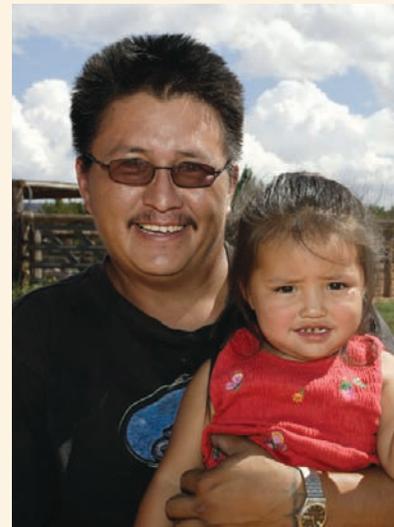


Data for Grant-Making:

*A Comparative Study of Community Health in
Los Alamos, Rio Arriba & Northern Santa Fe Counties*



Northern New Mexico Health Grant Group

July 6, 2008

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*The Heart & Soul of
Health in New Mexico*

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Preface

The Northern New Mexico Health Grant Group (NNMHGG) and Con Alma Health Foundation recognize that evidence is needed to help guide our future grant-making and galvanize targeted action and strategies to address priority health issues in New Mexico. Our work is informed and driven by the recognition that community perceptions and experiences as well as data on what happens within and outside the health care system are critical ways to assess priority health issues in Los Alamos, Rio Arriba and Northern Santa Fe counties.

The 2002 sale and transfer of the Los Alamos Medical Center (LAMC), a non-profit corporation to a for-profit corporation could have left a gap in the safety-net system serving those communities. However, because of the vision of key leaders, some proceeds from the sale of Los Alamos Medical Center were preserved to serve the unmet health care needs of the people of Los Alamos, Rio Arriba and Northern Santa Fe counties. To strengthen the grant-making process and assure that the NNMHGG can best target resources, we commissioned a study to assess health priorities and solutions in the three counties.

We appreciate the participation and contributions of everyone who generously shared their community stories, documents and data with us so that we could develop this initial report. We especially appreciate the participation and feedback from representatives from the non-profits, faith-based organizations, health care sector and funders who took time out of their busy schedules to have meaningful discussions on health issues affecting their communities. We also appreciate the contributions of the New Mexico Department of Health staff¹ who were instrumental in obtaining needed data and the University of New Mexico Bureau of Business and Economic Research² for providing technical feedback on collecting quality demographic data. Finally, we thank Dr. Lisa Cacari Stone for working closely with the NNMHGG in conducting the study and writing the report and Mr. Greg Tafoya and Ms. Michelle Peixinho for providing research assistance and data collection. We thank them all for their dedication and hard work.

DOLORES E. ROYBAL,
Executive Director
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Executive Summary

In May 2002 the Los Alamos Medical Center (LAMC), a non-profit corporation, was sold to a for-profit corporation. Some proceeds from the sale of Los Alamos Medical Center were preserved to serve the unmet health care needs of the people of Los Alamos, Rio Arriba and Northern Santa Fe counties. The Hospital Auxiliary for LAMC and Con Alma Health Foundation, working as the Northern New Mexico Health Grant Group (NNMHGG), distribute the investment income from those proceeds annually for grants that target the populations traditionally served by the Los Alamos Medical Center.

In the Spring 2008, the NNMHGG decided to conduct an assessment of health status priorities and health care systems challenges specific to the target area (Los Alamos, Rio Arriba and Northern Santa Fe Counties) in order to better inform the grant-making process. The objectives of the assessment are to:

1. Identify specific funding priorities for target area within the broader goal of addressing health needs left unmet by the sale of the Los Alamos Medical Center;
2. Incorporate CAHF Health Disparities Report as part of the broader grant-making framework (Report will be updated in 2008); and
3. Review/revise current NNMHGG grant guidelines as appropriate.

From March through May, both secondary and focus group data were collected, compiled and analyzed into this final report. A variety of secondary data gathered from public use data bases, reports, documents and directly from New Mexico Department of Health staff. Four focus groups were conducted in the Northern New Mexico area of Los Alamos, Rio Arriba and Northern Santa Fe Counties. Participants who volunteered to participate in the 1 hour to 1½ hour focus groups were from funding agencies/foundations, non-profit and faith-based organizations and health care providers.

The following key findings highlight the priority issues affecting health in Los Alamos, Rio Arriba and Santa Fe Counties: demographic characteristics, socio-determinants of health, health conditions, health systems and policies. Community perceptions on priority health issues are integrated throughout the report as a way to interpret and provide contextual descriptions of the challenges facing these communities. Recommendations made by focus group participants are summarized into four core areas to: 1) expand the definition of health to include wellness and life opportunities; 2) strengthen health systems capacities and improve health policies; 3) improve health conditions; and 4) create innovative funding.



Executive Summary Key Findings

What matters for health in Northern New Mexico?³

Findings show that multiple factors affect the health and well-being of children and families living in Rio Arriba, Los Alamos and Santa Fe Counties. Race/ethnicity, age, income, poverty and wealth, education, type of work and social resources all matter for health. These factors influence access to social and economic resources over a person's life, across generations of families and within entire communities. Non-medical factors such as housing, working conditions, affordable and nutritious food, transportation, and language and culture all impact health and access to important health services and family supports.

