally Qualified Health Centers (FQHC) provide community-based services to families who are low income. Both resources are needed to sustain services for low income and medically indigent populations who often remain unable to pay even the sliding scale fee to receive services at an FQHC. In addition, HKF provides resources for dental, mental health, eye exams, glasses and specialty visits. Unfortunately, the FQHC's funding does not provide many of these services at all of their sites (including prenatal care as well).

Children's Medical Services CYSHCN program provides care coordination/EPSTD case management for children and youth on Medicaid who have special health care needs. Through that service, ongoing evaluations or referral for periodic evaluations are assured. EPSTD case management billing has been resumed to assist the CYSHCN program in meeting increasing medical costs with ongoing level funded budgets.

Title V coordinates with the Social Security Administration, State Disabilities Determination Services unit, and Vocational Rehabilitation to identify families in need of appeal assistance. The family, then, with their permission is referred to Parents Reaching Out (PRO) and other support programs. CMS continues to work with parent organizations to increase the level of family participation in decision making and in Title V initiatives such as medical home and transition of YSHCN.

The Families FIRST Program coordinates case management services with the Managed Care Organizations (MCOs) provider network to address the needs of pregnant women and children to age 3. MCOs have expanded their interest in case management for other MCO clients including SALUD participants. Efforts have been made to increase Medicaid reimbursement rates and actual services as they currently differ by MCO. On going partnerships are encouraged through quarterly meetings held with the MCOs to discuss program issues. For HIPAA compliance, the entire billing process for these services will be changing as of October 2003. Discussions have been held with MCOs to determine the processes for these changes.

Title V programs in public health offices coordinate with the other providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for services through the Presumptive Eligibility-Medicaid On-Sight Application Assistance (PE-MOSAA) process. As cited in Part III.C Organizational Structure, Patricia Montoya, Secretary of the Department of Health, Pamela Heid, Secretary of Health and Human Services, Mary Boyleston, Secretary of Children Youth and Families Department and Michelle Grisham, Head of the Agency on Aging are conducting a series of Town Hall meetings across the State. The purpose of these meetings is to obtain community need and solution input relative to client/potential client/community experiences/expectations. The Secretaries are working on four initiatives, which include a Statewide Comprehensive Health Plan, Early Intervention, Medicaid Redesign, and Long Term Services Improvement. The meetings are designed to gather information from citizen stakeholders and set future direction for the new administration. There has been considerable input from providers, agency employees, consumers, and community health councils in developing the monograph for the Statewide Comprehensive Health Plan.

If awarded, the work of the State Early Childhood Comprehensive Systems (ECCS) grant will be integrated with the work of the Children's Cabinet, established by Executive Order 03-005 signed on February 5, 2003. The Cabinet is composed of the Secretaries of Children, Youth and Families, Human Services, Health, Labor, Corrections, Economic Development, Finance and Administration, Public Safety, Aging and Education; the Lt. Governor Diane Denish will take lead. The Children's Cabinet is committed to reform in the areas of strengthening linkages between health, developmental, and child protective services, including children in foster care and prevention and early identification of child abuse and neglect. Its aim is to focus state resources on improving the lives of New Mexico's children to achieve: A) Literacy by the third grade; B) Increased availability of health insurance for children; C) An improved rate of immunization; D) increased availability of childcare for parents working their way off welfare; E) Removal of bureaucratic roadblocks to public assistance for our

children.

The (ECCS) grant will provide a vehicle to support statewide efforts to create an affirmative environment for statewide systems integration. The State Title V Agency will administer the grant to assure coordination between stakeholder agencies and the New Mexico Children's Cabinet. Within state government there are renewed efforts to align systems, minimize duplication of services, and collaborate to better serve families in need. Efforts at the community level are demonstrating effective partnerships for strategic planning and coordination to address identified needs. Administrative oversight will be conducted by the Project Director, the Section Manager for the MCAF Section of the Family Health Bureau in the Public Health Division. //2004//

***/2005/The State Early Childhood Comprehensive Systems (ECCS) grant was awarded and is proceeding according to the anticipated time line. A statewide planning group was appointed by the Lieutenant Governor to represent state, tribal, community, business, and legislative partners in the early childhood system. This group has reviewed the Children's Cabinet outcome areas and developed an early childhood action plan. The ECCS grant has provided opportunities for Title V staff to provide leadership on child health issues to the Department and to the Lieutenant Governor. Although progress was delayed due to administrative barriers in contracting, the development of a statewide strategic plan for early childhood comprehensive services is now moving forward. This strategic plan will support the Lieutenant Governor's legislative agenda for 2005 and the identified goals and objectives of the Children's Cabinet. The Title V Agency is also working with the Office of the Lieutenant Governor to support House Joint Memorial 65, which directed the legislative and executive branches to work together to make "Kids, New Mexico's Number One Priority"//2005***

***/2005/The contract between CMS and UNM NICU was cut beginning FY '05. There was no contract with PRO, only with EPICS for family involvement however CMS continued to work with PRO liaisons statewide. The MCH Collaborative continues to meet and coordinate efforts around MCH initiatives and grant requests. The Enchanted Rainbow Collaborative continued to meet quarterly with a focus on care coordination and behavioral health issues for children birth to age 6. The Infant Mental Health Collaborative met monthly to develop a strategic plan for Infant Mental Health in NM. The Collaborative received training from Georgetown University on the implementation of a system of Infant Mental Health Consultants statewide. The Healthy Transition New Mexico Coordinating Council continued to meet regularly and worked on expanding partnerships with other state and private agencies that work with adolescents in transition. New Mexico will participate in the Champions for Progress Multi-State meeting to work on MCH goals, particularly the transition of youth with special health care needs. CMS continued to monitor the implementation of the Medicaid redesign with attention to care coordination. CMS continued to provide input into the statewide Comprehensive Health Plan. The Medical Home grant is closing however several sites are applying for grants to continue the project. The Title V CYSHCN Director is a member of the Early Childhood Comprehensive Services advisory board. The CMS FIT Coordinator assisted in the writing of the ECCS grant and became a member of the CYFD Task Force for inclusive child care as a result of the grant collaborative effort. The New Mexico Children's Cabinet is overseeing and participating in the ECCS effort. The CMS Planner participated in the Advanced Leadership Program of the Regional Institute for Health and Environmental Leadership. His participation resulted in the development of a Public Health Awareness film that highlighted the CMS multidisciplinary specialty clinics. CMS staff and leadership are involved in the New Mexico interagency Impacting Minority Participation and Recruitment Team (IMPART) whose focus is cultural competence training within DOH and other agencies. The Title V CYSHCN Director was elected as Region VI representative to the national AMCHP Board.//2005//***

***/2005/CMS staff participate in the Infant Mental Health Collaborative Committee, District community committees such as DWI Councils and Violence Prevention Councils, CYFD Task Force for Inclusive Child Care, IMPART, AMCHP, ECCS Advisory Board. CMS contributed to the DOH White Paper on Access to Care and continues to contribute to the development of the Statewide Comprehensive Health Plan. //2005//***

***/2005/ Due to text limits, the listing of partnerships according to the federal MCH pyramid are found in the attachment to this application.//2005//***

## F. HEALTH SYSTEMS CAPACITY INDICATORS

This set of indicators focuses on access to primary preventive care and on the ability of the state to monitor, analyze and interpret priority health data. The FHB has an MCH Epidemiology Program. There is not a dedicated MCH epidemiologist; the MCH Epi program manager works to provide Title V MCH data services. Other staff in the program are committed to NM PRAMS, NM CFR and NM MMR. As cited in Part III, C and D, the FHB is working to increase and consolidate MCH epidemiology capacity.

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 493.9) per 10,000 children less than five years of age. Asthma is an ambulatory care sensitive condition; hospitalizations for asthma may indicate problems of access to and use of primary preventive care for children with asthma in their communities. Using calendar years, state performance was 28/10,000 in 2001; 25.9/10,000 in 2000; 29/10,000 in 1999; 27.4/10,000 in 1998; 31.7/10,000 in 1997. The five year average was 28.4/10,000. In FY02, the estimated rate was less than 14/10,000. There is a need to re-evaluate the data which comes from the Hospital Inpatient Discharge Data (HIDD) of the NM Health Policy Commission. It seems unlikely for there to have been such a large decrease in a single year. The Healthy People 2010 Objective is not more than 25/10,000. NM has gaps & disparities that need to be evaluated and addressed. Higher rates of asthma hospitalization were reported for children ages <1, 1 and 2 than for those age 3 and 4 years. The FHB will work to assess asthma data and programs addressing asthma in FY04; this will be done in collaboration with the Asthma Prevention and Surveillance team in the Office of Epidemiology/PHD/DOH.

The percent of Medicaid enrollees whose age is less than one year who received at least one initial or periodic screening. The estimate in 2000 was 86.2% (15,401 of 17,875 infants); it was 80.5% in 1999 (13,892 of 17,255 infants). Current year data are pending and should be in hand by mid-July 2003; prior year data not available. The federal Medicaid standard is for all infants (100%) to have at least one screening.

A key issue to assessing this information is data. In the past, Medicaid required physicians to complete universal EPSDT forms. Physicians felt that they already cited EPSDT issues in their charting and did not want to duplicate this effort. HSD/Medicaid agreed; thus, it is unclear how EPSDT standards are reported and evaluated. This issue will be addressed in FY04, in collaboration with partners at Medicaid/HSD.

The service coordination provided by the Family Infant Toddler Program may be used to monitor and report on a portion of the EPSDT requirement. The NM CYSHCN program includes 12 service coordinators and 1 CMS FIT Coordinator. Approximately 800 children are served annually.

The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen. The estimate in 2000 was 40% (40 of 93 infants); Prior year data not available. The federal S-CHIP standard is for all infants (100%) to have at least one screening.

See discussion above; the same issues apply to SCHIP data.

The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. This is an index of prenatal care adequacy that adjusts for such factors as the duration of pregnancy and infant gestational age. The NM performance on this measure was 56.3% of births in 1999; \_\_\_% (not calculated) for 2000; 60.3% of births in 2001; and a provisional report of 57.8% in 2002. The HealthyPeople 2010 Objective is 90%. NM PRAMS reports in detail on many gaps, disparities and barriers. Key to Medicaid, the delay women experience to enroll and begin prenatal care. Obvious and continuing barriers to access to prenatal care include sparcity of providers outside metropolitan areas, transportation, poverty, substance abuse and domestic violence. PRAMS data for 1999 indicate that the following categories of women had much higher rates of low or no prenatal care than the overall population: Age 15-17 had 53% low or no prenatal care; women with less than high school education had 47%; Native American, 45%; Unmarried, 42%; women who wanted pregnancy later or never had 40%; women with income <100% of poverty, 39%. However, 60% of women, including those who received low levels of prenatal care, stated they got care as early as they wanted.

This may indicate that for many NM women, early prenatal care is not seen as desirable. Focus groups done by the multi-agency Prenatal Care Task Force verify that while young and Native American women know that they "should" get early prenatal care, personal issues of fear and shame prevent them. The Prenatal Care Task Force this year mounted a media campaign encouraging women, especially Navajo and young women, to seek early prenatal care. The Task Force and the Family Health Bureau will also be exploring ways to make prenatal care less intimidating and more rewarding for the marginalized groups of women who tend not to seek early care. Efforts continue to assure prenatal care providers are present in remote areas, including starting up prenatal care in local public health offices in Artesia and in Truth or Consequences, where prenatal care is otherwise not available. Unfortunately, the loss of two contracted providers and two PHD Physicians has made prenatal care precarious at the Ruidoso PHO. Prenatal care is unavailable in all of Guadalupe County, but PHD staff shortage and unsuccessful negotiations with various providers have made a solution impossible so far.

Health system capacity; compare groups that were paid-by-Medicaid with groups paid-by-other-sources. Groups are low birthweight; infant mortality; Kottlechuck Index at 80%. Generally, Medicaid paid groups have poorer performance than their more affluent comparison group. The linked birth+Medicaid project of the Epidemiology and Health Statistics Program, OVRHS, just completed a preliminary report for 1999 and 2000 births. The report is readily accessed at [www.health.state.nm.us](http://www.health.state.nm.us). This project does not, at this time, include use of the linked birth+death file. CMS is involved in the coordination of birth defects prevention education activities through CDC funds. Educational materials were developed that target the importance of preconception health, including folic acid in the diet, alcohol and tobacco prevention, and obesity and diabetes prevention and treatment.

A listing of percent of income eligibility by federal poverty level (FPL) for different Medicaid and S-CHIP programs: 185% FPL for prenatal care; 185% FPL for children; 185% FPL for family planning waiver; 185-235% for state child health insurance program (S-CHIP). No further comment is offered at this time. Assessment of health insurance coverage in selected groups suggests that the issues may be related to Medicaid or S-CHIP financial eligibility criteria as well as to other issues of new immigrants, undocumented persons, and psycho-social barriers to using health services.

The percent of EPSDT eligible children Medicaid aged 6 through 9 years who have received any dental services during the year. The estimate in 2000 was 33.8% (19,370 dental recipients of 57,263 eligibles age 6-9); it was 30.1% in 1999 (16,244 of 53,900). Prior year data not available. Federal standards for EPSDT enrolled children includes access to an timely use of dental care for 100% of enrollees. Initiatives by the DOH dental program include work to increase payment for Medicaid dental services, to increase the number of providers in the state who accept Medicaid payment. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program. Carrie Tingley Hospital, UNM was funded by the legislature to provide these services. A small number of CMS clients receive rehabilitation services due to their diagnosis. These diagnoses include cerebral palsy, spinal cord injuries or squal of central nervous system infection. Although the percentage is low, 7%, the cost is high to cover these diagnoses.

Ability of states to assure MCH program access to policy and relevant program information Aggregate data reports may be obtained from all but one of the data sources listed below. There is no direct access to the data files by the Title V MCH agency epidemiology staff. Access to the data files is possible through complying with requirements of the data request procedures that can be made to each data source.

Access to vital records (birth, death) data or reports; Access to linked birth-death data or reports; Access to Medicaid eligibility data, unduplicated by age, race-ethnic, services and diagnosis codes; Access to S-CHIP eligibility data, unduplicated by age, race-ethnic, services and diagnosis codes; Access to hospital discharge data for the state

There is limited access to reports from TANF, Food Stamp data; the HSD agency is unable to produce data files for analysis of unduplicated clients by age, race-ethnicity due to prohibitive programming costs. In FY02, it was estimated to cost in excess of \$25,000. There is no statewide data system for access to ambulatory care/emergency dept data for the state. Note that CMS has a cooperative agreement to receive birth file data for birth defects surveillance, newborn hearing and newborn genetic screening linkages; this arrangement based on the fact that Vital Records is a

component of PHD in which the CYSHCN program is located.

*//2005/ Ability of state to monitor tobacco use by children*

*NM has at least seven sources of surveillance to monitor tobacco use by children. These include the NM Tobacco Survey (done in alternate years to YRRS); the YRBS (now the Youth Risk and Resiliency Survey or YRRS) conducted in high schools and middle schools in alternate years; the NM Behavioral Risk Factor Surveillance System (BRFSS) for youth in transition age 18-24; and NM PRAMS for pregnant women, includes teens and youth 18-24.*

*Ability of state to monitor overweight or obesity among children and youth*

*NM has at least seven sources to monitor overweight, obesity and related nutritional issues in children and youth: These include the WIC program's Pediatric Nutrition Surveillance System (PedNSS); the YRBS (now the Youth Risk and Resiliency Survey or YRRS) conducted in high schools and middle schools in alternate years; the NM Behavioral Risk Factor Surveillance System (BRFSS) for youth in transition age 18-24; and NM PRAMS for pregnant women, includes teens and youth 18-24. YRBS High school. At the program level, the CMS social workers screen all CYSHCN clients for weight issues. These screens are then reviewed by CMS nutritionists who make referrals as appropriate. Note however that there is a scarcity of nutrition professionals and Medicaid regulations make referrals difficult due to the lack of provider numbers for dietitians in private practice.//2005//*

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

#### A. Background and Overview

Implementation of Performance Requirements. The New Mexico Title V Program uses a systems approach that begins with needs assessment and identification of priorities and culminates in improved outcomes for the target population. In carrying out the Needs Assessment in FY2000, the Program considered the Department of Health Strategic Plan, Healthy People 2010 objectives, as well as the nature of the districts in which the Needs Assessment would be held.

The goal of the Needs Assessment was to formally assess the needs of the three target populations--pregnant women; mothers and infants; and children with special health care needs. prepare a plan describing which services were to be provided to each of these groups. In New Mexico, about 41% of MCH funds are spent on preventive and primary health care for children, and 39% percent of MCH funds are spent on services for children with special health care needs.

The Title V MCH Program director and program managers traveled to the four Public Health Division Health Districts and conducted the MCH needs assessment workshops. The District Management Team along with selected MCH partners such as Head Start, MCH County Councils, and Indian Health Services (I.H.S), participated in the sessions. The team reviewed the Title V MCH Block Grant, the pyramid, data and the conceptual framework for assessing each of 4 population groups: 1) Reproductive age women, 2) Children age 0-3; 3) Children age 4-9; and 4) Preteens, teens and youth age 10-24. The group then used the conceptual framework to identify its district's problems in relation to the conceptual framework.