Among various health conditions affecting Northern New Mexico's residents (maternal and child health, leading causes of death, infectious diseases, chronic diseases), three appeared to be the greatest challenges: 1) teen pregnancy; 2) substance abuse; and 3) alcoholism.

Health systems and policy issues that showed marked alarm included: barriers to accessing health care⁴ such as lack of insurance coverage, higher out-of-pocket costs for the uninsured, shortage of service providers such as dentists and behavioral health providers, long-waiting lists, lack of access to health information and resources across non-profits, providers and for community members.



Finding 1. Demographics and Socio-Economic Determinants of Health

FINDING 1-1 Racial and ethnic background has profound effects on an individual's health primarily because of the different social and economic experiences — advantages and disadvantages — that go along with race and ethnicity⁵.

- Santa Fe County had the greatest population increase between 2000 and 2006 at 10.1% compared to the U.S. at 6.4%, New Mexico at 7.5% and Los Alamos at 3.7%. Rio Arriba had a population decrease by -0.6%. While the actual size of the population for Native Americans is larger in Rio Arriba and Santa Fe Counties, Los Alamos had the greatest percent growth between 2000 and 2006. Los Alamos had a 20% increase of Hispanic/Latino, Santa Fe an increase by 11.2% and Rio Arriba a slight decrease by -1.5%.

FINDING 1-2 The aging of the 20–54 year old group will bring new demands on resources for long-term health care needs to the state and Northern New Mexico area. Children and youth pose a demand for home and school-based services that promote wellness such as exercise and good oral health and prevent disease such as obesity and substance abuse.

- Los Alamos (23%) has a larger percent of 55–74 year olds than the U.S. (17%) and Rio Arriba (18%) and Santa Fe (20%). Rio Arriba has a larger percent of children and youth under age 19 at 31% compared to the US (27%) and NM (28%), Los Alamos (25%) and Santa Fe (25%).

FINDING 1-3 Research shows that poverty is linked to ill health. Whereas, wealth fosters good health by providing people access to economic resources, medical care and quality of life options such as nutritious foods, better child care, safe neighborhoods with good schools, and reliable transportation.

- Los Alamos income levels exceed NM and US with 9% of households earning more than \$150K, and 25% of households with incomes between \$110K and \$149K.
- Rio Arriba has the largest percent of households earning less than \$24,999 with 16% earning less than \$10,000.
- Rio Arriba has 7% of households living below poverty compared to the US (4%), NM (6%), Santa Fe (4%) and Los Alamos (1%).

FINDING 1-4 Work is linked to health via social resources, health care insurance coverage, hazardous or risky workplace conditions, and psychosocial characteristics of the work environment.

- Rio Arriba had the highest unemployment rate (5%) compared to Santa Fe (3%), Los Alamos (1%), NM (4%) and US (4%).

FINDING 1-5 Education is tightly linked with income and wealth which in turn are tightly linked with health.

- Los Alamos has the highest educated population with 36% graduate or professional degrees and 24% with bachelor's degrees. Rio Arriba has lower educational attainment with 27% of the population who have less than a 12th grade education compared to Santa Fe at 16% and Los Alamos at 3%.
- Espanola School District had the highest drop-out rate in 2005–06 at 6.8% followed by Santa Fe at 4.2%.
- Rio Arriba (33.2%) and Santa Fe (40.5%) had higher growth in owner occupied vs. renter occupied housing than Los Alamos (9.8%).

FINDING 1-6 Research demonstrates that socio-economic conditions and context matter for health.

- Participants in the non-profit and faith-based focus group in Rio Arriba and the funders focus group repeatedly discussed the significance of defining health broadly to include a web of factors that are considered "root causes" of and well-being such as income, poverty, education, land ownership, and cultural traditions.

- The cycle of poverty and its impact on children's well-being: "We have to go to the root causes of medical issues, a lot of it is poverty. It's a cyclical process. For example, in our organization we get kids when they are already damaged. They come in at a point to where they need help, we have to help them. But then we have to throw them back into the hopper. It is a revolving door, we are just spinning wheels. Poverty is basic along with lack of education. We need to keep kids focused along with academics."

FINDING 1-7 Hunger/food insecurity and lack of transportation in rural areas were two frequently discussed issues by the participants in Rio Arriba and the funders focus groups.

- "For home visitors the biggest cost of serving new parents and infants is transportation. Our workers have to travel to visit families in Dulce, Jicarilla and the Apache nation. It takes them all day to drive there from Espanola. We work with rural clinics, and this has created a need to budget and fund raise for transportation, New Mexico is a rural state."
- "Families need basic sustenance; many do not have enough food. We provide a food depot and have a bag of groceries for families once per month. Some families have nothing to eat, at first I was surprised to learn that some families had not eaten for four days."

FINDING 1-8 Other factors that impact health are language and culture. Both play a pivotal role for communities in Northern New Mexico and for persons who are limited English proficient (Native Americans, Hispanics and immigrants).

- Los Alamos (27.5%) and Santa Fe (25.4%) had a greater percent change among persons who reported they speak a language other than English compared to Rio Arriba (11.8%). Among those who speak Spanish, 35.6% reported speaking English less than "very well" in Santa Fe which is higher than the state, Los Alamos and Rio Arriba, but lower than the US change of 65.5%.

- Rio Arriba (248.9%) and Santa Fe (223.4%) had the greatest growth of foreign-born population compared to Los Alamos (46.7%), NM (85.8%) and the US (57.4%). It is important to note that the majority of New Mexico's residents are US born (86% statewide, 94% Los Alamos, 96% Rio Arriba, and 90% Santa Fe).

Finding 2. Health Conditions

Health priorities discussed by focus group participants were substance use (alcohol use, alcoholism, drug abuse and prescription drugs), teen pregnancy, diabetes, obesity including childhood obesity, child and adolescent mental health. Among these, teen pregnancy, substance abuse and alcoholism were identified as the most pressing health issues.

FINDING 2-1 Maternal & Child Health

- Rio Arriba has a higher rate of childbearing at 84.6 than Santa Fe at 59.4 and Los Alamos at 57.3 (number of births per 1,000 women ages 15–44).
- From 2004 to 2006, Rio Arriba had the highest teen birth rate at 40.5 which is higher than the state rate at 35.7 and significantly higher than Santa Fe at 27.3 and Los Alamos at 5.1.
- Adolescent pregnancy rates are cyclically connected to poverty levels. Poor adolescents are more likely to give birth, and mothers who gave birth as teenagers are more likely to be poor.
- While the teen pregnancy rate is low for Los Alamos, providers, non-profits and faith-based community members express concern about teen pregnancy and the need for parenting support.

FINDING 2-2 Leading Causes of Death

- Challenges for Rio Arriba include the higher rates in nine of the eleven leading causes of death compared to Los Alamos and Santa Fe: 883.2 for all causes, 177.69 for diseases of the heart, 160.28 for cancer deaths, 106.65 for unintentional injuries, 49.88 for diabetes, 32.15 for chronic liver disease and cirrhosis,

23.26 for suicide, 22.55 for homicide, and 16.41 for flu and pneumonia. The death rates for Rio Arriba are higher than the New Mexico state rates in seven of the eleven leading causes of death.

- Challenges for Los Alamos include the highest rates of circulatory, cerebrovascular diseases at 26.69 and 34.25 for chronic lower respiratory diseases.
- Santa Fe ranks second to Rio Arriba with a moderate rate of unintentional injury (accidents) at 58.98 and for flu and pneumonia at a rate of 11.93. Santa Fe ranks second to Los Alamos for chronic lower respiratory diseases at 36.11.

FINDING 2-3 Infectious Diseases

- Santa Fe has the greatest challenges including a higher number of cases for STD's including chlamydia, gonorrhea and syphilis and the highest rate for the prevalence of HIV/AIDS.
- Rio Arriba (103.36) had the second highest rate of HIV/AIDS per 100,000 persons.

FINDING 2-4 Chronic Diseases

- Challenges for Rio Arriba include higher rates for diabetes (10.7) and obesity (20.5) than Los Alamos and Santa Fe.
- Santa Fe has the highest incidence rate of cancer at 477.4 which exceeds the state rate of 415.0 followed by Los Alamos at 443.3 and Rio Arriba at 378.7.

FINDING 2-5 Substance Abuse

- Challenges for Rio Arriba include the most serious problems for six of the eight indicators in which data were reported: adult binge drinking (17.8), adult chronic heavy drinking (6.2), youth drinking and driving (22.3), youth marijuana use (42), youth cocaine, methamphetamine or inhalant use (14.1) and adult smoking (25).
- Challenges for Santa Fe include higher youth binge drinking (48.2), adult drinking and driving (2.3), youth drinking and driving (22.2), and youth smoking (33.8).
- Los Alamos has lower rates of alcohol, drug and tobacco problems.

- For youth drinking and driving, the prevalence of past 30 day drinking and driving was highest in Rio Arriba, which ranked the sixth highest percent in the state followed by Santa Fe.
- Youth marijuana use is highest in Santa Fe County which ranks third highest county in state, Rio Arriba is 9th highest.

Finding 3. Health Systems and Policy

Focus groups participants consistently expressed concern about barriers to accessing health care such as lack of insurance coverage including dental coverage, lack of preventative care, lack or late entry into prenatal care, shortage of service providers, or lack of providers such as dentists and behavioral health providers (prevention, treatment and after care), long-waiting lists and access to and exchange of information, referrals and resources among community members but also providers.

FINDING 3-1 Health insurance coverage is a critical factor in making health care accessible to children and families living in Northern New Mexico. Research has consistently documented that lower educational levels, type of employment and income are key determinants of the high rates of non-insurance among low-income and minority populations, especially Hispanics and Native Americans.

- A total 25% of New Mexicans are uninsured. Among the uninsured population, most are adults 19–30 (75% of the uninsured). Children comprise 25% of the uninsured. Hispanics comprise 43.5% of the uninsured population and Native Americans 13.3%. Non-Hispanic Whites represent 12.8% of the total uninsured population.
- Counties provide critical support and access to needed services to the local hospitals, primary health care, dental, pharmacy and behavioral health.
- In 2007, county expenditures totaled \$15.7 million for Santa Fe, \$1.1 million in Rio Arriba and almost \$1 million in Los Alamos.
- Out-of-pocket costs for New Mexicans is higher for persons who are uninsured (\$858 vs. \$669).