Conclusions and Priorities: The Title V Programs studied the data from the Title V Performance Measures, the DOH Strategic Plan, and analyzed the information obtained in the needs assessment to develop the Priority Needs.

The priority health status problems of the MCH and CSHCN populations are attributed largely to problems associated with poverty, working families with too few resources, no universal health coverage and its related issues of access to/use of primary care, health risk behaviors associated with stresses of "making ends meet" , and a high proportion of the state's counties having health professional shortage areas . The state has too few services for prevention, screening, treatment and counseling for those who have problems with tobacco, alcohol and other drugs. Significant gaps in measures of health, healthy & health risk behaviors and access to/use of health service health status measures are seen for the MCH populations. Population-based surveillance systems and community knowledge contribute to understanding key factors that underlie these gaps. In previous decades, the Title V MCH programs provided a large safety net for mothers, infants, children and CSHCN through direct and enabling services. Local health offices (LHOs) throughout New Mexico offered a core of prenatal, well child and adolescent health care. With the transition to Medicaid paid services for prenatal and childcare the LHO safety net is now much smaller with focus on specific areas where access to providers is problematic. Populations that are not eligible for several of the state and federal programs are at greatest risk. There are no reliable estimates of undocumented women and children by health indicators and by access/utilization indicators regarding unmet needs for prenatal, family planning, preconceptional and primary care services.

While a large portion of New Mexico's children live in poverty, participation in the Food Stamp program has declined. Participation in the School Food Program participation is also low. There is very limited access to nutrition assessment and counseling. The Maternal Health Office carefully reviewed the spending patterns of the High Risk OB Fund. This revealed that there was a network of providers who were alerted to this part of the safety net as a payor of last resort for non-Medicaid eligible women. Applications to this fund continue to exceed its available resources. New sources of funding may be necessary to ensure viability. A database is being constructed to provide information on providers, clients, services and birth outcomes.

New Mexico Title V Program used the information from the Health Status Indicators and the needs assessment to shape New Mexico's priority needs. Of continued concern are social determinants that underlie the state's performance for family violence, substance use/abuse and relatively high adolescent pregnancy rates. Access to and use of prenatal care and dental care are priorities as well. FHB has taken leadership in an evaluation of factors associated with maternal-neonatal care, to

increase the proportion of very low birth weight infants that are born in a level III institution (with appropriate levels of maternal-fetal and neonatal care).

The three priority areas that the Family Health Bureau is focusing on are: 1) Promoting healthy families, 2) Breaking the cycle of substance abuse and 3) Improving the quality of life.

In promoting healthy families, our focus is on raising healthy children by decreasing the teen birth rate, decreasing unintended pregnancies, and increasing immunizations through age 2. In order to increase births to healthy families, we focus on youth strengths, increasing the percentage of 20 year olds who have graduated from high school/technical school/ or vocational school or who have obtained a GED; and increasing the percent of children with positive health/social/ and family support. Finally, FHB works to affect a reduction of violence in families, by monitoring confirmed cases of child abuse/neglect; confirmed cases of abuse, neglect and exploitation among adults; domestic violence, and measuring of substance abuse in families with children. The State has experienced a reduction in state matching funds for contracts again this year. Contracts for training and technical advice are especially hard to obtain, therefore, the State requests technical assistance in these areas during the following year. It will be more likely that the contracts would be passed through the system if the funding for these types of initiatives were from MCHB.

## B. STATE PRIORITIES

### IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

#### B. State Priorities

The needs statement of FY 99 was reviewed and found to be consistent with policy, the evidence gathered through the needs assessment process and the direction of programs at the community level. /2002/ The Title V Programs studied the data from the Title V Performance Measures, the DOH Strategic Plan, and analyzed the information obtained in the needs assessment to develop the "Priority Needs". /2003/ and /2004/ No changes in the priority needs for this year.//2004//

**/2005/ No changes were made in priority needs which are listed below://2005//**

1. Reduce barriers and disparities to accessing community-based health and health related services for women, children and youth. E/I
2. Reduce fatal and non-fatal family violence. PB
3. Reduce the incidence of substance abuse and mental health disorders and other high-risk behaviors in youth under age 21, by promoting youth development strategies. PB
4. Expand primary prevention home visiting services to teen parents and first-time parents statewide. E
5. Increase the proportion of women receiving adequate prenatal care. E/I/PB/D
6. Establish an infrastructure to support and monitor transition services for adolescents with special health care needs. I
7. Develop policies and programs that assure the oral health needs of the MCH population are met, including CSHCN. I/PB/D
8. Reduce the proportion of pregnancies that are unintended in women that are 13-44 years old. I/E/D
9. Develop capacity for MCH program evaluation and population assessment to attain timely monitoring of program performance, effectiveness of interventions, status and trend in population measures, and identification of gaps and disparities in health. I
10. Develop policies and procedures that prevent birth defects, poor fetal outcomes and MCH morbidity by reducing violence, alcohol, substance and tobacco use, and promoting health behaviors (folic acid, health diet) among child bearing and child rearing New Mexicans. E/I/PB

11. Reduce medical services funding gaps for children in NM, i.e. children who are non-Medicaid eligible, children with orthopedic/rehabilitative needs, and children in need of catastrophic medical funding such as organ transplants. I/E

12. Establish infrastructure in NM, to support the development of a system to respond to genetic breakthroughs and their implications.

***//2005/ The reader is referred to table 4b for text on each measure with a report of FY03 and FY04 accomplishments and issues; and a plan for FY05. Figure 4b summarizes major ongoing activities by the federal MCH pyramid of services: direct, enabling, population based and infrastructure building. Two state performance measures were modified for reporting and planning FY05: Measure Number 6 (25 in series) regarding mortality and fatality review. The state will discontinue planning for fetal-infant mortality review (FIMR) and modified its reporting scale to reflect this change. The detail measure sheet was amended. Measure Number 7 (26 in series) regarding birth defects prevention and surveillance was modified to a 6-point measure that includes one point for each of the following: 1= passive surveillance with data linking, birth file to 3CR; 2= active surveillance with record abstraction; 3= folic acid-birth defects prevention initiatives; 4= other pre-conceptional health/birth defects prevention initiatives; 5= fully staff (positions or contracts); and 6 = adequate funding and resources. The detail measure sheet was amended.***

***New State Performance Measure: A new state performance measure is the prevalence of overweight and obesity among children age 0-5. The state CDC PEDNSS data indicates that since 1992, the prevalence of being overweight among children 0-5 in the WIC population has grown from 6.88 percent to 10.11 percent in 2001. Weight gain in an infant is a poor predictor of obesity later in life. Overweight if an infant is less than 3 years old does not predict adult obesity unless one parent is obese as well. At age 6 years, the probability that obesity will persist to adulthood is over 50%. At adolescence, the probability that obesity will persist is 70-80%. The state will work to adopt the Youth Risk Behavior Survey data next year (2006) to capture prevalence of overweight and obesity in that older population that more accurately describes the status of the population. The Children's Cabinet has also adopted prevalence of childhood overweight and obesity as an outcome indicator for the NM Report Card on children's well-being.//2005//***

### C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

#### a. Last Year's Accomplishments

FY03, Direct Health Care: Activities include developing metabolic clinic infrastructure which involved partnering with University of New Mexico, Dept of Peds/Dysmorphology; Worked with CMS and Family Infant Toddler Social Workers on providing follow-up services for service coordination for infants identified through the screening program.

FY03, Enabling Services: Activities include providing in-service training to birthing hospitals and CMS social workers on improving dried blood collection techniques; Monitoring of all birthing hospitals to ensure tracking of confirmed cases for appropriate treatment.

FY03, Population Based Services: Activities include training held in 9 sites statewide and included 353 health care professionals on newborn screening program, procedures and techniques. Developed a training module for medical school residents for University of New Mexico, School of Medicine, and held 2 training sessions.

FY03, Infrastructure Building: Activities include developing a strategic plan to improve the newborn screening program based on recommendations of the

National Newborn Genetic Resource Center technical review for the NM DOH and Scientific Laboratory Division.

### b. Current Activities

FY04, Direct Health Care: Activities include monitoring contract for metabolic services at University of New Mexico. This year 6 Outreach Metabolic Clinics were held statewide. The metabolic team consists of a clinical geneticists, genetic counselor and metabolic nutritionist.

FY04, Enabling Services: Activities include provide care coordination to families identified through our program, services provided by CMS Social Workers. Training was held for CMS Social Workers regarding metabolic care. This year we monitored all birthing hospitals to ensure tracking of confirmed cases for appropriate treatment.

FY04, Population Based Services: Activities include providing training to birthing hospital and laboratory staff to ensure the quality of metabolic screening. Results on intervention are measured by reports generated by the State Lab on Unsatisfactory Screens on a quarterly basis. Training was held at 9 sites with 353 people attending.

FY04, Infrastructure Building: Activities include hiring and training a Newborn Screening Follow-up Nurse located at the State Lab, who does daily surveillance (position vacant for 1/2 year). Program follow-up policies, procedures, and algorithms have been updated.

### c. Plan for the Coming Year

NM has an estimated 26,900-27,000 in-state occurrence live births per year with less than 20 positives per year; all children receive appropriate follow-up and referrals. The program anticipates continuing at 100% performance.

FY05, Direct Health Care: Planned Activities include monitoring contract for metabolic services at University of New Mexico. This year 6 to 8 Outreach Metabolic Clinics will be held statewide. The metabolic team consists of a clinical geneticists, genetic counselor and metabolic nutritionist Will continue with limited case management activities (dietary PKU levels, PKU formula ordering) with our PKU families.

FY05, Enabling Services: Planned Activities include providing care coordination to families identified through our program, services provided by CMS Social Workers.

Further training of CMS Social Workers will be on request only and for new employees.

FY05, Population Based Services: Planned Activities include providing training to birthing hospital and laboratory staff to ensure the quality of metabolic screening.

Quarterly reports will be used to target our intervention and training efforts.

FY05, Infrastructure Building: Planned Activities include developing a 3-5 year plan on improving our program and integrating suggestions from our Site Assessment done by the National Newborn Screening and Genetic Resource Center.

Databases linkages between Newborn Genetic Screening and Hearing Screening Program and Vital Records, electronic birth certificates will be strengthened.

*Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

### a. Last Year's Accomplishments

Previous measure, #14 The degree to which the State assures family participation in program and policy activities in the state CSHCN program:

FY03, Enabling Services: Family participation included: 1) MCH Collaborative

referrals to/from Parents Reaching Out (PRO), NM Interagency Coordinating Council for birth to 3;

2) Parents & family members of diverse cultures are involved as advocates in multidisciplinary diagnostic clinics ; 3) MCH Collaborative referrals to/from PRO, NM Interagency Coordinating Council (birth to 3), CMS Annual Statewide Meeting, AMCHP Conference, PRO Partnership Conference, SSI Coalition, and CMS Initiatives including Medical Home and Adolescent Transition.

FY03, Infrastructure Building: 1) EPICS (Educating Parents of Indian Children with Special Needs) received a CMS contract to provide staff training, review of MCH Title V grant. Both EPICS and Parents Reaching Out (PRO) provided consultation on planning and program activities and the DOH strategic plan. PRO continued to provide these services without contractual reimbursement due to difficulties in the contracting process. 2) Family meetings were held periodically to ensure Program offers family-centered services. Parent Liaisons connected with the School for the Deaf and the School for the Visually Handicapped, along with PRO worked collaboratively with CMS Social Worker Care Coordinators to provide services to families with CYSHCN and with the FIT --children with our at risk for developmental delay: IDEA Part C- families.

Family participation included) CMS Annual Statewide Meeting, AMCHP Conference, PRO Partnership Conference, SSI Coalition, and CMS Initiatives including Medical Home and Adolescent Transition. 3) Legislation passed to cover PKU formula with input by the parent-driven PKU Support Group. 4) Trainings provided through Medical Home Initiative for parents and providers address partnering in decision-making; In the State CYSHCN, on-going family-centered approach in care coordination.

## b. Current Activities

(Previous measure, #14) The degree to which the State assures family participation in program and policy activities in the state CSHCN program:

FY04, Direct Health Care: 1) Partnering in decision-making training for parents and providers provided through Medical Home Initiative. 2) In the State CYSHCN, ongoing family-centered approach in care coordination.

FY04, Enabling Services: 1) Family participation in MCH Collaborative referrals to/from PRO, NM Interagency Coordinating Council , CMS Annual State Meeting, AMCHP Conference, PRO Partnership Conference, and Medical Home and Adolescent Transition. 2) EPICS received a CMS contract to increase family involvement. 3) Parents involved as advocates in multidisciplinary diagnostic clinics. 4) The parent-driven PKU Support Group is advocating for legislation to cover PKU formula.

FY04, Population Based Services: CMS Annual State Meeting, AMCHP Conference, PRO Partnership Conference, and Medical Home/Adolescent Transition Initiatives; and contract with EPICS, a family organization, to improve family involvement by providing staff training, parent-to-parent education, review of MCH Title V grant and consultation to program, and the support of 3 family members attendance at the AMCHP conference. Unfortunately, due to a lengthy approval process PRO did not receive a contract, but as a partner with CMS and UNM in the Medical Home Project provided transition training for providers and families regarding services that benefited CYSHCN. 1) Parents involved as advocates in multidisciplinary diagnostic clinics. 2) Parent involvement in decision making and planning in the SDE Statewide Transition Council was critical. 3) A continued barrier that surfaced during FY03 was a change in the local Social Security office computer system disabling capacity to generate an SSI denial list that would allow us to refer clients to PRO. Social Security is still working to remedy this problem. 4) A family member/parent organization representative is sitting on a MCO/Salud/Meidicaid Advisory Board. 5) Parent involvement continues to be

included statewide in Early Childhood initiatives as well as Part C.

### c. Plan for the Coming Year

#### c. Plan for the Coming Year

The FY02 performance indicator, based on national survey of CSHCN, shows 46% of CSHCN age 0-18 whose families' partner in decision-making at all levels and are satisfied with the services they receive. The target of 55% is set for FY07 based on reasonable estimate of impact that the CYSHCN Program, provider and agency partners can have. There will be continued contracts with family organizations, and on-going training with staff, providers and families.

FY05: Direct Health Care: 1) The Medical Home Initiative is closing. Family members were intricately involved in the decision making process. 2) Continue State CYSHCN Program on-going family-centered approach in care coordination.

FY05: Enabling Services: 1) Contract with family organizations to improve involvement through staff training, parent-to-parent education, review of MCH Title V grant and consultation to program. The funding for these organizations was continued through a very difficult budgetary crisis that resulted in the cutting of other contracts. This funding was not touched because of the MCH Family involvement performance measure and initiative. 2) Sustain family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, CMS State Meeting, AMCHP Conference, PRO Partnership Conference, Medical Home and the Healthy Transition New Mexico Council. 3) PKU Support Group will continue more informally to provide advocacy for their families.

FY05: Population Based Services: Contract with family organizations to improve family involvement; sustain family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, CMS Annual State Meeting, AMCHP Conference, PRO Partnership Conference; and CMS Medical Home and Healthy Transition New Mexico Council Initiatives.

FY04: Infrastructure Building: CYSHCN will: sustain partnerships with family organizations, seeking input in all Program areas and involving them in decision making; work with partners to identify statewide strategies to address the 6 CYSHCN performance measures; and partner to provide input in the Medicaid redesign and the State Health Plan design resulting from a change in administration in NM.

*Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

#### a. Last Year's Accomplishments

FY03, Enabling Services: Increase to 85% the number of CYSHCN who have an identified "medical/health home". The SLAITS survey includes a state sample of 751. The planned achievement for FY'02 was addressing clients within the CYSHCN program only. All subsequent reports will be statewide reports.

FY03, Infrastructure Building: Delivered medical home training to physicians serving CYSHCN. Medical home training for physicians and other partners was included in the fall Transition training for CYSHCN. Work continued with UNM regarding training within 5 identified clinics in New Mexico. Social workers from CMS will continue as leaders/trainers in addressing the medical home concept.

#### b. Current Activities

FY04, Enabling Services: Increase to 85% the number of CYSHCN who have an identified "medical/health home". The SLAITS survey is statewide. The planned achievement for FY'02 was addressing clients within the CYSHCN program only. All subsequent reports will be statewide reports.

FY04, Infrastructure Building: Champions for Progress Multi-State Meeting will provide training to the CYSHCN Director, community representative and family member regarding all MCH initiatives. Newborn Hearing Screening trainings to medical providers include medical home training. Telehealth training to providers includes the medical home concept. Work continues with UNM regarding the implementation of the medical home within clinics in New Mexico. Social workers from CMS will continue as leaders/trainers in addressing the medical home concept.