FINDING 3-2 Counties have had significant flexibility and latitude in how to administer local funds for indigent health care, including eligibility determination.

- All three counties have a 90 day residency requirement in order to be eligible for county funded health services. As of 2007, Los Alamos and Santa Fe Counties reimburse hospitals and providers for health services rendered to LEGAL immigrants while Rio Arriba does not.

FINDING 3-3 Preventative services play a key role in early detection of disease and in promoting population health.

- Los Alamos has the highest immunization rate compared to the other two counties and state (92.1%) while Santa Fe is the lowest (77.2%).
- Rio Arriba has the lowest access to prenatal care at 15.8% compared to Los Alamos at 2.6% and Santa Fe at 5.0%.

FINDING 3-4 New Mexico has had a disproportionate amount of professional shortage areas and has struggled with recruitment, training and hiring a diverse workforce that is reflective of the composition of our communities.

- While none of New Mexico's counties reached the national benchmark for a physician FTE at 2.42, Los Alamos FTE was 2.41, Santa Fe (1.83) and Rio Arriba (1.04).
- Dentists and dental hygienist rates per 1,000 population vary across counties. Los Alamos had the highest rate of dentists (.80) and dental hygienist (.80) followed by Santa Fe at .75 for dentists and .43 for dental hygienist. Rio Arriba had the lowest rates at .23 for each.
- The rate of RNs per 1,000 population was highest in Los Alamos (7.84), followed by Santa Fe (7.58), whereas Rio Arriba was 4.80.
- Santa Fe had the highest rate of licensed pharmacists at .74 followed by Los Alamos at .50 and Rio Arriba at .30.

Executive Summary Recommendations

The recommendations in this report draw from the priority health and health care needs identified by the secondary data analysis and the focus group discussions. Four focus groups were conducted with funders, non-profits and faith-based organizations, and health care providers in the three county area of Northern New Mexico. The co-moderator's questions were designed to elicit advice on how the NNaMHGG should act to solve perceived health and health care issues and how to prioritize funding. Key themes discussed by focus group participants were synthesized and compared to the results of the data analysis (demographics, socio-determinants of health, health conditions, and health systems and policies). Next, these findings were compared to a recent review of the literature on interventions to reduce health disparities. Consistent with the findings and the literature, multifaceted interventions targeting different leverage points within and outside the health care system are highlighted below.

Recommendation 1. Expand the definition of health to include wellness and life opportunities

RECOMMENDATION 1-1 Recognize that health is influenced by factors outside the health care system.

- Build on community assets and embrace the notion of wellness.

RECOMMENDATION 1-2 Raise awareness and mobilize action to improve health through a broad range of interventions.

- Participate in public education campaigns conducted in partnership with public-health entities, private sector, universities and community-based organizations to encourage comprehensive approaches to address health inequalities among communities in Northern New Mexico.

- Reduce poverty through programs that focus on the educational attainment of children and youth. Education is the cornerstone to promoting and protecting intergenerational health and well-being. Education is also a vehicle for securing employment and attaining economic security, programs that prepare children early in life for school success and continue to support academic engagement are critical for future health.
- Promote public-private investments that protect mortgages and home ownership for low and middle income families.
- Promote workforce development, especially in the health professions at the K–12 and community college levels.
- Protect the rights of all to equally participate in the labor market through monitoring and compliance of federal Equal Employment Opportunity laws, the guarantee of minimum living wages and provision of employer sponsored health insurance.
- Invest in local farmer's markets and food banks that provide access to nutritional and affordable food to local residents, especially in rural areas.
- Foster public-private collaborations and alliances to address transportation issues in rural areas.

Recommendation 2. Improve health conditions

RECOMMENDATION 2-1 Expand and implement nutrition and health education programs.

- Make sure people have access to high quality nutritious foods at an affordable price, especially if it supports the local growers.
- Offer health education for healthy lifestyles and provide lifestyle counseling.

RECOMMENDATION 2-2 Build awareness of and strengthen investments in early prevention of infections (pneumonia and flu), diseases (HIV and STD's), chronic conditions (asthma, diabetes, obesity, heart disease) and risks behaviors (substance use, teenage pregnancy, unintentional injuries, violence) among private and public health systems and governments.

- Support science-based and culturally appropriate prevention strategies for children and youth at the individual, family, school and community levels (teenage pregnancy, youth drinking and driving, smoking and drug use).
- Advocate for government and private investments in preventative screenings and early detection of diseases and health risks at community health centers, hospitals and other health providers.
- Promote school and mobile health clinics and their capacities to offer comprehensive preventative services (immunizations, vaccinations, dental, behavioral health and physical health).
- Increase opportunities for free screenings and health, nutrition and wellness information at public accessible places beyond the health care system (i.e. Wal-Marts/grocery stores, community events, churches, etc.).

RECOMMENDATION 2-3 Focus state health care reform efforts and health disparities initiatives on culturally appropriate disease management efforts.

- Align efforts among state, tribal and local governments, managed care organizations, community health centers, hospital systems and public health entities to improve access to prescription drugs and other medical devices/tools that empower individuals to monitor and control their disease (i.e. HIV, diabetes).
- Foster the health literacy of patients to manage their health and promote cultural and language literacy among providers to assist diverse patients in understanding and managing their health conditions.