### c. Plan for the Coming Year

The FY05 target of 55% is set for FY07 based on reasonable estimation of impact the CYSHCN Program coupled with provider and agency partners can have on ensuring CYSHCN ages 0-18 receive coordinated, ongoing, comprehensive care within a medical home (CSHCN Survey)

FY05, Direct Health Care: CMS CYSHCN Program will work with partners to identify statewide strategies to address the 6 CYSHCN performance measures. Medical Home Project will continue in targeted sites in NM. The CMS CYSHCN Program continues to pilot transition assessment for youth addressing adult medical home.

FY05, Enabling Services: CYSHCN will work with partners to identify statewide strategies to address the 6 CYSHCN performance measures.

FY05, Infrastructure Building: CMS CYSHCN Program will work with partners to identify statewide strategies to address the 6 CYSHCN performance measures. CYSHCN and partners have and are providing input in the Medicaid redesign and the State Health Plan design resulting from a change in administration in NM. CMS has requested in several meetings that the purchasing specifications for CYSHCN that are present in the Medicaid program at this time, be carried forward in the redesign of Medicaid and it is expected that they will not be changed. In addition, a request to include and address issues of immigrant children and youth continues. Medical Home Project will continue in targeted sites in NM. Healthy Transition New Mexico Council will continue. Champions for Progress Grant, if funded, will provide an annual train the trainers meeting that will then become regional. Enchanted Rainbow -- replaced former MCH funded Double Rainbow - will use Medical Home as a way to address access to care for immigrant children and youth.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

### a. Last Year's Accomplishments

FY99-FY01 data were based on CMS Program's assessment, yes if child had a source of payment listed in the CMS/3CR database. Data for FY02 Report from the National Survey of CSHCN/SLAITS. The survey is population based and the CMS data is a CMS program-based rough estimate. Both sets of data are shown in this transition year.

FY03, Direct Health Care - Activities and their results: Provided funding and/or services for 5683 children and youth with special health care needs CMS CYSHCN Program provides assessment of insurance options for clients, and does MOSAA/PE if the children or youth are eligible. In terms of statewide target, children and youth with special health care needs who have Medicaid may lose insurance temporarily because of renewal difficulties.

FY03, Enabling Services: CMS CYSHCN Program provides assessment of insurance options for clients, and does MOSAA/PE if the children or youth are eligible. Activities and their results: CMS CYSHCN Program provides assessment of insurance options for clients, and does MOSAA/PE if the children or youth are eligible. In terms of statewide target, children and youth with special health care needs who have Medicaid may lose insurance temporarily because of renewal difficulties.

FY03, Infrastructure Building: CMS CYSHCN Program provides assessment of insurance options for clients, and does MOSAA/PE if the children or youth are eligible. CMS and partners continue to address the need for 'family friendly' service at the ISD office -- the access point for renewal of Medicaid clients.

#### b. Current Activities

No new needs assessment.

Planned achievement for FY04, Direct Health Care: Provided funding and/or services for over 5000 children and youth with special health care needs.

Planned achievement for FY04, Enabling Services: Care coordination provided to 5683 children and youth with special health care needs. Activities and their results: CMS CYSHCN Program provides assessment of insurance options for clients, and does PE-MOSAA if the children or youth are eligible. In terms of statewide target, children and youth with special health care needs who have Medicaid may lose insurance temporarily because of renewal difficulties

Planned achievement for FY04, Infrastructure Building: The Secretary of DOH has approved the closing of HKF in order to address the need for these changes within the CYSHCN program: increase in the limit for CYSHCN clients to providers, increase hospital per diem rates, increase in reimbursement for cancer, cardiac and renal conditions. The legislature provided \$100,000.00 in funding for cancer treatments.

Unfortunately, 1500 non-medicaid eligible children lost primary medical care services when HKF closed. CMS continues to provide leadership in provider and pediatric specialist infrastructure issues as well as access to health care for immigrants.

#### c. Plan for the Coming Year

The FY05 target of 70% is set for FY07 based on reasonable estimation of impact the CYSHCN Program coupled with provider and agency partners can have.

FY05, Infrastructure Building: CMS CYSHCN Program will work with partners to identify statewide strategies to address the 6 CYSHCN performance measures.

CYSHCN and partners have and are providing input into the comprehensive State Health Plan design. As the Medicaid changes become solidified CMS will continue to monitor the impact of the changes.

*Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

#### a. Last Year's Accomplishments

FY03, Direct Health Care: Increase to 100% the number of CYSHCN identified as eligible for Title V Program and are participants in needed areas of service:

Activities and their results: CMS eligible receiving nutrition services were 100 %.

Nutrition screenings and referrals were provided for 5683 of CYSHCN by 4 nutritionists statewide. CMS sponsored 115 specialty clinics statewide. The clinics included: cleft lip and palette, pulmonary, neurology, endocrine, genetic and

dysmorphology, serving 3077.

FY03, Enabling Services: Increase to 100% the number of CYSHCN who have access to a list of services, and other information about the program. CMS eligible children receiving care coordination is 100% of 7872. CMS CYSHCN staff includes 52 social workers 19 clerks and 16 state office staff serving 5683 children and youth. Part C (FIT) staff includes 12 social workers and 6 clerks serving 768 children birth to three. FIT and CYSHCN social workers are involved in on-going community coordination efforts with providers, managed care organizations and early intervention programs as well as clinics and individual providers. CMS did print a list of services (brochures) in English and Spanish which were distributed to the communities. Families receive a letter describing the services available to them based on their medical eligibility. CMS worked with representatives from the 3 Medicaid MCO's -- Cimarron, Lovelace and Presbyterian to achieve a block request for authorization of services for children and youth with cleft lip and palate. This continues to move forward -- a multidisciplinary team specialist has been contracted for documentation of recommendations made by the providers, and a letter to the primary care provider (PCP) regarding same.

#### b. Current Activities

FY04, Direct Health Care: Increase to 100% the number of CSHCN identified as eligible for Title V Program and are participants in needed areas of service: CMS eligibles receiving nutrition services was 100 %. Nutrition screenings and referrals were provided for 5683 of CYSHCN by 4 nutritionists statewide. CMS sponsored 115 specialty clinics statewide. The clinics included: cleft lip and palette, pulmonary, neurology, dysmorphology and served ~3070 clients.

FY04, Enabling Services: : Increase to 100% the number of CYSHCN who have access to a list of services, and other information about the program. CMS eligible children receiving care coordination is 100% of 5683. CMS CYSHCN staff includes 52 social workers 19 clerks and 16 state office staff serving 5683 children and youth. Part C (FIT) staff includes 12 social workers and 6 clerks serving 768 children birth to three. FIT and CYSHCN social workers are involved in on-going community coordination efforts with providers, managed care organizations and early intervention programs as well as clinics and individual providers. CMS continued its work with MCOS and community agencies to increase the level of awareness and need for coordinated care in New Mexico. CMS worked with representatives from the 3 Medicaid MCO's -- Cimarron, Lovelace and Presbyterian to achieve a block request for authorization of services for children and youth with cleft lip and palate. This continues to move forward -- a multidisciplinary team specialist has been contracted for documentation of recommendations made by the providers, and a letter to the PCP regarding same. CMS social workers are working diligently on transitioning the HKF clients to FQHC and RPHCA funded primary care clinics.

#### c. Plan for the Coming Year

FY02 performance indicator and state justification targets from FY04-FY08: Target of 75% is set for FY07 based on reasonable estimation of impact the CYSHCN Program coupled with provider and agency partners can have on addressing access to community based health care services.

FY05, Direct Health Care: Increase to 100% the number of CSHCN identified as eligible for Title V Program and are participants in needed areas of service: Planned Activities include maintain current areas of reimbursement (items 1-9) on checklist; increase efforts of nutrition screening and referral for services, as well as nutritionists working in CMS clinics; continue care coordination which is provided by CMS staff and available to all CYSHCN and their families; strengthen linkages to early intervention services and Part C program through data sharing development

areas; and maintain specialty clinics statewide.

FY05, Enabling Services: Increase to 100% the number of CYSHCN who have access to a list of services, and other information about the program. Planned Activities include: assure that all CYSHCN have access to a list of services and other information about the program. Continue transition efforts with HKF clients.

FY'05 Infrastructure Building: CMS CYSHCN Program will work with partners to identify statewide strategies to address 6 CYSHCN performance measures.

CYSHCN and partners continue providing input into the Comprehensive State Health Plan and monitoring the implementation of the Medicaid plan. CMS will monitor the compliance with the purchasing specifications for CYSHCN that is present in the Medicaid program at this time. A request to include and address issues of immigrant children and youth continues. Continue MCO/CMS efforts toward achieving block authorization for services for children and youth with special health care needs.

*Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

#### a. Last Year's Accomplishments

Data for FY02 Report from the National Survey of CSHCN/SLAITS but estimate is statistically unreliable

FY03 Report of activities

FY03, Enabling Services: The State CYSHCN Program partnered with the University of New Mexico, Parent Organizations, State MCOs, Public School personnel to establish a multi-disciplinary Coordinating Council to address barriers/gaps in transition services for youth with special health care needs.

CYSHCN Program established a Program-specific Transition Team to create a data collection tool for transition planning. Contracted with Education for Parents of Special Needs (EPICS) to provide training on transition issues. A series of three transition trainings were held throughout the State, addressing many transition issues for youth.

FY03, Population Based Services: Program partnered with the University of New Mexico, Parent Organizations, State MCOs, Public School personnel as well as others to establish a multi-disciplinary Healthy Transition New Mexico Coordinating Council (HTNMCC) to address barriers/gaps in transition services for youth with special health care needs. Contracted with Education for Parents of Special Needs (EPICS) to provide training on transition issues. A series of three transition trainings were held throughout the State, addressing many transition issues for youth.

FY03, Infrastructure Building: CMS Transition Team implemented a transition plan to address many aspects of youth transition including medical, vocational, recreational, educational, goal setting/attaining, etc for all 45 CYSHCN Social Workers to use in transition planning with youth aged 14-21. From the Summer 2000-2003 State Department of Education-sponsored Transition Institutes, about 60 "transition specialists" were identified by their school districts to take the lead in developing or improving local systems' capacities to support appropriate transition services. They formed the "Transition Specialist Cadre" and have committed to participating in four training and technical assistance activities annually, preparing information for colleagues and community partners, and developing and carrying out action plans to address critical local priorities, all centered around enhancing student achievement of their desired post-school outcomes. They also recruit and lead district/agency teams for the annual Summer Transition Institute.

Recommended by the 1994-1996 House Bill 981 Task Force on Transition of Youth with Disabilities to Postsecondary Education, the Department of Education-sponsored Statewide

Transition Coordinating Council was founded. This council consists of approximately 25 individuals who meet quarterly to help plan and develop strategies to support a seamless transition system from school to adulthood for youth with disabilities.

#### b. Current Activities

FY04, Direct Health Care: All CYSHCN Social Workers (45) provide service coordination & transition planning to youth aged 14-21. CMS Transition Team reviews and updates policy on transition issues for every CMS office.

FY04, Population Based Services: The multi-agency/multi-disciplinary Healthy Transition New Mexico Coordinating Council (HTNMCC) works to address barriers/gaps in transition services for YSHCN. It's Tools for Transition Conference gave participants tools to use in working with youth in transition and regions developed plans for improving transition services in their own communities through collaboration. CMS Transition Team utilizes a tool for transition planning for YSHCN, addressing such topics as health, education, vocation, recreation, future goals/dreams. The Transition Plan was tailored for immigrant youth and translated into Spanish. User-friendly transition booklet for youth, available in English and Spanish, was revised, printed and is available to all Social Workers working with youth. Funded by the Developmental Disabilities Planning Council and implemented by Executive Leadership Council and the Statewide Transition Coordi the Student Leadership & Self-Directed IEP Training initiative will expand training statewide on the ChoiceMaker Self-Determination Curriculum. Students learn to plan for and direct their own IEPs and related transition planning.

FY04: Infrastructure Building: Reviewed/updated policy to be used by CYSHCN Social Workers in transition planning with YSHCN and kept in the CMS Manual of Operating Procedures. A Newsletter was issued quarterly to all CMS Staff and other interested parties featuring updates on activities for both HTNMCC & CMS Transition Team, resources available, website links. A case study involving elaborate transition issues is profiled each issue. Senate Bill 287 was introduced to the Legislature proposing an appropriation of \$54,000 from the General Fund to the NMSDE to support activities of a Statewide Transition Coordinating Council, to be made up of a variety of agencies concerned with meeting transition needs and providing leadership and professional development training to school districts. The bill was not passed, but the Council continues to exist without funding. From 4 pilot districts in year 1 to 36 districts, state supported schools, and juvenile corrections facilities in year 3, the implementation of the Transition Outcomes Project has helped districts use procedures and tools to improve their transition planning within the IEP for 14-22 year olds. The Transition Outcomes Project trains teams to review IEP files to assess quality implementation of transition planning requirements and assist school personnel to make changes in practice as needed.

The annual NMSDE-sponsored Summer Transition Institute will build upon the past 5 Institutes to support districts' creation of local action plans.

#### c. Plan for the Coming Year

FY05, Direct Health Care: CYSHCN Social Workers will continue to provide service coordination and transition planning to youth aged 14-21. Staff training will be determined and developed through follow-up evaluation of transition plan.

FY05, Enabling Services: HTNMCC will focus its goal to improve transition into the workforce. Recruitment of members is on-going. New Mexico has received an offer of technical assistance from HRSA and is exploring workforce linkages for YSHCN and anticipate funding to pursue this effort. New Mexico will apply for the Champions for Progress Grant to support transition efforts. It is hoped that the grant will fund a 3-year series of annual train the trainer sessions as well as strategically located regional transition trainings. The Transition Team will review, evaluate and update transition plans if needed. Copies of the transition booklet will be printed through the University of New Mexico/Continuum of Care Project to be distributed to public and private agencies dealing with transition planning for youth. CMS will continue to contract with parent organizations to provide training on transition issues.

FY05, Population Based Services: HTNMCC will sustain the Transition Conference with a possible focus on transition into the workforce. CMS will continue to contract with parent organizations to provide training on transition issues. New Mexico will send 3 representatives (including the State Title V Director and community partner) to the Champions for Progress Multi-State Meeting. The meeting will focus on building partnerships, strengthening action plans, community-based strategies, and measuring progress. These 3 participants will share what they've learned through work with the HTNMCC.

FY05, CMS will review and update policy for use by CYSHCN Social Workers in transition planning with youth. Follow-up on transition plan usage will determine policy changes. CYSHCN Program will work with partners to identify statewide strategies to address 6 CYSHCN performance measures. CYSHCN and partners will provide input in the Medicaid redesign and State Health Plan design resulting from a change in administration in NM. A request to include and address issues of immigrant children and youth continues. The Statewide Follow-up and Follow-along Studies, funded by the New Mexico Public Education Dept. (NMPED) and carried out by the UNM Institute for Public Policy overseen by an advisory group, are just starting, with one random cohort just interviewed one year after exit, regarding their school and post-school experiences. Tenth graders later will be randomly asked about their post-school goals and how their schooling is helping them achieve those.

*Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

#### a. Last Year's Accomplishments

FY03 Report of activities and results

Factors that contributed to reaching/not reaching targets included: 1) Late starts -- Infants who start DPT series before 3 months of age are twice as likely to be up to date at 24 months than those who don't start early; 2) Increased burden of age appropriate immunization -- 3-fold increase in the number of shots required; 3)

Parents often think they are up to date when they are not; 4) Children with a "Medical Home" are more likely to be up to date; and 5) Missed opportunities- in Clinic Assessment Software Application (CASA) assessments performed in 2001, NM children not up to date had an average of 5.9 'missed opportunities' per child.

FY03, Population Based Services: Activities included 1) Establishing a statewide immunization information system (SIIS) with linkage to central database by 2004.

Worked towards consensus among providers and other Committee

members to identify the best system and procure financial support. 2) Implemented the new NM 'Done By One' simplified childhood immunization schedule and new roll-out 'Health Passport' statewide. 3) Developed Immunization Provider Outreach and Communication plan with Clinical Prevention Initiative. 4) Developed new provider assessment/quality improvement plan

Results of activities included: 1) Decision making by the SIIS Executive Committee to identify ; 2) 'Done By One' roll-out, Immunization Provider Outreach

Plan, and Provider Assessment Plan are in process; and 3) 429 VFC providers were enrolled.

#### b. Current Activities

FY04 Report of activities

FY02 performance indicator and state justification for targets from FY04-FY08: The Governor has made immunization a priority. The State Immunization

Program has improved this measure. Result: The State wide immunization rate is at 71% up 10% from 61%. FY04, Population Based Services: The program is in the process of

Implementing an immunization registry, including recruitment and training of providers, development of electronic interfaces to facilitate provider data uplinks, and population of database with provider, Medicaid and public health (INPHORM) immunization data.

### c. Plan for the Coming Year

FY05 Planned Achievement Infrastructure Building: Plan to implement the Electronic Immunization Registry which will enable providers to log on and research the immunization status of children throughout NM as opposed to a manual search. . Continue to implement the Shot Team Initiative that recruits nurses to provide agencies with additional support such as record keeping, systems issues and quality assurance.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

### a. Last Year's Accomplishments

FY03, Direct Health Care:

1) Increase services to adolescents- Result: Local health offices distributed 12,000 flyers, 68 PSAs, 34 Newspaper/Media Articles, 193 Posters, and participated in 189 Health Fairs, and 772 Clinic Promotions. 42,830 materials distributed for reduction of teen pregnancy most were pamphlets, 14 Spanish titles. 19,000 male involvement pamphlets were distributed, 4 Spanish titles.

2) Develop community networks- Result: 2,598 teens were seen at local health offices and networking was done 464 local physicians. There were 248 health council contacts and 169 detention center contacts.

3) Expanded services- Result: 2366 teens were seen during flex hours and 233 teens in the mobile van units.

FY03, Enabling Services:

1) Target outreach efforts for adolescents.

Result: 42 offices provided outreach through local high schools, mobile van units, community colleges, and alternative high schools.

FY03, Population Based Services:

1) Provide community education and outreach.

Result: 9321 participants received family planning education through educational contacts.

Local health offices provided 70 educational sessions done with youth groups, 92 done through JPOs.

FY03, Infrastructure Building:

1) Ensure quality assurance through training, client satisfaction surveys and EMA -- (Standards of Care, Best Practice, and Client Centered Care).

Result: A yearly client satisfaction survey is distributed to local public health offices. 103 staff members received medical training and 91 received QLP training. The Family Planning Program provided 46 trainings and a total of 888 participants.

### b. Current Activities

FY04, Direct Health Care:

1) Increase services to adolescents- Result: Local health offices distributed 126,773 flyers, 8 PSAs, 4 Newspaper/Media Articles, 4 Posters, and participated in 28 Health Fairs where 950 teen clients were educated.

2) Develop community networks- Result: Networking with 84 local physicians, 60 health councils, 16 MCH councils, 16 religious organizations, 276 school-related contacts, and 52 detention center contacts. 1385 teens were reached through community networks.

3) Expanded services- Result: The Family Planning Program added 24 Provider Agreement sites. 1,910 clients were served during flex hours at local health offices, 572 clients were served in mobile vans.

FY 04, Enabling Services:

1) Target outreach efforts for adolescents- Result: 40 offices provided outreach through local high schools, mobile van unit, community colleges, alternative high schools, family related organizations and youth groups.

FY04, Population Based Services:

1) Provide outreach and education in local public health offices- Result: 1,458 received family planning education through educational contacts. Local health offices provided educational sessions at 320 community sites, 52 civic organizations, and 56 religious sites. 1,059 teens received family planning education.

FY04, Infrastructure Building:

1) Ensure quality assurance through training, client surveys and EMA -- (Standards of Care, Best Practice, Client Centered Care).

Result: A yearly client satisfaction survey is distributed to local public health offices. Family planning provided 47 trainings with a total of 1,425 participants.

### c. Plan for the Coming Year

FY05, Direct Health Care:

1) Increase services to the hard to reach population.

2) Develop community networks.

3) Expanded services.

? Planned achievement for FY05, Enabling Services: Target outreach efforts for male and female adolescents.

? Planned achievement for FY05, Population Based Services: Provide education and outreach in local public health offices.

? Planned achievement for FY05, Infrastructure Building: Ensure quality assurance through needs assessment, client surveys and EMA -- (Standards of Care, Best Practice, Client Centered Care) Continue to analyze and report NM PRAMS data for teens age 15-17 and age 18-19; with presentation of data to target groups.

*Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

### a. Last Year's Accomplishments

FY03 Target: The goal for percentage of 3rd grade children who have received dental sealants was met for FY 2003. The Office of Dental Health (ODH) used state funds to provide dental sealants to the target population in schools with free and subsidized lunch programs; it serves about 75% of target schools, a total of 120 reached by DOH staff and about 30 additional reached by contracted services. ODH also contracted with private school based companies to increase the number of children receiving dental sealants.

FY03, Direct Health Care: Activities and there results: Ensured adequate numbers and distribution of school-based providers. Private school based companies offered preventive services to children through the use of portable dental equipment. The ODH used general funds to increase services to the low-income families through contracts with community health care centers. A contract with the University of New Mexico (UNM) increased care for children with early childhood caries. UNM offered hospital treatment for those children needing extensive dental treatment. For those unable to qualify for Medicaid, the ODH will paid for the necessary services.

FY03, Population Based Services: Activities and results: Ensure sealant placement in under-served areas. Activities and results: The ODH selected schools having 50% or greater free-lunch participation

FY03, Infrastructure Building: Activities and results: The ODH has helped build infrastructure by supporting school-based companies and community health care centers. ODH contracts with these dental providers to provide direct dental services to low-income families. The contract money resulted in an increase in preventive services, emergency dental care, and hospital dentistry.

#### b. Current Activities

FY04 performance indicator for targets from FY04-FY08: The performance measure for FY04 is the number of 3rd grade children who have received protective sealants on at least one permanent molar tooth. The target was set at 50% based on the Healthy People 2000 initiative to increase to >50% the proportion of children who have received protective sealants on the occlusal surface of permanent teeth. The key factors are family income, education level, lack of access to care, low number of pediatric dentists/dentists who treat young children.

FY04, Direct Health Care: Ensure children in under-served areas are receiving dental sealants. Planned Activities: The ODH will continue to use general funds to support the ongoing sealant program. ODH will also partner with private school based companies to increase the number of children receiving preventive dental treatment.

FY04, Population Based Services: The ODH will target low-income children in under-served areas. Planned Activities: ODH will select schools with 50% or greater participation in the free or reduced lunch program.

FY04, Infrastructure Building: Ensure adequate numbers and distribution of schoolbased sealant providers. Planned Activities: The ODH will continue its efforts to work with the NM Dental Board and NM Oral Health Council to increase access for dental care. The ODH will continue to support public-private partnerships with hopes to increase dental services to the lower income children. The ODH will use general funds to support low-income families who do not qualify for Medicaid but are in need of dental treatment.

#### c. Plan for the Coming Year

FY05 Performance indicator for targets from FY05-FY08: The performance measure for FY05 is the number of 3rd grade children who have received protective sealants on at least one permanent molar tooth. We will continue to work towards the target that was set at 50%.

FY05 Population based services: The ODH will target low-income children in under-served areas. ODH will select schools with 50% or greater participation in the free or reduced lunch program.

FY05, Infrastructure Building: Ensure adequate numbers and distribution of schoolbased sealant providers. Planned Activities: The ODH will continue its efforts to work with the NM Dental Board and NM Oral Health Council to increase access for dental care. The ODH will continue to support public-private partnerships with hopes to increase dental services to the lower income children. The ODH will use general funds to support low-income families who do not qualify for Medicaid but are in need of dental treatment.

### a. Last Year's Accomplishments

In FY03, the SAFE KIDS network was expanded to 12 coalitions and chapters, 32 car seat technicians received the National Highway & Transportation Safety Agency (NHTSA) training, 22 car seat clinics were completed, 4 training of trainers and 10 trainings of child care providers for the Safety curriculum, distribution of 60,000 pieces of literature; introduction of helmet legislation for bicycles, skateboards, scooters and in-line skates.

FY02: Key factors from needs/resources assessment that were to be addressed included Lack of access to weight appropriate car seats. Barriers included lack of access to appropriate car seats at the community level.

FY03, Population Based Services: Improved access to and utilization of appropriate child restraint in vehicles. Activities and results included 3,000 children and booster car seats were provided, 60 certified car seat technicians were trained, and 40 car seat clinics were provided.

FY03, Infrastructure Building: Expanded the network of SAFE KIDS chapters. Activities and results included The SAFE KIDS network was expanded to 12 chapters.

### b. Current Activities

FY04-FY08: It is anticipated that performance will improve due to the passage of the All Positions seat belt law, and increased access to car seats and car seat technicians. Lack of access to weight appropriate car seats will be addressed.

Planned achievement for FY04, Population Based Services: Improve access to and proper utilization of appropriate child restraint in vehicles. Planned Activities include: 1) Continue support for implementation of the Child Restraint Law and the new All Positions seat belt law; 2) Develop legislative proposals for car seat funding; and 3) Continue Title V support for the Childhood Injury Prevention specialist.

Planned achievement for FY04, Infrastructure Building: Planned Activities include: 1) Expand network of SAFE KIDS chapters via support from statewide coalition and collaboration with nonprofits and community agencies. 2) Evaluate car seat certification and distribution programs.

### c. Plan for the Coming Year

In FY 05, plans are to expand SAFE KIDS network to 16 chapters and coalitions; retain the coordination of the New Mexico SAFE KIDS Coalition from the Dept. of Health Title IV position, introduce booster seat legislation; reintroduce all-terrain vehicle legislation; reintroduce helmet legislation for bicycles, skateboards, in-line skates and scooter; set up distribution of safety literature from site in City of Albuquerque to supplement the Injury Prevention Resource Center site in City of Santa Fe, introduce initiative for permanent fund to increase car seat distribution from 3,000 per year to 6,000 per year, and to also double the number of child car seat clinics from approximately 20 to 40 per year in the SAFE KIDS network.

FY02 performance indicator target was at 3.5 per 100,000, and will remain there through FY08. Education and distribution of seats via car seat clinics will continue to improve the state performance, although it is anticipated the improvements will eventually flatten out unless the number of free seats for distribution to low income families increasing substantially.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

### a. Last Year's Accomplishments

FY03, Enabling Services: Continued WIC Peer Counselor Program in Dona Ana

County, Valencia Co, and expanded into NE Heights Clinic in Metro Albuquerque; WIC clinics provided group breastfeeding support sessions and individual counseling to WIC mothers per protocols. WIC provided high-risk and working/school WIC mothers breast pumps: ~ 3,500 women received manual breast pumps; 800 single-user electric pumps; 1,800 multi-user electric pumps.

FY03, Population Based Services: Continued media campaign to increase public acceptance of breastfeeding: WIC aired over 300 television advertisements from USDA's Loving Support for breastfeeding through 5 different local area networks broadcasting statewide. WIC Clinics celebrated World Breastfeeding Week (WBW): 38 clinics sponsored a ceremony, luncheon etc. for clients; a press release about WBW went to all radio and TV stations statewide and 17 news articles about breastfeeding during that week; clients received breastfeeding water bottles and staff received USDA Loving Support Breastfeeding t-shirts and new educational videos on breastfeeding.

FY03, Infrastructure Building: Development of WIC breastfeeding reports of initiation and duration data. PRAMS and WIC collaborated on analysis of PRAMS breastfeeding data. WIC presented "Breastfeeding Basics" workshop in 5 locations, training approximately 100 Public Health and WIC staff, as well other community health care professionals; aApproximately 60 WIC and Public Health Staff attended NM Breastfeeding Task Force Annual Breastfeeding Conference. WIC Breastfeeding Advisory Board conducted annual evaluation of supplies and resources; based on a staff survey recommendations implemented were \$170,000.00 for breast pump equipment, \$70,000.00 for other breastfeeding supplies/events; WIC provided quarterly breastfeeding newsletters, posted an intranet site for staff to access the Breastfeeding Promotion Program's information and resources.

#### b. Current Activities

FY04, Enabling Services: 1) Provide a WIC Peer Counselor Program in Dona Ana and Valencia Counties, and one clinic in the Albuquerque metro area, and expanded program into 18 other WIC clinics statewide (approximately 4 additional sites per district). 2) Provide group breastfeeding support sessions and individual counseling to WIC pregnant and breastfeeding mothers. 3) Support high-risk and working mothers WIC mothers with an effective breast pump: ~ 4,000 women received manual breast pumps; 1,000 single-user electric pumps; 1,800 multi-user electric pumps, and 150 pedal pumps.

FY04, Population Based Services: 1) WIC Clinics celebrated World Breastfeeding Week (WBW). 42 clinics sponsored a ceremony, luncheon etc. for clients; a press release about WBW went to all radio and TV stations statewide and 17 news articles about breastfeeding during that week. Clients received baby t-shirts promoting breastfeeding, and clinics received breastfeeding lunch tote bags, new breastfeeding videos and framed artwork.

FY04, Infrastructure Building: 1) Develop WIC Breastfeeding Duration Report to establish a baseline. Analyze PRAMS breastfeeding data for state and community use. 2) Provide breastfeeding education and training opportunities for health care professionals statewide: WIC presented "Breastfeeding Basics" workshop in 7 locations, training approximately 130 Public Health and WIC staff, peer counselors, as well other community health care professionals.; Approximately 100 WIC and Public Health Staff attended NM Breastfeeding Task Force Annual Breastfeeding Conference. 3) Ensured WIC clinic access to adequate breastfeeding supplies and resources, with emphasis on internet sources.

#### c. Plan for the Coming Year

Planned achievement for FY05, Enabling Services: 1) Expand WIC Peer Counselor Program

into one-half of all WIC clinics statewide 2) Provide group breastfeeding support sessions and individual counseling to WIC pregnant and breastfeeding mothers. 3) Support high-risk and working mothers WIC mothers with an effective breast pump. 4) Provide breastfeeding education and support information to WIC fathers.

Planned achievement for FY05, Population Based Services: 1) Conduct outreach efforts to increase public acceptance of breastfeeding. Planned achievement for FY05, Infrastructure Building: 1) Analyze WIC

Breastfeeding Initiation and Duration Reports. 2) Analyze PRAMS breastfeeding data for state and community use. 3) Provide breastfeeding education and training opportunities for health care professionals statewide. 4) Continue collaboration with the University of New Mexico to evaluate the WIC Peer Counselor Program. 5) Ensure WIC clinic access to adequate breastfeeding supplies and resources, with emphasis on father-involvement sources. 6) Develop a curriculum for pregnant and breastfeeding client education. 7) Facilitate the creation of state legislation for supportive workplace policies for breastfeeding.

Planned achievement for FY04, Infrastructure Building: 1) Analyze WIC Breastfeeding Duration Report to establish a baseline. Develop and make additional data reports concerning breastfeeding statistics available to WIC staff statewide. Analyze PRAMS breastfeeding data for state and community use. 2) Provide breastfeeding education and training opportunities for health care professionals statewide. 3) Ensured WIC clinic access to adequate breastfeeding supplies and resources, with emphasis on internet sources.

*Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.*

#### a. Last Year's Accomplishments

FY03, Enabling Services: 1.) Work continued implementing the electronic birth certificate which has captured screening and risk factor information. 2.) The CMS resource guide was revised and translated into Spanish. 3.) The Newborn Hearing Screening Coordinator continued to provide training and technical assistance to hospitals on proper procedures and required follow-up referrals to CMS/FIT staff.

FY03, Population Based Services: 1.) Tracking system continued to be refined. Work done on implementation of electronic birth certificate. 2.) Training and technical assistance was provided on proper procedures for hospital reporting and referrals. 3.) Tracking form was implemented by the Coordinator to gain feedback from CMS FIT staff on the status on the referrals received. 4.) NM Vital Statistics continued to work with CMS staff and allowed CMS access to the birth file to enhance the tracking system. 5.) Family handbook was translated into Spanish. 6.) The CMS/FIT Coordinator provided quarterly training to staff. 7.) CMS/ FIT staff continued to work closely with Part C Early Intervention (EI) providers statewide. An EI system continued to be in place. 8.) Family support agencies continued to work with CMS in policy development, materials development and in direct services.

FY03, Infrastructure Building: Training to reinforce compliance to State Regulations continued along with training and technical assistance to birthing hospitals, medical care providers including physicians and audiologists. Hospital referral process was reinforced on a regular basis.

#### b. Current Activities

FY04, Enabling Services: Data from hospitals, birth files, CMS/fit social workers follow-up data is being entered into a data base. CMS began to partner with FHB Epidemiology to analyze

screening data. The screening follow-up form was implemented and utilized by the CMS/FIT social workers. CMS social workers provide care coordination to ensure access to a medical home for the child and family. CMS continues to work closely with parent-to-parent organizations to ensure family satisfaction.

FY04, Population Based Services: The Newborn Hearing Screening Coordinator provided training and technical assistance to all birthing hospitals on awareness and documentation of risk factors, proper referral procedures, and utilization of the electronic birth certificate. The Coordinator and State CMS staff provided intense support and technical assistance to several birthing hospitals that experienced repeated equipment failure. Partnership with the FHB Epidemiology staff began for the analysis of screening data. Training continued to be provided to all new CMS staff on proper follow-up procedures.

FY04 Infrastructure Building: The Screening Coordinator continued to provide training and technical assistance to birthing hospitals and expanded training to medical care providers and audiologists. CMS State Office staff presented program information to the NM Department of Health/Public Health Division General Staff meeting, the New Mexico Pediatric Society, the Advances In EDHI Conference, and a poster session at the National EDHI Conference. The Newborn Hearing Screening Advisory Council was re-established to provide recommendations and guidance to the program with an focus on follow-up.