Recommendation 3. Strengthen the capacities of community-based organizations to improve health care access and solve problems

RECOMMENDATION 3-1 Help community-based organizations (CBOs) to develop a one-stop shop.

- Assist in developing a centralized assessment and referral.

RECOMMENDATION 3-2 Support and assist CBOs with streamlining electronic records.

- “My agency has actually started electronic record-keeping, having all our agencies go there, being able to transfer files across the board.”

RECOMMENDATION 3-3 Help non-profits improve communications and information exchange.

- “We need a resource book (maybe it exists), this would be helpful.”

RECOMMENDATION 3-4 It is important to build capacity of community-based organizations and supports to address health care and social needs.

- To strengthen family networks and in changing the outlook of that community.
- Expand drug counseling support systems.

RECOMMENDATION 3-5 Help build the capacity of organizations to provide services so they can be more effective.

- Offer grants in terms of systems change and development, collaboration and capacity building.
- Support the leaders in these organizations.
- Train non-profits to build those skills and support their efforts.

RECOMMENDATION 3-6 Build on the assets of community colleges and universities.

- Recruit students into health care professions.
- Tap into UNMHSC and the medical students there, we have a wonderful resource via the medical school.

RECOMMENDATION 3-7 Support mechanisms for enlarging the pool of health professionals to provide culturally competent care, particularly in underserved areas.

- Foster the regeneration of new talent into educational and training programs for health professionals through local leadership and community-based strategies.
- Collaborate with K–12, colleges and universities on innovative initiatives that promote the recruitment, training and hiring of local residents into the health professional schools (i.e. dentists, nurses, pharmacists, physicians).

RECOMMENDATION 3-8 Promote culturally and language appropriate services.

- Encourage health and social service providers to adopt and use the National Standards for Culturally and Linguistically Appropriate Services in Health Care.
- Work with the New Mexico Department of Health, Human Services, Children Youth and Families, IHS and tribes to explore innovative mechanisms for promoting language access (i.e. the use of federally funded Medicaid waiver and reimbursements to New Mexico for language access).
- Sponsor local health and behavioral care professionals, para-professionals and community health workers to participate in accredited medical interpreters training and train-the-trainer programs.

RECOMMENDATION 3-9 Promote efforts that reduce discrimination, bias and misinformation among health providers and local health systems.

- Work with other public health stakeholders to disseminate clarifications of federal, state, county and tribal eligibility and benefits criteria for various classifications of immigrants, i.e. those who are legal but fall within a five-year bar for federally funded health care and unauthorized pregnant women and children).
- Encourage health professional training schools and universities and state licensing entities to incorporate anti-discrimination and internalized racism techniques into their cultural competency curriculums and licensing requirements.
- Encourage state quality improvement and pay-for-performance requirements and initiatives to include cultural and language competency indicators.

Recommendation 4. Engage community leaders in policy development and policy change efforts.

RECOMMENDATION 4-1 Assist in policy development that supports the capacities of non-profits.

- “Tap into the tag on motorcycle registrations which could be used to support community-based organizations.”
- “In terms of a policy, we could introduce a memorial and do away with the provisions that put a cap on insurance pools.”

RECOMMENDATION 4-2 Provide opportunities for residents in Northern New Mexico to build policy advocacy skills and to meaningfully engage in state health care reform initiatives (i.e. Hispanic/Latino, Native American, immigrants, people living with disabilities, youth and elders).

- Sponsor local forums that foster exchange of information and dialogue around key elements of health reform.

- Assist in fact-finding and gathering research on the impact of health care reform on communities in Northern New Mexico (i.e. take-up patterns via employer-sponsored coverage; innovative coverage for low income adults; state administrative obstacles to enrollment and retention; and incentives to promote innovative coverage initiatives that are culturally, linguistically and financially appropriate for various subgroups).
- Support community-based organizations and leaders in using media advocacy efforts to hold elected and appointed officials accountable to the use publicly financed health care including the flow of funds to managed care organizations.

Recommendation 5. Create innovative funding mechanisms

RECOMMENDATION 5-1 Move from being the one-shot funding to systemic change.

RECOMMENDATION 5-2 Avoid funding specific programs for specific agencies. Foundations could “tweak their funding mechanisms” so that collaborators are effective.

RECOMMENDATION 5-3 When programs are successful, continue funding those areas to sustain the improvement.

RECOMMENDATION 5-4 Small funders have a unique opportunity to be advocates.

RECOMMENDATION 5-5 Provide more sustained funding – multi-year funding leads to systemic change.

RECOMMENDATION 5-6 Foundations can play a role in convening people and coming together and sharing with each other.

RECOMMENDATION 5-7 Keep grant processes simple and streamlined.

Introduction

In May 2002 the Los Alamos Medical Center (LAMC), a non-profit corporation, was sold to a for-profit corporation. Some proceeds from the sale of Los Alamos Medical Center were preserved to serve the unmet health care needs of the people of Los Alamos, Rio Arriba and Northern Santa Fe counties. The Hospital Auxiliary for LAMC and Con Alma Health Foundation, working as the Northern New Mexico Health Grant Group (NNMHGG), distribute the investment income from those proceeds annually for grants that target the populations traditionally served by the Los Alamos Medical Center.