### c. Plan for the Coming Year

FY05, performance indicator targets form FY 05 -- FY08: Proportion of newborns who received hearing screening and proper follow-up services.

FY05, Enabling Services: Continue to follow gold standard of care of screening at within one month; identification of hearing loss by 3-4 months, and referral to early intervention services by 6 months of age. CMS will provide and maintain care coordination through tracking and follow-up of all infants referred through a data base system.

FY05, Population Based Services: For all infants referred from screening, identify all those with hearing loss by 3-4 months of age and begin early intervention by 6 months of age. CMS will analyze data from all sources of information regarding infants who are identified as requiring follow-up services including timeliness of contact and referrals and provide training to audiologists and PCP's on the screening program and the importance of timely intervention. Continue the partnership with FHB Epidemiology for data analysis.

FY05, Infrastructure Building: Maintain the number of birthing hospitals that provide universal screening at 100%. Continue to provide in-service trainings to all birthing hospitals on quality screening procedures. Ensure all referrals receive diagnostic evaluations and medical care coordination. Explore working with a new acquired data entry program (SNAP) purchased by FHB for tracking of hospital screening and referrals. Continue with FHB Epidemiology on data analysis. Continue training and technical assistance to CMS social workers on requirements of quality care provision of the screening program. CMS State Office staff and/or Coordinator continue to present program information to health professionals and community groups. Continue the Newborn Hearing Screening Advisory Council with a focus on statewide public awareness through the use of media modalities.

In FY05, the CSTE-CDC assigned MCH epidemiology fellow, Tierney Murphy, MD, MPH, will use 2003 data to evaluate the program's objectives: the percent of infants screened by 30 days of age; percent who failed screening who were referred to and seen by an audiologist; and percent found to have hearing loss and referred into/participating in an early intervention program. This evaluation will include issues related to screening services and the quality of reporting by participating hospitals, CMS social workers and FIT program.

## Performance Measure 13: *Percent of children without health insurance.*

### a. Last Year's Accomplishments

FY03 Report , Direct Health Care - Activities and their results: Provided funding and/or services for 5094 children and youth with special health care needs. The Families FIRST and the CMS CYSHCN Program provides assessment of insurance options for clients, and does MOSAA/PE if the children or youth are eligible. In terms of statewide target, children and youth with special health care needs who have Medicaid may lose insurance temporarily because of renewal difficulties. FY03 Report, Enabling Services: CMS CYSHCN Program provides assessment of insurance options for clients, and does MOSAA/PE if the children or youth are eligible. Activities and their results: CMS CYSHCN Program provides assessment of insurance options for clients, and does MOSAA/PE if the children or youth are eligible. In terms of statewide target, children and youth with special health care needs who have Medicaid may lose insurance temporarily because of renewal difficulties.

FY03 Report, Infrastructure Building: CMS CYSHCN Program provides assessment of insurance options for clients, and does MOSAA/PE if the children or youth are eligible. CMS and partners continue to address the need for 'family friendly' service at the ISD office -- the access point for renewal of Medicaid clients.

Activities and their results: CMS CYSHCN Program assesses insurance options for clients and does MOSAA/PE for eligibles. In terms of statewide target, children and youth with special health care needs who have Medicaid may lose insurance temporarily because of renewal difficulties. MCAF reported: in order to increase access to comprehensive preventive care for clients participating in Medicaid Managed Care programs worked with state agencies and community-based groups to address barriers to access to comprehensive preventive care, qualified providers, and culturally competent services resulted in reduction of identified barriers in transportation. In some areas of the state, coordination of existing services was improved; Inconsistent formulary- the State Medicaid agency attempted to address this problem; Language-the Public Health Division initiated a quality improvement initiative to facilitate translation and interpretation services. Identified barriers were not reduced in access to nutrition services. Medicaid reimbursement mechanisms remain a barrier. Other barriers include Lack of knowledge of available family planning services. Anticipated outreach and provider education regarding the Family Planning waiver was not done by the state Medicaid agency.

#### b. Current Activities

In FY04 CMS provided education and advocacy with Secretary of DOH regarding need for sufficient funding to increase the \$15,000 limit for CMS clients, increase dated hospital per diem rates, increase number of multidisciplinary clinics. The Secretary of DOH has approved the closing of HKF in order to address the need for these changes within the CYSHCN program: increase in the limit for CYSHCN clients to providers, increase hospitals per diem rates, increase in reimbursement for cancer, cardiac and renal conditions. The legislature provided \$100,000.00 in funding for cancer treatments. Unfortunately, 1500 non-medicaid eligible children lost primary medical care services when HKF closed. CMS continues to provide leadership in provider and pediatric specialist infrastructure issues as well as access to health care for immigrants.

#### c. Plan for the Coming Year

In FY05 the FHB team will work with partners to identify statewide strategies to address issues of uninsured or underinsured. CYSHCN leadership and partners are providing input in to the State Health Plan. CMS will monitor the implication of the purchasing specifications for CYSHCN that are present in the Medicaid program at this time, which will be carried, forward in the redesign of Medicaid and be included in any state health planning. In addition, a request to

include and address issues of immigrant children and youth will continue. The Children's Cabinet will work to address universal coverage for children.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

**a. Last Year's Accomplishments**

FY03, Enabling Services: Implement Title 21 to involve previously unserved children - Activities and their results - SCHIP Phase II services were not approved by HCFA and therefore the Phase II kinds of opportunities for outreach to promote participation did not occur.

FY03, Infrastructure Building: Address geographic, ethnic, age related, and other disparities in Medicaid participation. Activities and results: The SSDI project identified disparities in access to health and health related services. These disparities were between types of service, men and women, age groups, ethnic groups, and families with either one or three children. Lack of staffing and resources has prevented implementing effective interventions.

**b. Current Activities**

FY04: There is year to year variation in the data that one might attribute to obtaining unduplicated counts from a billing system.

Known issues from needs assessment: potential eligibles include immigrant children, working poor, families who could but do not enroll in Medicaid, areas of state where families report difficulties such as unpleasant enrollment processes. Title V MCH will work with Medicaid teams to further explore issues.

Infrastructure Building activities and results: Three FHB programs work actively to enroll eligible children in Medicaid: Families FIRST Case Management, Children's Medical Services and Family Planning Program; School-based health centers work on this as well. The presumptive eligibility-Medicaid on-site application assistance (PE-MOSAA) procedure is implemented in LHOs and by contractors as well.

**c. Plan for the Coming Year**

In FY05 key factors that need to be addressed: Collaboration with Medicaid.

Planned achievements and activities for FY04, Infrastructure Building: Three FHB programs will continue to work actively to enroll eligible children in Medicaid:

Families FIRST Case Management, Children's Medical Services and Family Planning Program; School-based health centers work on this as well. The PE-MOSAA procedure will continue to be implemented in LHOs and by contractors; however because the Medicaid agency has decided not to reimburse for this service, it may be reduced in local health offices.

FHB leaders will work with Medicaid leaders to assess the data to understand the year to year variability, and to identify issues that need to be addressed.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

**a. Last Year's Accomplishments**

FY03, Direct Health Care: Supported filling of gaps in PNC with services in select PHOs. PNC services added in two unserved communities: Truth or Consequences and Lordsburg. Enhanced cultural relevance of public health PNC through support for group PNC.

PNC clinicians each given a subscription to Audio Digest, Ob/Gyn track. One conference attended together by all PNC midlevels. Patient educational materials upgraded.

FY03, Enabling Services: 1) Developed a position for health educator into Maternal Health Program to strengthen all program activities; continue current contracts and provider agreements enabling PNC. 2) Initiated provider agreements to 2 more primary care clinics to enable care for medically indigent. Continued provider agreements with specialists enabling PNC for high risk medically indigent.

FY03, Population Based Services: 1) through a contract with a public relations firm, continued toll-free preconception and prenatal referral and info number. 2)

Billboards, screen slides shown in movie theaters during intermissions, take-home info cards and 30" radio spots targeting Native American women, encouraging early prenatal care and cessation of harmful substances use.

FY03, Infrastructure Building: Promoted cultural responsiveness by caregivers and partnered with rural CNMs and UNM CNM program to explore, and develop strategies to enhance CNM access to appropriate hospital privileges. Worked with March of Dimes, Behavioral Health Program and other agencies to reduce harmful substance use by childbearing women through media campaign: 2 billboards, screen slides shown in movie theaters during intermissions, take-home info cards and 30 radio spots targeting Native American women, encouraging early prenatal care and cessation of harmful substances use.

#### b. Current Activities

FY04, Direct Health Care: Continued support for PHOs in giving PNC to underserved women. Developed and negotiated provider agreement with primary care to give PNC to unserved women in Clovis. Continued previous provider agreements with primary care agencies.

FY04, Enabling Services: Pursue establishment of a position for a Health Educator in the Maternal Health Program to strengthen all program activities. Visited most PHO PNC clinics , including new clinics in Truth or Consequences and Lordsburg. Continued Audio Digest, Ob/Gyn Track for PHO clinicians giving PNC. Presented first day-long conference on PNC for PHO clinical staff, with 40 attendants. Continued provider agreements with specialists enabling PNC for high risk medically indigent.

FY04, Population Based Services. Negotiated, administered and oversaw a contract with an agency to provide training, technical and material support for 8 representative pilot sites throughout the state to initiate culturally appropriate group PNC in PHOs, IHS offices and primary care sites. Continued to develop interagency Prenatal Care Task Force.

#### c. Plan for the Coming Year

FY05, Direct Health Care: Continue to partner with clinics and providers and PHD district staff to enhance access to PNC and support PNC in PHOs as needed. Initiate PNC in Clovis and Santa Rosa to provide PNC in communities where it is now unavailable for medically indigent women.

FY05, Enabling Services: Continue support to 8 pilot sites giving culturally appropriate group PNC in representative communities. Encourage use of these pilots as models to demonstrate to and train more providers in culturally appropriate group PNC.

FY05, Infrastructure Building: Implement chart audit system for PNC in PHOs. Update clinical records forms to meet current needs and standards. Produce second annual PHD PNC Conference. Continue to build partnerships by strengthening the NM Prenatal Care Task Force.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

#### a. Last Year's Accomplishments

## FY03 Report of activities and results

FY03, Direct Health Care: Continued to work closely with Office of School Health and Injury Prevention EMS Bureau to improve mental health services offered through school based health clinics. Expanded use of the screening tool piloted last year. Four school based health centers participated in Columbia Screening Tool test in New Mexico. The medical director ran a 6-week series of support groups for young males in one elementary school, which addressed many issues, including youth suicide. In addition, he participated in the development of a local arts for boys program, and provided similar prevention messages.

FY03, Enabling Services: Continued public/professional education efforts aimed at increasing proper gun storage practices, with over one thousand educational contacts.

FY03, Infrastructure Building: Two-day conference held to bring together community activists, and to follow up on state suicide prevention plan. There is now a statewide active Council of 15 members meeting regularly. Through IPEMS Bureau, six eight-hour youth suicide prevention gatekeeper training retreats were provided for 19 adults and 91 peer educators (youth) in Northern New Mexico Communities. A tool kit that included information about 1) the warning signs of suicide, 2) risk factors for suicide, 3) local youth suicide completion statistics and 4) community contact information for suicide ideology and attempts was created and provided to the training participants. An evaluation plan was created. Pre and posttests were given to each group who participated in the training. Findings showed that knowledge about warning signs of and how to prevent a suicide increased at an average of 39% across the trainings. Continued to work with MCH councils to increase community-based initiatives related to youth suicide prevention. Continued to monitor suicides through vital statistics and fatality review teamwork.

## b. Current Activities

FY04 Direct Health Care: The Bloomfield School District in San Juan County delivered the Signs of Suicide Program that educates students, parents and staff on identification of risk, and surveyed 500 students for risk and had 20 counselors on hand to further address students needing counseling and referral, as part of this process. Eight school based clinics or wellness centers delivered the Columbia Teen Screening process to over 800 students. Three additional sites are trained and preparing to screen next school year.

FY04 Enabling Services: Worked closely with the Department of Public Safety as they created regulations around the Concealed Carry Weapon permit process, to ensure that part of the educational requirements included a module on youth suicide/ gun violence prevention.

FY04 Infrastructure Building: Currently the only real funding for suicide prevention in NM consists of \$53,000 through funding from the Centers for Disease Control Preventive Health and Health Services Block Grant. This funding currently provides suicide prevention programs and services in four counties. The contract is with the comprehensive program of New Mexico Suicide Intervention Project (NMSIP), and provides warning sign and referral training in schools and in communities, offers technical assistance on community based coalition development and curriculum development, offers counseling services for youth and their families at risk for suicide. NMSIP mainly serves Santa Fe, Rio Arriba, Taos and Sandoval County. They are unable to expand due to limited resources. United Way in San Juan County received \$1,500 to enhance the awareness of the problem of suicide through PSAs and media events. NM Suicide Survivors received \$1,200 to provide training for survivors to start their own groups in their local communities. A Suicide Prevention Coalition exists to guide the Public Health Division in addressing gaps of programming within the state and finding resources for prevention activities. The membership consists of agency representatives and community members with direct knowledge of suicide issues. The MCH Medical Director participates in these efforts.

## c. Plan for the Coming Year

In FY05, the youth suicide rate continued to be highly variable, and NM targets are based on

national trends which suggest a declining rate of youth violence in general, some minimal improvement in substance abuse use in youth, although the most commonly used drugs, alcohol and marijuana, remain essentially unchanged, and some improvement in our statewide capacity in terms of mental health service delivery. In cooperation with other relevant public health programs, Family Health focuses on raising awareness about the importance of proper storage of firearms, engaging communities in prevention efforts, improving services in school based environments, and monitoring trends through vital statistics and fatality review team efforts.

FY05 Direct Health Care: Continue to work closely with the Office of School Health and Injury Prevention EMS Bureau to improve and expand mental health services and screenings offered through school based health clinics. Provide some direct services to programs serving boys in the Santa Fe area.

FY05 Enabling Services: Continue public/professional education efforts aimed at increasing proper gun storage techniques. Monitor the effects of the concealed carry law, which began issuing permits January of 2004.

FY04 Infrastructure Building: Continue to work with MCH councils to increase community-based initiatives related to youth suicide prevention. Continue to monitor suicide trends through vital statistics and fatality review teamwork. Continue to educate the public and professionals about depression and youth suicide through educational conferences, radio, newspaper and television programs. Coordinate with the activities of the statewide suicide prevention coalition.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

FY03, Continued networking with transport, NICU and rural shareholders to develop strategies. Financial barriers prevented significant progress for this year.

b. Current Activities

FY04, Infrastructure Building: Networked and met with UNMH personnel directly involved in preterm labor transport and NICU. Encouraged development and implementation of increased efforts to train rural physicians and hospital staff in rapidly accessing transport for women in preterm labor. Tocolytics are now known to be ineffective for preventing labor more than 2 to 4 days.

c. Plan for the Coming Year

FY05, Infrastructure Building: Continue networking with personnel involved in NICU, transport and rural hospitals. Negotiate with adjacent states to smooth diversion of transports to nearest tertiary care center with neonatal intensive care unit (NICU) with sufficient staff and capacity at the time. 3) Approach Air Force and/or National Guard for assistance with transport vehicles or to carry out transports.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

a. Last Year's Accomplishments

FY03, Direct Health Care: Supported filling of gaps in prenatal care (PNC) with services in select LHOs. PNC services added in two unserved communities: Truth or Consequences and Lordsburg. Enhanced cultural relevance of public health PNC through support for group PNC.

PNC clinicians each given a subscription to Audio Digest, Ob/Gyn track. One conference attended together by all PNC midlevels. Patient educational materials upgraded.

FY03, Enabling Services: 1) Developed a position for health educator into Maternal Health Program to strengthen all program activities; continue current contracts and provider agreements enabling PNC. 2) Initiated provider agreements to 2 more primary care clinics to enable care for medically indigent. Continued provider agreements with specialists enabling PNC for high risk medically indigent.

FY03, Population Based Services: 1) through a contract with a public relations firm, continued toll-free preconception and prenatal referral and info number. 2) Billboards, screen slides shown in movie theaters during intermissions, take-home information cards and 30" radio spots targeting Native American women, encouraging early prenatal care and cessation of harmful substances use.

FY03, Infrastructure Building: Promoted cultural responsiveness by caregivers and partnered with rural CNMs and UNM CNM program to explore, and develop strategies to enhance CNM access to appropriate hospital privileges. Worked with March of Dimes, Behavioral Health Program and other agencies to reduce harmful substance use by childbearing women through media campaign: 2 billboards, screen slides shown in movie theaters during intermissions, take-home info cards and 30 radio spots targeting Native American women, encouraging early prenatal care and cessation of harmful substances use.

#### b. Current Activities

FY04, Direct Health Care: Continued support for LHOs in giving PNC to underserved women. Developed and negotiated provider agreement with primary care to give PNC to unserved women in Clovis. Continued previous provider agreements with primary care agencies.

FY04, Enabling Services: Pursued establishment of a position for a Health Educator in the Maternal Health Program to strengthen all program activities. Visited most LHO PNC clinics , including new clinics in Truth or Consequences and Lordsburg. Continued Audio Digest, Ob/Gyn Track for LHO clinicians giving PNC. Presented first day-long conference on PNC for PHO clinical staff, with 40 attendants. Continued provider agreements with specialists enabling PNC for high risk medically indigent. Regulations for both CNMs and LMs are being revised to further reduce barriers to CNM prescribing and the connect LMs better with their national credentialing organization. CNM services continue to increase, reaching 30% of deliveries in 2002. Provided technical assistance (TA) to direct entry midwifery association to overcome barriers to accessing Medicaid payments for services.

FY04, Population Based Services: Negotiated, administered and oversaw a contract with an agency to provide training, technical and material support for 8 representative pilot sites throughout the state to initiate culturally appropriate group PNC in LHOs, IHS offices and primary care sites. Continued to develop interagency Prenatal Care Task Force

#### c. Plan for the Coming Year

FY05, Direct Health Care: Continue to partner with clinics and providers and PHD district staff to enhance access to PNC and support PNC in PHOs as needed. Initiate PNC in Clovis and Santa Rosa to provide PNC in communities where it is now unavailable for medically indigent women.

FY05, Enabling Services: Continue support to 8 pilot sites giving culturally appropriate group PNC in representative communities. Encourage use of these pilots as models to demonstrate to and train more providers in culturally appropriate group PNC. Finalize and implement revised CNM and LM protocols to decrease barriers to practice and enhance national participation. Continue TA to direct entry midwives to overcome barriers to Medicaid reimbursement.

FY05, Infrastructure Building: Produce second annual PHD PNC Conference. Continue to build partnerships by strengthening the interagency NM Prenatal Care Task Force.

FY05 Population Based Services: Develop and pursue grant for needs assessment for medically indigent pregnant women statewide.

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

**General Instructions/Notes:**

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Oversee ongoing collection of newborn genetic screening samples and submission to state laboratory division	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop Metabolic Clinic Infrastructure from 6 sites to 8 sites.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Train Newborn providers regarding genetic screening program protocols, procedures & practices.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop Strategic Plan to Improve Screening Program. Coordinate through Newborn Genetic Screening Advisory Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Care coordination by CMS FIT social workers for families who have infants with positive genetic screen.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Development/implementation of linkage between screening and vital records to monitor coverage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Establish contracts with family organizations and/or selected family members to assure family involvement in decision making.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Family organizations will provide transition training to CMS social workers and other providers on family involvement practices.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Establish new or utilize existing councils to review CYSHCN survey outcomes and to develop plan for improvement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Analysis of NM specific data in national survey of CYSHCN to identify key issues to improve performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Medical home project will continue in 7 targeted sites - Farmington, Gallup, Albuquerque, Santa Fe, Taos, Las Cruces.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. CMS will continue to pilot transition assessment for youth moving to an adult medical home	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. CMS works with partners to identify statewide strategies to institute medical home	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Analysis of NM specific data in national survey of CSHCN to identify key issues to improve performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. CMS works with partners to identify statewide strategies to address access to health insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work with state agencies and legislative committees to improve access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Analysis of NM specific data in national survey of CSHCN to identify key issues to improve performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			

	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. CMS maintains specialty clinics statewide	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. CMS will continue to provide care coordination to all CYSHCN and their families	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CMS works with partners statewide to address issues of access to community based care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CMS works with Medicaid's Managed Care Organizations towards achieving block authorizations for services for CYSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Analysis of NM specific data in national survey of CSHCN to identify key issues to improve performance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Transition planning services to youth age 14-21 through care coordination by 45 social workers to cover all 33 counties in New Mexico.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Educate professionals & families, all aspects youth transition, with Healthy Transition NM Coordinating Council.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Contracts with family organizations to provide training in youth transition, statewide	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CMS Transition Team reviews issues, works to inform policies regarding transition-age CYSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Use NM Behavioral Risk Factor Surveillance System, data for age 18-24 to monitor transition indicators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Analysis of NM specific data in national survey of CSHCN to identify key issues to improve performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis,				

Haemophilus Influenza, and Hepatitis B.

1. Develop statewide immunization registry (a NM Dept. Health initiative)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Build & support local and state immunization coalitions.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop an informational immunization website to promote immunization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to implement the Vaccines for Children program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Family Planning, increase community education efforts	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Family Planning, expand clinic hours and teen targeted services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Family Planning, target outreach efforts for adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Family Planning, develop community networks	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Family Planning, offers clinical family planning services in local health offices, contract sites and school based health centers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Use of vital records, NM PRAMS, NM BRFSS and NM YRRS surveillance data to identify disparities, target	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Statewide promotion of emergency contraceptive pill (ECP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Sealant program staff (dentists, hygienists and dental assistants) target low-income schools with free & reduced lunch programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contracts with school based health providers to provide dental sealants to target population.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Implement fluoride-rinse program through target-schools in communities with sub-optimal fluoride levels.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Monitor fluoride levels in community wells, free testing results for families with private wells.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Oral Health Council (NM DOH, NM Dental Assn., UNM, Delta Dental,				

others) addresses oral health issues such as dental care access, oral health status.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Promote implementation of the NM Child Restraining Law and the new "all positions seat belt law"	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop legislative proposals for car seat funding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Expand network of SafeKids chapters with support from statewide coalition and collaboration with non-profits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Support and evaluate the car seat certification and distribution programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Analysis & interpretation, non-fatal motor vehicle crash data;use in policy and program planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Use of fatal crash data and NM Child Fatality Review findings, fatal motor vehicle crashes in policy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Peer counseling & support via NM WIC and NM Breastfeeding Task Force	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provision of breast pumps via WIC; promote breast-pump access for Medicaid clients	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Media campaign and Breastfeeding Week celebration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Policy & program planning using WIC and NM PRAMS data regarding breastfeeding initiation, and continuation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Provide inservice training to all birthing hospitals on quality screening procedures and data report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Data collection on all infants referred for audiological evaluation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide & maintain care coordination through tracking and follow-up for all infants referred	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Collaborative meetings with Medicaid's Managed Care Organizations to market services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborative networking with state agencies, legislative committees to promote universal access funding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Promote on-site eligibility/enrollment procedures for children's insurance/Medicaid/S-CHIP and other payors	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Monitor and use data for policy and program planning (NM PRAMS, NM BRFSS, CSHCN survey, Medicaid dat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Promote on-site eligibility evaluation and registration for Medicaid in many sites that serve childr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Promote use of Medicaid/S-CHIP cards by NM families who are on the program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Decrease harmful substance use among childbearing women (tobacco, drugs, alcohol)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work to increase early prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Use of NM Child Fatality review findings about suicide for policy and program planning	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Newsletters promoting locked gun storage practices	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Suicide prevention trainings (schools & communities)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. School-based Columbia Screening Tool implemented in selected NM Schools	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Statewide suicide prevention council addressing community coordination issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Public & professional training sessions, educational or informational opportunities are ongoing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NATIONAL PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.					
1. Work to upgrade staff, capacity and systems of transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2. Analysis of linked birth-death data to identify gaps or disparities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NATIONAL PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.					
1. Offer prenatal care in local health offices to women who have no other source of care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
2. Contractual agreements with clinics to provide prenatal care for medically indigent women	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
3. Social marketing, media messages to encourage early prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
4. Assess marginalized women's needs regarding prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5. Use of NM PRAMS data to identify key factors, gaps and disparities, associated with late entry & low level of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**D. STATE PERFORMANCE MEASURES**

State Performance Measure 1: *Number of 33 counties adopting the conceptual framework of Healthy Youth/Healthy Communities through an Assets/Resiliency model approach when working with youth*

<p>a. Last Year's Accomplishments</p> <p>a. Last Year's Accomplishments FY03          Enabling Services: Empowered pregnant teens and teen parents to develop a healthy lifestyle, access needed services, maintain social support system and build appropriate parenting</p>
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expectations and behaviors. Assessed medical and psychosocial risks to identify individual client(s) needs. Educated clients regarding health, pregnancy, stress, and parenting to assist in making healthy choices and provided information regarding accessing needed services. Linked clients to appropriate services to acquire needed care immediately. Collaborated with Youth Development Advisory Council Coordinators to evaluate services.

Infrastructure Building: Increased the number of agencies providing services to youth that are implementing best practice in youth development, including but not limited to, the Assets model. Activities and results: Title V staff and YDAC members partnered with statewide efforts in youth development, such as the Building A Foundation for Adolescent Health Conference, the DOH Program Area 1 Youth Development Work Group, and the New Mexico Forum for Youth and Communities.

Enhanced operations of the Youth Development Advisory Council (YDAC) to assist in the planning, implementation, and evaluation of policies and services to youth. Activities and results: Recruitment efforts expanded and maintained diverse membership. Three YDAC statewide meetings were held with input from the youth into the development of agendas, objectives, and priorities.

## b. Current Activities

### b. Current Activities Plan and Report of Activities

FY04 Planned Achievement.

Enabling Services: Empower pregnant teens and teen parents to develop a healthy lifestyle, access needed services, maintain social support system and build appropriate parenting expectations and behaviors. Assess medical and psychosocial risks to identify individual client (s) needs. Educate clients regarding health, pregnancy, stress, and parenting to assist in making healthy choices and ensured client(s) have the "know how" to obtain the services they need. Link clients to appropriate services to acquire care needed immediately.

Infrastructure Building: Enhance the development of the Youth Development Advisory Council (YDAC) to promote youth leadership in planning and evaluation of programs serving youth. Support operations of the YDAC through youth coordination, statewide trainings, and diverse membership. Network with community organizations and public/private partnerships to promote a statewide assets/resiliency framework. Train and conduct outreach focused on fostering developmental assets and healthy sexuality, through planning, evaluation, community organizing, advocacy, and peer education in New Mexico.

### FY04Results-

Goals and objectives for promoting healthy sexuality statewide during 2004 were created for the by the YDAC during statewide trainings and presented to service providers and youth workers at statewide conferences.

## c. Plan for the Coming Year

### c. Plan for the Coming Year

Enabling Services: Empower pregnant teens and teen parents to develop a healthy lifestyle, access needed services, maintain social support system and build appropriate parenting expectations and behaviors. Assess medical and psychosocial risks to identify individual client (s) needs. Educate clients regarding health, pregnancy, stress, and parenting to assist in making healthy choices and ensured client(s) have the "know how" to obtain the services they need. Link clients to appropriate services to acquire care needed immediately.

### Infrastructure Building:

Enhance the capacity of the Youth Development Advisory Council (YDAC) to promote youth leadership in planning and evaluation of programs serving youth through advocacy, peer and elder education. Support operations of the YDAC through youth coordination, statewide meetings, diverse membership, and outreach. Advocate for needed community resources and

encourage communities to offer these resources and services to our population. Training and outreach will focus on fostering developmental assets for prevention of teen pregnancy, substance use/abuse, suicide, obesity and their antecedents. The program will work to coordinate with Governor's Youth Alliance and the Children's Cabinet.

*State Performance Measure 2: Percent of first newborns and mothers receiving support services/parenting through community home visiting/support programs*

a. Last Year's Accomplishments

a. Last Year's Accomplishments

FY03 Report of activities July 1, 2002-June 30, 2003

FY03 performance indicator & target: NM PRAMS measures if any home visiting was received & if any parenting classes were attended; the estimates for 2000 were as follows: prenatal period, women reported 17.72% had parenting classes and 4.93% had home visiting; post partum (up to ~9 weeks) 4.3% had parenting classes and 8.16% had home visiting. The statewide estimates report if women had any of these services in prenatal or postpartum period. FY03 Target: 14%  
FY03, Enabling Services: The program provided parenting education and support services to 25 families of newborns.

FY03, Infrastructure Building: Interagency partnership for implementation of the Infant Mental Health Strategic Plan resulted in the Children, Youth and Families Department statewide assessment of agency services, capacity, and awareness of the importance of infant mental health..

b. Current Activities

b. Current Activities

FY04, Planned Achievement Enabling Services: Observe and enhance the home environment and parent child interactions by providing parenting education and support services through home visiting. Results-Title V supported a home visiting contract to provide parenting education and support services to 25 families of newborns in Las Cruces. FY04, Planned Achievement Infrastructure Building: Partner with state and community agencies to implement the Infant Mental Health Strategic Plan for New Mexico. Results-Although activities were reduced because of a position that was vacant for the entire year, Title V staff attended the Georgetown Infant Mental Health Academy as part of a team that included state and community agencies with follow up to implement the training goal of the Infant Mental Health Strategic Plan; promoted best practice in primary prevention home visiting through interagency partnership; integrated discussion of home visiting into activities of the Early Childhood Comprehensive Systems Grant.

c. Plan for the Coming Year

c. Plan for the Coming Year

FY05 Planned Achievement Enabling Services: Shift Child Health funds to maintain the Las Cruces Home Visiting contract to make up for the Department budget cuts.

FY05 Planned Achievement Infrastructure Building: Fill the Child Health Educator position and provide staff development as needed to assure knowledge, skills, and abilities to provide Title V leadership in public health assessment, assurance, and policy development ; Partner with state and community based agencies to implement the Infant Mental Health Strategic Plan Training Goal; Promote best practice in primary prevention home visiting; Integrate identified

home visiting priorities into the work of the Early Childhood Comprehensive Systems grant.

**State Performance Measure 3: *Reduce unintended pregnancy in New Mexico to less than 30% of births***

**a. Last Year's Accomplishments**

FY03, Direct Health Care:

1) Increase services to the hard to reach population- Result: Local health offices distributed 12,000 flyers, 68 PSAs, 34 Newspaper/Media Articles, 193 Posters, and participated in 189 Health Fairs, and 772 Clinic Promotions. 42,830 materials distributed for reduction of teen pregnancy most were pamphlets, 14 Spanish titles. 19,000 male involvement pamphlets were distributed, 4 Spanish titles.

2) Develop community networks- Result: 464 with local physicians, 248 health council contacts and 169 detention center contacts.

3) Expanded services- Result: 2366 teens were seen during expanded hours and 233 teens in the mobile van units.

FY03, Enabling Services:

1) Target outreach efforts for adolescents- Result: 42 offices provided outreach through local high schools, mobile van unit, community colleges, and alternative high schools.

FY03, Population Based Services:

1) Provide community education and outreach- Result: 9321 received family planning education through educational contacts. Local health offices provided 70 educational sessions done with youth groups, 92 done through JPOs.

FY03, Infrastructure Building:

1) Ensure quality assurance through training, client satisfaction surveys and EMA -- (Standards of Care, Best Practice, Client Centered Care) Result: A yearly client satisfaction survey is distributed to local public health offices. 103 staff members received medical training and 91 received QLP training. The Family Planning Program provided 46 trainings and a total of 888 participants.

**b. Current Activities**

FY04, Direct Health Care:

1) Increase services to the hard to reach population- Result: Local Health offices distributed 126,773 flyers, 8 PSAs, 4 Newspaper/Media Articles, 4 Posters, and participated in 28 Health Fairs.

2) Develop community networks- Result: Networking with 84 local physicians, 60 health councils, 16 MCH councils, 16 religious organizations, 276 school-related contacts, and 52 detention center contacts. 1385 teens were reached through community networks.

3) Expanded services- Result: The Family Planning Program added 24 Provider Agreement sites. 1,910 clients were served during flex hours at local health offices, 572 clients were served in mobile vans.

FY04, Enabling Services:

1) Target outreach efforts for adolescents- Result: 40 offices provided outreach through local high schools, mobile van unit, community colleges, alternative high schools, family related organizations, youth groups, and soup kitchens.

FY04, Population Based Services:

1) Provide outreach and education in local public health offices. Result: 1,800 received family planning education through educational contacts. Local health offices provided educational sessions at 320 community sites, 252 government sites, 52 civic organizations, and 56 religious sites.

FY04, Infrastructure Building:

1) Ensure quality assurance through training, client surveys and EMA -- (Standards of Care, Best Practice, Client Centered Care) Result: A yearly client satisfaction survey is distributed to local public health offices. The Family planning Program provided 47 trainings with a total of 1,425 participants.

c. Plan for the Coming Year

FY05 Plan for activities

FY05, Direct Health Care:

1) Increase services to the hard to reach population. Develop community networks and expand services.

FY05, Enabling Services:

1) Target outreach efforts for male and female adolescents.

FY05, Population Based Services:

1) Provide outreach and education in local public health offices.

FY05, Infrastructure Building:

1) Ensure quality assurance through needs assessment, client surveys and EMA -- (Standards of Care, Best Practice, Client Centered Care)

State Performance Measure 4: *Reduce the number of children witnessing violence (exposed to domestic or sexual violence) as expressed by percent of children present at a domestic violence scene*

a. Last Year's Accomplishments

FY03: Key factors from needs/resources assessment that were to be addressed included continuation of coalition building around domestic violence prevention, continuation of sexual assault prevention activities and expansion of SANE programs.