The NNMHGG grant-making is overseen by a five-member Local Advisory Committee, two of whom are appointed by Con Alma Health Foundation (CAHF) and two of whom are appointed by the Auxiliary (Figure 1). The fifth member, Dr. Erin Bouquin, M.D., appointed by the Attorney General of New Mexico, serves as the Committee Chair. CAHF provides administrative and program support (i.e. management of investments, financial management, grant-making due diligence, etc.). NNMHGG operates under CAHF's 501(c) 3 tax-exempt status.

Purpose

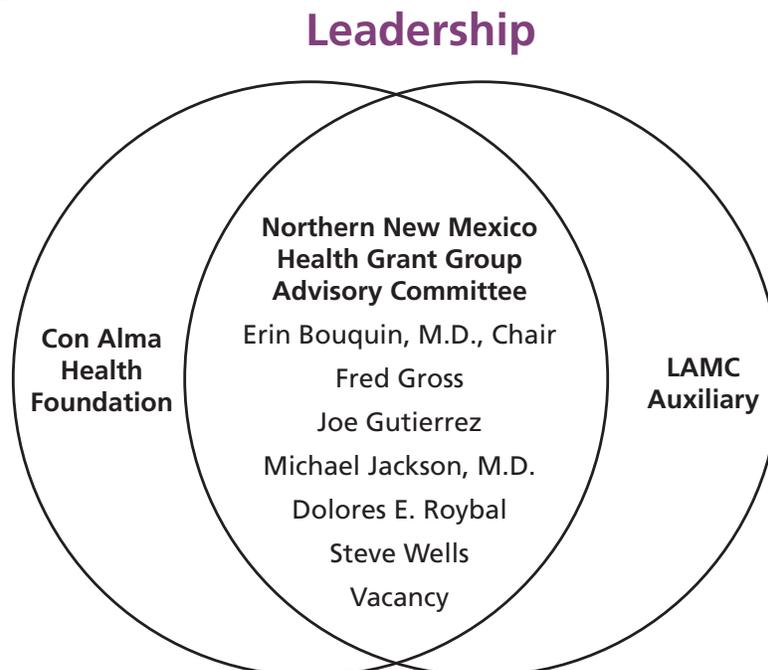
The NNMHGG decided to conduct an assessment of health status priorities and health care systems challenges specific to the target area (Los Alamos, Rio Arriba and Northern Santa Fe) in order to better inform the grant-making process. The objectives of the assessment are to:

1. Identify specific funding priorities for target area within the broader goal of addressing health needs left unmet by the sale of the Los Alamos Medical Center;
2. Incorporate CAHF Health Disparities Report as part of the broader grant-making framework (Report will be updated in 2008); and
3. Review/revise current NNMHGG grant guidelines as appropriate.

Framework Guiding Data Collection

Research demonstrates that there are multiple dimensions which explain inequalities in health.^{6, 7, 8, 9} Factors such as income and education, personal behaviors, and access to medical and public health services influence health. Non-medical factors such as housing, working

FIGURE 1



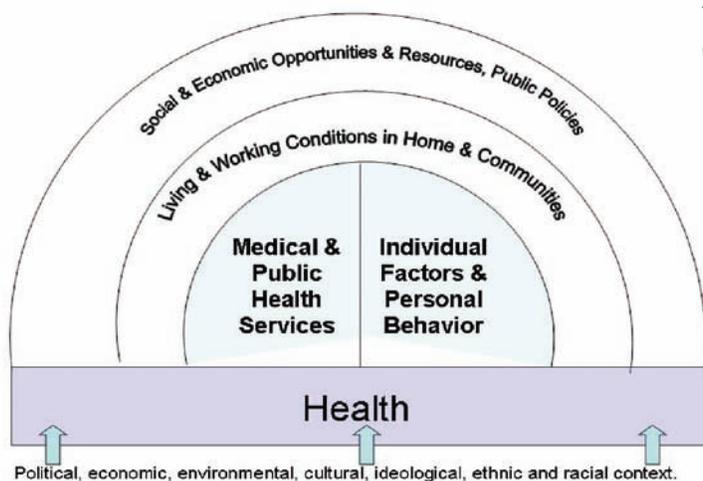
conditions and support from family and friends also impact poor or good health. Social and economic opportunities and public policies provide access to resources across the lifespan and ultimately affect poor or good health. At any given time, these factors interact to moderate health and well-being within New Mexico's political, economic, environmental, cultural, ideological, ethnic and racial context. Recognizing that a person's health is shaped by factors within and outside the health care system, the NNMHGG decided to use a framework endorsed by the U.S. Commission to Build a Healthier America as a guide for this study and data collection efforts (Figure 2).

Methods

The NNMHGG Local Advisory Committee Chair, CAHF Executive Director and research consultant jointly selected the methods for gathering, compiling and analyzing the data for the comparative health profiles. Quality, time constraints and available resources were taken into consideration when considering the combination of methods.