FY03 Direct Health Care: Social services trainings done but pilot site not yet established.

Medical director provided 6 week support group for boys in an elementary school, many of whom were exposed to violence in their homes.

FY03 Enabling Services: 300 copies of Stolen Childhood video distributed to mental health and community agencies for use in trainings and direct counseling with offenders. Monthly E newsletter, with statewide distribution, started to educate about resources and research related to DV and sexual violence prevention issues in New Mexico.

FY03 Infrastructure Building: A new statewide coalition, called "The Network, working to end domestic and sexual violence in New Mexico" was established through a series of strategic planning meetings; the old Domestic Violence Advisory Council was transitioned into this new group. This group complements and supports the work of the two separate existing coalitions against domestic violence and against sexual assault, and has broader representation than either of those groups. A number of legislative successes included more funding for batterer treatment programs (a fee on convictions), and 1 million dollars for funding to prevent sexual violence.

b. Current Activities

b. Current Activities

In September 2003, the NM Interpersonal Violence Data Central Repository released a report, "Sex Crimes in NM". Nineteen percent of NM's adult women have been raped at least once in their lifetime. One third to one half of those who were sexually abused as a child experienced a second sexual assault at an older age. Fifty four percent of reported non-penetration sexual crimes and forty five percent of reported penetration crimes (thus just the tip of the iceberg) were perpetrated upon children, 12 and under. In addition, more than one hundred children were present when a criminal sexual penetration occurred in another family member. A report released in July 2003 on Domestic Violence revealed that, in 2002, there were 17,397 victims of domestic violence identified from 24,905 reports from 93 of 130 law enforcement agencies across the state. This gave us a 2002 rate of 15.8 incidents of domestic violence for every 100 persons. There were 3,381 children present at the scene of their family violence episodes in 2002. There were 7,957 DV incidents that documented both the number of incidents with children present and the number of children present. Of these incidents, 1,100 (14%) had children present and the total number of children present was 1,595.

FY04 Direct Health Care: Expand SANE activities in the state, with two new sites currently being established. Sexual assault prevention outreach training to schools continues through the efforts of the Coalition of Sexual Assault Programs.

FY04 Enabling Services: Participated in some activities of the Governor's Task Force on DV, and helped write the final recommendations concerning children exposed to violence. Monthly E newsletter on violence related issues produced and distributed.

FY04 Population Based Services: Men's wellness activities/ trainings this last year have focused on issues of male violence and its prevention.

FY04: Infrastructure Building: Cross trainings for domestic violence and sexual assault providers occurred. Worked to support and strengthen "The Network" by providing training for the group, and highlighting the needs of children exposed to violence.

### c. Plan for the Coming Year

#### c. Plan for the Coming Year

FY05: Direct Health Care: Continue to work towards expanding SANE activities in the state. Utilize men's wellness activities in the state to deliver direct violence prevention messages to the men involved in those programs.

FY05: Enabling Services: Continue to provide a monthly E newsletter devoted to prevention of violence, primarily sexual assault and domestic violence, that highlights studies relevant to the effects on children of exposure to violence.

FY05: Population Based Services: Provide more outreach to men, helping to educate them and enroll them as part of the solution in the struggle against violence.

FY05 Infrastructure Building: Continue to expand the activities and outreach of the Network. Continue to assist the NM Interpersonal Violence Data Central Repository in obtaining more accurate data from Law Enforcement.

## State Performance Measure 5: *Implement New Mexico's Pregnancy Risk Assessment Monitoring System (PRAMS)*

### a. Last Year's Accomplishments

#### a. Last Years Activities

Planned achievement for FY03, Infrastructure Building: Activities and results

1) Funding support: CDC PRAMS Cooperative Agreement of 4/14/2001- 4/14/06 (Year 2 of funds), Title V MCH Block Grant and revenue via matched state funds from Medicaid.

2) Steering Committee: 2 meetings held; input into revision of the state-based questions and year 2000 NM PRAMS Surveillance Report

- 3) Full operations: The coordinator is a contracted position; it was empty for ~4 months early in FY2003, and again in late FY03. A new contract is anticipated in July 2003.
- 4) 70% Response rate: achieved; lower rates persist among women of relatively low SES.
- 5) Annual Surveillance Report, Year 2000 data: to be released in late June 2003, over 100 pages of data with special features on food security, breastfeeding, intention of pregnancy.
- 6) Special Reports: Dr. Weng presented to the American College of Epidemiology, factors influencing breastfeeding and made a presentation to the OB-GYN grand rounds at UNM that featured an overview of PRAMS data Year 1997-2000 data were used for special reports and data consultations with the US Mexico Border Counties of New Mexico; teen data for the annual school health conference; Families FIRST Perinatal Case Management. Dr. Nalder & Carol Leonard (NDOH/NNHRRB) presented at national MCH Epi meeting on topic of tribal & state collaboration, featuring tribal ownership of data. Twelve media reports that combined PRAMS data with local County MCH Council activities were released to local newspapers in spring-fall 2003; there were 7 articles in local papers as a result. Councils report this serves to highlight local action with data.
- 7) Data used for policy, program and education: NM PRAMS data on unintended pregnancy spurred action on improving access to emergency contraceptive pills (ECP) by the NM Pharmacy Board and the NM legislature (a bill passed to promote education and prescription of ECP for victims of rape).

## b. Current Activities

### Infrastructure Building:

- 1) Funding support: no change, continues Title V MCH Block Grant, CDC PRAMS Cooperative Agreement and revenues from Medicaid (state portion of expenditures)
  - 2) Steering Committee: Will meet 2-3 times; use committee to promote use of 2000 data report; special reports.
  - 3) Full operations: no changes anticipated; new version of PRAMTrack installed late 2003; majority of effort this year devoted to developing and testing new state questions, contributing to national group's efforts on core questions. The new questionnaire used with 2004 births. Will have data on maternal depression, infant car seats, awareness of emergency contraception, food security/insecurity, more information about breastfeeding continuation, more on home visiting.
  - 4) 70% Response rate: no changes anticipated; to introduce a telephone calling card of 20 minutes as the incentive.
  - 5) Annual Surveillance Report: 2001 data report to come out around December 2003.
  - 6) Special Reports: focus this year on Medicaid MCO's
  - 7) Data used for policy, program and education: work with MCO's and Families FIRST to improve performance on several indicators among the Medicaid clientele. Work with FHB team to use 1997-2001 PRAMS data for the comprehensive assessment of the Title V MCH Block Grant.
- \* Special activities: Dr. Ssu Weng to work with UNM's MPH program to use NM PRAMS data for classroom instruction in analysis of data from complex survey.

## c. Plan for the Coming Year

### Planned achievement for FY05, Infrastructure Building, Planned Activities

- 1) Funding support: no change, continues Title V MCH Block Grant, CDC PRAMS Cooperative Agreement and revenues from Medicaid (state portion of

expenditures)

2) Steering Committee: Will meet 2-3 times; use committee to promote use of 2000, 2001, 2002

data reports and special reports; work with committee to explore response rate options.

3) Full operations: no changes anticipated; new version of PRAMTrack installed late 2003; Phase 5 new questionnaire in the field.

4) 70% Response rate: no changes anticipated;

5) Annual Surveillance Report: 2001-2002 data report to come out around December 2004.

6) Special Reports: focus this year on Medicaid MCO's; teen pregnancy; and the Families FIRST program users.

7) Data used for policy, program and education: work with MCO's and Families FIRST to improve performance on several indicators among the Medicaid clientele.

Work with FHB team to use 1997-2001 PRAMS data for the comprehensive assessment of the Title V MCH Block Grant.

\* Special activities: Dr. Ssu Weng to continue work with UNM's MPH program to use NM PRAMS data for classroom instruction in analysis of data from complex survey.

## State Performance Measure 6: *The state Title V program has a coordinated program of maternal, fetal, infant and child death review*

### a. Last Year's Accomplishments

#### a. Last Year's Accomplishments

List key factors from needs/resources assessment: Vital Records reports provide mortality data by age, gender, E-code and diagnosis, geo residence. CFR provides insight into risk reduction, prevention or systems improvement factors that may prevent future deaths in the MCH population. NM mortality rates for intentional and unintentional injuries are very high.

Target was on track: New coordinator hired and some proposed activities delays due to need for orientation. Development of MMR and CFR database, creation of MMR special reports, and release of CFR annual report delayed. CFR panel membership expanded to include representation by child protective services (CPS) and juvenile justice division (JJD), resulting in increased access to information from these agencies. Memorandum of Understanding agreements established between CFR and Navajo Area Indian Health Services, CFR and CYFD for increased access to information on case reviews.

Planned achievements, activities and results for FY02, Infrastructure Building:

1. MMR team fully functioning with co-chairs and membership. 2. MMR reviewed full year of cases, reorganization of case files from 1996-2000, began work on MMR database. 3. CFR panels fully functioning with additional agencies' participation. 4. CFR revision of protocols; written procedures distributed to all members. 5. CFR's MOA established between CFR and CYFD and the Navajo Area Indian Health Service. 6. Began work on CFR database. 7. CFR annual report written and formatted. 8. Hired new epidemiologist for CFR/MMR. 9. Unable to find community interest or resources to develop and maintain local team. 10. Each case summary for CFR and MMR includes written identification of contributing factors, risk reduction and system improvement issues with accompanying recommendations for the adoption of evidence-based strategies.

### b. Current Activities

## b. Current Activities

Key factors from needs/resources assessment: Vital Records reports provide mortality data by age, gender, E-code and diagnosis, geo residence. CFR provides insight into risk reduction, prevention or systems improvement factors that may prevent future deaths in the MCH population. NM mortality rates for intentional and unintentional injuries are very high.

Targets were on track however main activity was database development: A consultant was hired to assist coordinator in developing database to track case status, link OMI, VR and panel information, and analyze CFR and MMR data for special and annual reports. Contract services were interrupted 4 months in FY03 with subsequent delays in database development and suspension of some CFR panels for several months. A media consultant was hired to assist CFR and PRAMS to highlight community issues and prevention strategies in articles appearing in community newspapers written in coordination with local MCH councils.

Planned achievements, activities and results for FY03, Infrastructure Building:

1. MMR and CFR fully functioning with chairs, co-chairs and membership.
2. MMR and CFR panels fully abstracted and reviewed one years worth of cases.
3. Data produced for MMR co-chair to present findings from MMR data (1996-2002) at OB/Gyn conference: pregnancy-related and pregnancy-associated deaths in NM; demographic and cause of death distribution.
4. Data produced for chair of CFR Child Abuse & Neglect (CAN) panel to present findings (1997-1999) at Child Abuse and Neglect conference.
5. CFR annual report printed, released, and distributed; highlighting effective prevention programs in NM.
6. CFR subpanel developed to review overdose deaths of children/youth ages 18-24.
7. CFR database completed: case tracking, data entry and data analysis components.
8. Developing similar MMR database.
9. MMR special report on adult, infant and child restraint use in fatal MVCs of women within one year of pregnancy termination.
10. Data produced for NM Firearm Safety Task force on distribution and characteristics of firearm deaths of NM children.
11. Contracts in place for program assistant in CFR/MMR at 32 hours/week; to develop MMR and CFR database; and media consultant to implement media outreach project for CFR.
14. CFR assisted local MCH councils to write 12 press releases for community newspapers on MCH issues based on data from CFR annual report and PRAMS surveillance report.
15. Instituted protocols and procedures to become HIPAA compliant.

## c. Plan for the Coming Year

Key factors from needs/resources assessment: Vital Records reports provide mortality data by age, gender, E-code and diagnosis, geo residence. CFR provides insight into risk reduction, prevention or systems improvement factors that may prevent future deaths in the MCH population. NM mortality rates for intentional and unintentional injuries are very high.

Targets were on track however main activity was database development: A consultant was hired to assist coordinator in developing database to track case status, link OMI, VR and panel information, and analyze CFR and MMR data for special and annual reports. Contract services were interrupted 4 months in FY03 with subsequent delays in database development and suspension of some CFR panels for several months. A media consultant was hired to assist CFR and PRAMS to highlight community issues and prevention strategies in articles appearing in community newspapers written in coordination with local MCH councils.

Planned achievements, activities and results for FY03, Infrastructure Building:

1. MMR and CFR fully functioning with chairs, co-chairs and membership.
2. MMR

and CFR panels fully abstracted and reviewed one years worth of cases. 3. Data produced for MMR co-chair to present findings from MMR data (1996-2002) at OB/Gyn conference: pregnancy-related and pregnancy-associated deaths in NM; demographic and cause of death distribution. 4. Data produced for chair of CFR/CAN panel to present findings (1997-1999) at Child Abuse and Neglect conference. 5. CFR annual report printed, released, and distributed; highlighting effective prevention programs in NM. 6. CFR subpanel developed to review overdose deaths of children/youth ages 18-24. 7. CFR database completed: case tracking, data entry and data analysis components. 8. Developing similar MMR database. 9. MMR special report on adult, infant and child restraint use in fatal MVCs of women within one year of pregnancy termination. 10. Data produced for NM Firearm Safety Task force on distribution and characteristics of firearm deaths of NM children. 11. Contracts in place for program assistant in CFR/MMR at 32 hours/week; to develop MMR and CFR database; and media consultant to implement media outreach project for CFR. 14. CFR assisted local MCH councils to write 12 press releases for community newspapers on MCH issues based on data from CFR annual report and PRAMS surveillance report. 15. Instituted protocols and procedures to become HIPAA compliant.

### State Performance Measure 7: *The state has a program for Birth Defects Prevention and Surveillance*

#### a. Last Year's Accomplishments

Direct Services, pre-conception genetic counseling/folic acid distribution: 12 families that had a neural tube defect (NTD) affected pregnancy received counseling and folic acid supplements purchased with funds from the March of Dimes.

#### Infrastructure:

1. Passive data linking, birth file to Children's Chronic Conditions Registry (3CR): Birth file used as basis for obtaining cases for abstracting; 3CR data collection continued with contractors.
2. Active surveillance: Contractors abstracted statewide.
3. Folic acid/birth defects prevention initiatives: The Birth Defects Prevention Task Force's folic acid education initiative was expanded to include other pre-conception health risks in a larger education project (see below). Teaching module was developed for use in FY 04 pilot project. Folic acid education materials were printed and distributed. Project was funded by a grant from the March of Dimes.
4. Other pre-conception health/birth defects prevention initiatives: Expansion of pre-conception health education project, Life Long Happiness (LLH), to include avoidance of tobacco use, avoidance of drugs and alcohol, management of diabetes, management of diet/obesity, and proper intake of folic acid. Pilot project locations determined by analysis of counties with high occurrence of NTDs and orofacial clefts (OFCs). Three "training the trainer" workshops held to introduce the motivational interviewing techniques. Agreements made with 17 organizations to participate in the pilot project.
5. Fully staffed (position or contract) with epidemiologist, data manager/programmer, abstractors, and grant manager who also provides prevention education services: Half-time CMS medical director, M.Gallaher, guided the program and analyzed the 2000 data. She left to take a different position in the state department of health. Abstractors worked on contract.
6. Adequate funding and resources: Partial only.

#### b. Current Activities

Direct Services, pre-conception genetic counseling/folic acid distribution: 14 families that had

an NTD-affected pregnancy received counseling and folic acid supplements purchased with funds from the March of Dimes.

Infrastructure:

1. Passive data linking, birth file to 3CR: 2001 birth files linked to existing 3CR files. Extremely poor data quality encountered; modifications will be made in FY05.
2. Active surveillance: abstracting continued; protocols reviewed and necessary modifications identified.
3. Folic acid/birth defects prevention initiatives: Folic acid publications were mailed out when requested. Additional folic acid educational materials were incorporated into LLH module.
4. Other pre-conception health/birth defects prevention initiatives: LLH pre-conception health education pilot project carried out in 3 NM counties. 400 women completed surveys before and after education interventions. Analyzed surveys demonstrated gain in knowledge and gain in motivation to change behaviors identified as increasing risk for birth defects.
5. Fully staffed (position or contract) with epidemiologist, data manager/programmer, abstractors, and grant manager who also provides prevention education services: CDC/CSTE MCH Epidemiology fellow, Tierney Murphy, MD, MPH, assigned to NM for 2 years. She will work to strengthen and guide the surveillance system, write reports, and present findings to varied audiences. Program will submit position creation for programmer/data manager in July 2004.
6. Adequate funding and resources: Existing funding was redirected to create the data management position

c. Plan for the Coming Year

Direct Services, pre-conception genetic counseling/folic acid distribution: Families that have an NTD-affected pregnancy will be offered the opportunity to receive counseling and folic acid supplements purchased with funds from the March of Dimes.

Infrastructure:

1. Passive data linking, birth file to birth defects data from hospitals and providers: Create new database for birth defects. Link 2002 birth file to birth defects database. Monitor coding of birth defects and perform routine quality checks of data. Strengthen passive surveillance system by working with the NM hospitals (data sharing agreements with each of them are in place) and the Health Policy Commission to obtain hospital inpatient discharge data and by increasing hospital and health care provider awareness of birth defects reporting requirements.
2. Active surveillance: Continue abstraction with modified protocols and targeting of surveillance sites to capture high priority birth defects in NM (NTDs, OFCs, cardiac defects, and gastroschisis/omphalocele). Plan to implement use of SNAP software to collect data (software scans paper copy abstracting forms to database; eliminates data entry needs). Note that 3CR is being reviewed and hopefully improved; it was not set up to be a surveillance system and has significant limitations for such uses.
3. Folic acid/birth defects prevention initiatives: Present four folic acid awareness workshops for teen peer educators. Distribute folic acid brochures to CMS social workers for client education.
4. Other pre-conception health/birth defects prevention initiatives: Partner with WIC to continue distribution of LLH modules in their core curriculum. Continue coaching support and advanced training in motivational interviewing to organizations that participated in the pilot project. Offer additional workshops to new organizations that want to utilize the module, including Navajo Nation organizations. Restructure partnership with the March of Dimes to align with their new focus on reducing low birth weight babies.
5. Fully staffed (position or contract) with epidemiologist, data manager/programmer, abstractors, and grant manager who also provides prevention education services: CDC/CSTE assignee with state through March 2006. Plan to create and fill position for data

manager/programmer.

6. Adequate funding and resources: Anticipated budget cuts will impact contracted abstractors in surveillance activities funded in part by CMS. NM will apply for continued funding with new 5 year competitive cooperative agreement; NM anticipates continued CDC funding of birth defects grant

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Number of 33 counties adopting the conceptual framework of Healthy Youth/Healthy Communities through an Assets/Resiliency model approach when working with youth				
1. Maintain and recruit diverse membership in the statewide Youth Development Advisory Council continues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to provide technical assistance to state agencies, and facilitate focus groups with youth participation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue support for 2 YDAC youth coordinators to help facilitate, guide and promote positive youth development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Partner with state and community agencies to implement best practices in youth development programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Partner with Governor's Youth Council to promote best practices in youth development programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percent of first newborns and mothers receiving support services/parenting through community home visiting/support programs				
1. Partner with state and community agencies to Improve access to primary prevention home visiting services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Participate in the implementation of the Infant Mental Health Strategic Plan for New Mexico.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue support for the Las Cruces Public Schools primary prevention home visiting services as a model.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Address appropriate home visiting issues through the MCH Early Childhood Comprehensive Systems Grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Work with Children's Cabinet and Children Youth & Families Department to strengthen home visiting programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.				

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Reduce unintended pregnancy in New Mexico to less than 30% of births				
1. Inform public of available family planning services through collaboration with resources such as STD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Increase and maintain existing community networks by partnering with providers, schools, First Choice	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop creative outreach activities for FP; increase cultural awareness and sensitivity activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Establish or enhance clinical services by expanded hours, days, walk-in services, mobile vans	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Use of NM PRAMS data to identify factors associated with unintended pregnancy, for use in policy & program planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Reduce the number of children witnessing violence (exposed to domestic or sexual violence) as expressed by percent of children present at a domestic violence scene				
1. Expand the number of SANE sites	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cross training for domestic violence & substance abuse provider & program communities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Strengthen "The Network" (the domestic violence & substance abuse coalition)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to create the coalition's agenda for working on children exposed to violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Work with young men directly through school based program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Implement New Mexico's Pregnancy Risk Assessment Monitoring System (PRAMS)				
1. Collect monthly sample, achieve 70% response rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Analysis of data, produce annual surveillance report (2001-2002 data to be available December 2004)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Produce one special report per year (examples teens, Medicaid paid, US-Mexico Border Counties)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide ongoing data reports to data clients in DOH, other agencies, community groups, tribal commun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Train students, professionals in analysis & use of PRAMS data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide data-use consultations to state, community, tribal groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Produce data required by Title V MCH Block Grant, DOH strategic plan, Title X Family Planning, Medic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The state Title V program has a coordinated program of maternal, fetal, infant and child death review				
1. Maternal Mortality Review (MMR): obtain annual data for case review from vital records, OMI and othe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. MMR: conduct reviews & maintain database of panel findings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. MMR: produce reports or present findings to key groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Child Fatality Review: obtain annual data for case review from vital records, OMI and other sources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. CFR: conduct reviews & maintain database of panel findings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. CFR: produce reports of 5 specialized panels in annual report or special releases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. MMR and CFR: new data base developed in MS Access; continue upgrades and data entry, to make more detailed data available for reporting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) The state has a program for Birth Defects Prevention and Surveillance				
1. Maintain active and passive surveillance, including database entries, for selected birth defects (NTD, Orofacial cleft,gastroschisis and heart.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Produce annual or bi-annual report of birth defects, and special reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide ongoing support for Birth Defects prevention initiatives with focus on people who were trained to use Lifelong Happiness prevention materials in communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide genetic counseling and folic acid to mothers who had an NTD-affected pregnancy.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Abstractors collect data to contribute to the Birth Defects Prevention and Surveillance System.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Genetic counseling provided at Dysmorphology and Genetic Clinics via the Childrens Medical Services program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. FY2005-2006: work to improve data collection and databases used for birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## E. OTHER PROGRAM ACTIVITIES

### E. Other Program Activities

The Toll Free Hotline Effective July 1998, a new toll free line was implemented for access to the MCH and CSHCN programs: 1-877-890-4692, however because we can report on only one line, the previous line continues to be reported on.

/2003/The new statistics for BabyNet are much lower than previous years because in July 2001, the phone service moved from the Developmental Disabilities Planning Council to the UNM Center for Development and Disabilities. Calls were not transferred successfully from the old number to the new 1-800 number. The coordinator worked to have this straightened out but problems persisted.

/2003/As a result of the work to raise awareness about intendedness of pregnancy, and the benefits of early prenatal care in the Prenatal Care Utilization Media Committee, a new toll free number was developed so that the public could call in with questions as a result of the media campaign: 1-866-PRE-NATL began April 2002.

WIC, related education programs, other health, developmental disability and family planning programs: Title V Programs enjoy a close, collaborative working relationship with the NM WIC program. WIC's agenda for prevention of low birth weight has been coordinated with Title V and has shown excellence in practice by adopting facilitated learning and support groups around topics of smoking cessation, infant care, breast-feeding, meeting maternal and infant nutritional needs. /2004/ WIC implemented a three year special projects grant through USDA to study the value of teaching "Division of Responsibility" to parents in an effort to create healthy feeding relationships between new parents and their children. This research has implications for the treatment of childhood obesity and failure to thrive cases.

//2004// WIC is often the program of first recourse for uninsured pregnant women, who are then referred on to appropriate services including Medicaid eligibility. WIC and other MCH nutrition trained personnel are assisting in the new Governor's Hunger Summit in October 2003. National data on food insecurity for New Mexico and NM PRAMS data will be shared with the summit planners. //2004// Family Planning: Similarly, Title V programs work in unison with the Title X Family Planning program's initiatives in preventing unintended pregnancy, preventing teen pregnancy, male involvement in reproductive health, improving birth outcomes through child spacing and preventing poor birth outcomes through a preconceptional health approach to clinical family planning services. The Male Involvement Coordinator has been pivotal in planning and implementing the Department's VAST initiatives. Key FP staff worked with the Title V programs and Medicaid to plan the objectives and strategies for the Medicaid Family Planning waiver, and carry the leadership role in the DOH for

implementation and monitoring. Details are provided in the report and planning grids.  
/2004/ Providers of services to identify pregnant women and infants eligible for Title XIX: The Families FIRST program within the FHB/Title V MCH programs was lead in this initiative.//2004//  
Family leadership and support programs The Home Visiting Coordinator, Doreen Sansom, provides key resources for technical guidance and training for providers of early childhood services. One of four sites opted to include primary prevention of child abuse and neglect through home visiting. Evaluation reports are not yet available.  
***/2005/ Title V MCAF staff are collaborating with the Department of Children Youth and Families to develop strategies for universal access to newborn home visiting. MCAF staff are providing technical assistance regarding standards for best practice and are facilitating community linkages with providers of home visiting services/2005//***  
***/2004/ Partnership Consultations by NM PRAMS NM PRAMS strives to work directly with data clients to promote and support use of PRAMS data in forming program policy, targeting program resources, education of providers and the general public. Three significant consultations were held in FY03. A special report was developed for the US-Mexico Border Counties, the consultation was co-sponsored by the Border Health Office, the County MCH and NM PRAMS in Las Cruces in March 2003 and attended by 41 participants. A special report for Families FIRST case managers was presented in April 2003; immediate program and policy implications were identified, including the need to work with WIC to improve access to breast-pumps by mothers who return to work soon after delivery. A special report was made for the Alphabet Soup Group (executives and leaders from Medicaid, the Medicaid MCOs, Health and CYFD) to examine differences between outcomes for Medicaid-paid and non-Medicaid-paid mothers and infants.***

***/2005/ There are no updates regarding the 2002 notes on the Dona Ana Healthy Start Initiative: and the Luna County Healthy Start Initiative. A review of program progress will be featured in the comprehensive Title V assessment exercise of FY05. These two initiatives have worked to integrate perinatal systems of health care to help eliminate disparities in the health status experienced by racial and ethnic minorities while continuing to improve the health of all women and children.//2005//***

***/2005/ New Mexico Obesity Initiative: The NM Children's Cabinet has chosen obesity as one of several health outcome indicators for the work of the Cabinet and all state programs. The DOH is working on a State Plan for Obesity Prevention and Control through CDC and is working with the Governor's Council For Physical Fitness which will used champions for special projects to highlight the obesity issue in local communities. The DOH identified obesity as one of the top three priorities for this Administration, in its Statewide Comprehensive Health Plan. Department of Finance is auditing funding streams to compare where funds are spent as related to priorities for children's programs. The NM WIC Program is cutting edge with their work in Healthy Feeding Relationships. Encouraging family connectedness, i.e. eating together, turning off the TV, portion control when eating out, nutrition education supports research on children's internal regulators, and encouraging increasing physical activity opportunities as families within their local communities. Title V is working with several departments to promote a new school policy proposal that would set nutritional standards for foods sold in elementary schools and promote physical fitness. //2005//***

## **F. TECHNICAL ASSISTANCE**

### **F. Technical Assistance Needs**

NM Title V MCH has no requests at this time for technical assistance.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

*/2005/*

#### **V. BUDGET NARRATIVE**

##### **A. Expenditures**

**Significant year to year expenditure variations:**

***In the fiscal year 2003, the expenditures for services for children and adolescents as well as children with special health care needs are higher than the required percentages. The amount expended toward services to children and adolescents represents approximately 46% of the total MCH federal budget. The amount allocated toward children with special health care needs represents 39 percent of the federal budget. Thirteen percent of the total was spent on women out of the federal budget. Overall, the amount allocated toward Children and Adolescents, including the state funding equals 46 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 42 percent. The amount spent on mothers represents 11 percent of the entire budget.***

***There is only one significant variation in expenditures from FY2002 to FY 2003. The grant state match amount has been met and there is significantly more state funds expended on MCH services during FY2003. This occurred in spite of cuts to contractual services.***

***In FY2003, the Title V Program continued to experience significant funding reductions in state resources available for implementing MCH Programs. In the area of MCH County Councils, the new administration combined MCH County Councils and Community Health Initiative Councils into one entity. While the administration has indicated that funding will continue to be provided to operate the 28 councils, the amount to be expended solely on MCH activity is no longer in the control of the title V Director as that activity has been moved to the Public Health Director's Office.***

***The current administration has indicated a 7 million dollar deficit for the FY2004. The year has been spent analyzing current expenditures and has resulted in major cuts of several programs within the Bureau. From FY2003 to the proposed budget for SFY2005 (state year), the Family Health Bureau has sustained a \$512,000.00 cut in MCH funding. The new administration has lengthened the time it takes to contract with providers. Although the Bureau applied for expansion of state funding for children with special health care needs, that request was denied. Instead, the administration required cuts to the budget within Family Health Bureau. This necessitated the termination of the Healthier Kids Fund (\$800,000.00) which covered dental and glasses for immigrant children so that the funds could be used for the escalating costs of serving children with special health care needs. The flat budget for the CMS Program had resulted in increased pressure from the hospitals to increase per diem rates for hospitalized children and youth. The Healthier Kids Fund Program has been level funded since 1999 resulting in extremely limited enrollment of approximately 1500 children. The cost to serve children under this program was less than \$300.00 per child per year. Fortunately, during the legislative session, \$100,000.00 was given to children with cancer which will help cover some of the costs of treating some of New Mexico's most vulnerable children. The new administration has also indicated insufficient funding the cover salaries and benefits next year and has started the year out with an across the board cut to all line items. They have indicated that they will require that the Bureau maintain a 15% vacancy rate all year and will stall hiring of vacant positions.***

***The Bureau continues to try to proactively address such factors as impacting birth outcomes and prenatal care utilization, such as violence, alcohol, substance abuse, tobacco, mental health, unintended pregnancy, and eliminating disparities between documented and undocumented pregnant women in access to services. The MCH Epidemiology Unit was successful in obtaining at no additional cost, a two year CSTE fellow from Centers for Disease Control, as well as an MCHB intern and a two year Prevention Specialist from CDC as well. The***

**MCHB Intern accomplished an analysis of the SLAITS data, the CSTE fellow will work with the birth defects data and the CDC fellow will assist with the Comprehensive Assessment for 2005. While evidence-based interventions are increasingly requested, there are few resources to evaluate the impact of programs.**

**The Family Planning Program received a continued federal in FY2003 to support reproductive health services in the state. The initiative consists of increased funding to provide services in the Bernalillo Detention Center. That clinic has proven very effective in screening and treatment for STD's as well.**

**The need for safety net programs has not diminished in the face of Medicaid budget deficits. The High Risk Prenatal Care fund has far outstripped current resources. Decisions were made this year to stop services during the last week of the state year due to the lack of resources. Referrals were made to local providers. Next year does not look any better for this fund. //2005//**

## **B. BUDGET**

**/2005/**

### **B. Budget**

**The Federal support received from the MCH Block grant complements the State's total efforts to optimize services to the MCH population. In the 2005 federal grant budget, the amounts allocated to services for children and adolescents as well as children with special health care needs are higher than the required percentages. The amount allocated toward services to children and adolescents represents approximately 46% of the total MCH federal budget. The amount allocated toward children with special health care needs represents 48 percent of the federal budget. The remaining amount of \$189,488.00 allocated for women, represents only 4 percent of the federal budget. Overall, the amount allocated toward Children and Adolescents, including the state funding equals 48 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 41 percent. The amount spent on mothers represents 10 percent of the entire budget. This, however, is changing currently as all resources previously spent for prenatal care media campaigns have been shifted to the High Risk Prenatal Care Fund. In addition, other resources are being sought to fill this need.**

**The summary budgets are an aggregation of all of the Organization Codes (programmatic financial accounts) that relate to Maternal and Child Health. These Organization Codes are program specific: e.g., Maternal Health, Title V /2005/ Adolescent Pregnancy Prevention/Family Planning, Child Health, Adolescent Health/Youth Development, Children's Medical Services, etc. Each Organization Code is allocated funding showing the federal/state distribution. The state match amount is considerably greater than the required three state dollars to four federal dollars and is also greater than the 1989 Maintenance of Effort amount of \$3,087,900.**

**The state match is almost entirely from appropriations from the state general funds; a very small amount is from third party payments. The federal share of the budget is based upon the level of funding in New Mexico's share of the MCH Block Grant for FFY 2005. Budget expansions have not yet been submitted for 2006. Rejection of all of last year's requests is an indication that the Department is supporting only a flat budget this coming year, in spite of this, the Bureau will re-submit expansions for CMS services. Budget allocations are official for 2005 as submitted in this grant application. Reductions in certain expense categories, i.e. contractual services represents a move out of contracted services to services offered by in-house staff, a direction reflecting the Cabinet leadership's priorities.**

**While 1.8 million was first cut from the MCH County Council budget by this administration, the advocates restored the 1.8 million during the legislative session for the FY2005 state year. In addition, several counties received additional monies directly from the General Fund. The amount of \$122,000.00 was appropriated to the county of San Miguel to start a home visiting**

**program. Santa Fe County also has its own state funded home visiting program serving only that county.**

**The Direct health services are targeted to those with low incomes or with limited access to services who are uninsured or underinsured. The administrative component, paid totally out of state funds is comprised of the Family Health Bureau Chief's budget and includes fiscal, program, and personnel management, systems maintainance, strategic planning, and advocacy.**

**The budget meets the target percentages for Preventive and Primary Care for Children , Children with Special Health Care Needs, and Administration (is totally paid out of general fund).**

**The Department of Health's accounting system contains defined accounting codes for revenues and expenditures in each specific component of the maternal and child health program. Budgets are detailed by these accounting codes and expenditures charged to each specific component. The Department maintains financial accounting records and has a fiscal management system, both of which ensure a clear audit trail.//2005//**

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.