FIGURE 2

Framework for Understanding the Causes of Health



Source: Adapted from D. Williams, U.S. Commission to Build a Healthier America. WK Kellogg Symposium, Washington, D.C., 2007

Recognizing that a person's health is shaped by factors within and outside the health care system, both qualitative and quantitative data were collected to include, socio-determinants of health, health systems capacity, and community and provider perceptions and experiences in the three county area of Northern New Mexico.

Secondary data were compiled and analyzed from multiple sources. A list and description of the databases are found in Appendix A. Data indicators selected to assess health issues across counties include:

- Demographics (total population, race/ethnicity, age);
- Socio-determinants of health (poverty, income, employment, education, language, nativity, housing);
- Health conditions (maternal and child health, leading causes of death, infectious diseases, chronic diseases, and behavioral health/substance use);
- Health systems and policies (per capita health care cost, county health expenditures, insurance status, county eligibility policies, immunization coverage, emergency room use, Medicaid eligibility and enrollment, health professional capacity, prenatal care).

Primary data were collected through four focus groups that were conducted in Santa Fe, Los Alamos, and Rio Arriba. The focus groups included (1) funders, (2) non-profits and faith-based organizations, and (3) health care providers. The co-moderator's questions were designed to elicit information from the participants in two areas (see Appendix B-Focus Group Guide):

- What are the top health issues in Los Alamos, Rio Arriba & Northern Santa Fe Counties?
- Advice on how the NNMHGG should act to solve issues and prioritize funding?

Key themes discussed during the focus group were analyzed and summarized into this final report and compared against the secondary data described above.

Approximately 60 representatives were invited to participate in the four focus groups. A total of 40 persons participated in the focus groups (see Appendix C-Demographics). All participants were working in public health (i.e. primary health care, hospitals, specialty care, emergency medicine, social services, advocacy) and serving one of the three targeted counties in Northern New Mexico (Los Alamos, Rio Arriba, and/or Northern Santa Fe). Participants were recruited based on a review of lists of organizations and providers serving the target area and referrals from key stakeholders in the communities.

The invitations to participate were extended and confirmed by the principle investigator via telephone and/or email. In all initial contacts (personal/phone and by mail/e-mail), the information describing the actual contents of the focus group was limited in order to prevent participant bias prior to the meeting. The invitations stated that participation was strictly *voluntary* and emphasized that participation *would not* affect any future funding or grant applications from the invitees' organizations. All lists and names of participants were protected and kept in a confidential file by the research consultant. Staff and volunteers from the CAHF and NNMHGG do not have access to the names of invitees, participants and/or their organizations.

The Focus Group sessions were recorded on a digital recorder and transcribed in a manner that assures anonymity. For example, the transcribed word documents do not include names or any identifying information. Transcribed focus group materials were kept in a secure location and computer maintained by the researcher. The demographic information does not contain any individual identifiers.

Limitations

Although this study provided critical evidence for prioritizing health needs and for guiding the grant-making process, there are some limitations to note. As with other community profiles using public use data sources, there are problems getting county and sub-county level measures of health conditions and health systems issues. Most data sources are summarized at the state-level. When county level data is available it is not consistently collected across various health conditions i.e. diabetes, obesity, cardio-vascular disease. The health status data is not consistently broken down by important socio-demographic measures such as age, income, education and race/ethnicity. Sensitive health information (i.e. HIV/AIDS) may be potentially linked to person-level identifiers so is not publicly available at the sub-county level. Finally, while New Mexico has a wealth of data sets collected and stored within various state agencies, the information is not always synthesized in ways that useful to the public. For this reason, this study relied on a variety of data sources to provide useful information for grant-makers.

Findings

The following findings present a comparative profile of demographic characteristics, socio-determinants of health, health conditions, health systems and policies across the three Northern New Mexico counties (Los Alamos, Rio Arriba and Santa Fe). Community perceptions on priority health issues are integrated throughout the report as a way to interpret and provide contextual descriptions of the challenges facing these communities. Recommendations made by focus group participants are summarized into four key themes: 1) expand the definition of health to include wellness and life opportunities; 2) strengthen health systems capacities and improve health policies; 3) improve health conditions; and 4) create innovative funding.

Findings

Demographics and Socio-Determinants of Health

Between 1990 and 2005, New Mexico’s population increased from 1.5 million to 1.9 million. This growth rate of 27.2% surpassed the U.S. growth of 19.2% over the 15 year period. Of the three Northern New Mexico counties, Santa Fe had the greatest growth (42.3%) followed by Rio Arriba (18.2%) and Los Alamos (4.1%). Among incorporated and metro areas with populations over 65,000 (2005), Santa Clara Pueblo’s population had the greatest percent change (58.7%) followed by Santa Fe (26.8%). Population growth needs to be tracked at the state, county and community levels. **Table 1** shows the total population (numbers) in 1990, 2000 and 2005 for US, NM, and three county area.

Racial and ethnic background has profound effects on an individual’s health primarily because of the different social and economic experiences — advantages and disadvantages — that go along with race and ethnicity.¹⁰ According to the 2006 population estimates, 84.6% of New Mexicans were White, 2.5% were African American, 9.8% were American Indian, 9.8% were Asian, and 44% reported Hispanic/Latino ethnicity. Compared to the U.S. (1.0%), New Mexico (9.8%), Rio Arriba (15.2%) and Santa Fe (3.4%) has a higher proportion of Native American population. The Hispanic/Latino population is the higher in Rio Arriba (72.2%) and Santa Fe (49.5%) compared to NM (44%) and the U.S. (15.2%). **Figure 3** and **Table 2** illustrate the composition of the population by percent race/ethnicity in 2000 and 2006 for the US, NM and the three county area¹¹. Los Alamos has the highest proportion of Whites at 91.8%.

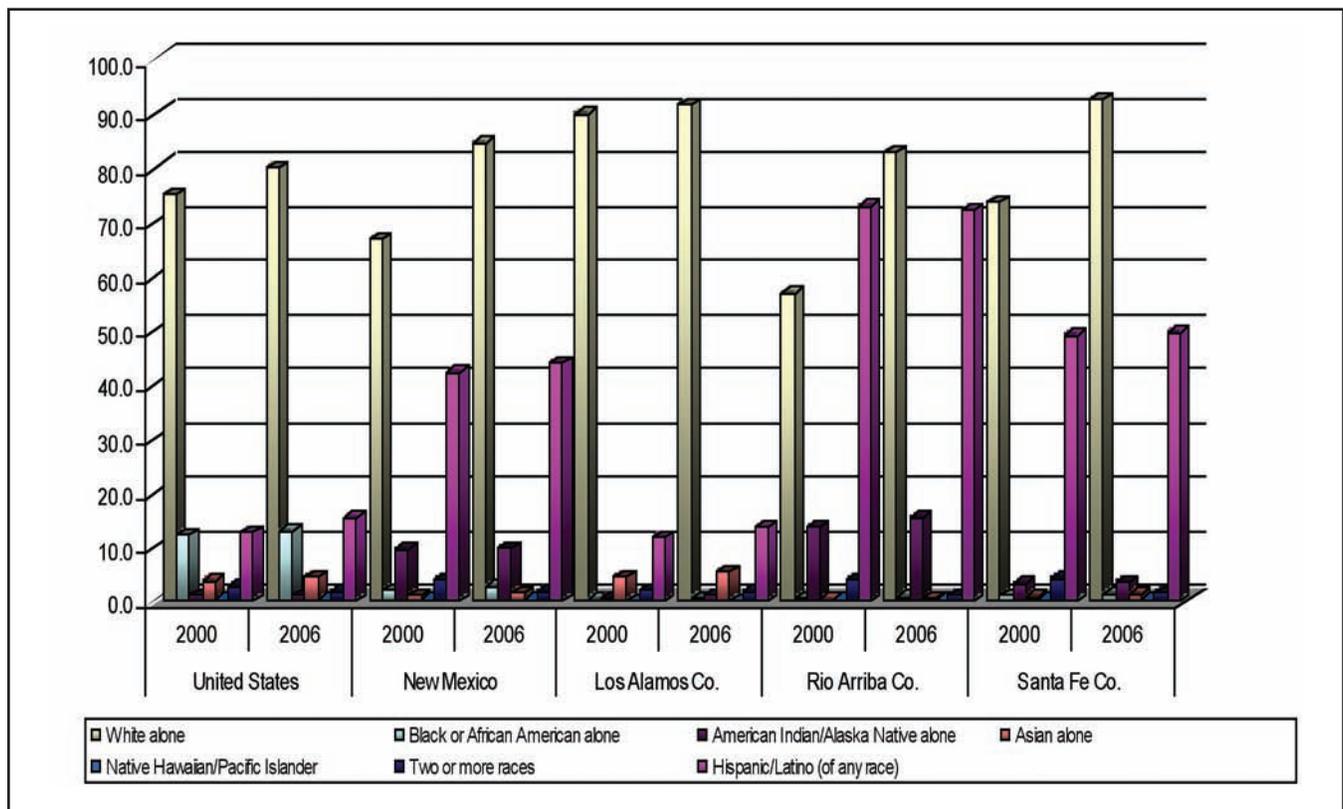
TABLE 1
Total Population

Population	1990	2000	2005	Percent Change: 1990 to 2005
US	248,709,873	281,421,906	296,507,061	19.2
NM	1,515,069	1,819,046	1,925,985	27.1
Los Alamos Co.	18,115	18,343	18,858	4.1
Rio Arriba Co.	34,365	41,190	40,633	18.2
Santa Fe Co.	98,928	129,292	140,801	42.3
Chama Village	1,048	1,319	1,167	11.4
Espanola	8,389	9,731	9,599	14.4
Santa Clara Pueblo	1,156	1,077	1,834	58.7
Santa Fe	55,859	61,805	70,830	26.8

Source: US Census

FIGURE 3

Percent Race per Total Population by Race/Ethnicity 2000 & 2006



Source: US Census, ACS

Note: The US Census gathers data for those who report multiple races and ethnicity. In Figure 3 and Table 2 "alone" refers to those who reported only one race or ethnicity.

TABLE 2

Percent Race per Total Population by Race/Ethnicity for 2000 and 2006	United States		New Mexico		Los Alamos County		Rio Arriba County		Santa Fe County	
	2000	2006	2000	2006	2000	2006	2000	2006	2000	2006
White alone	75.1	80.1	66.8	84.6	90.1	91.8	56.8	82.9	73.6	92.8
Black or African American alone	12.2	12.8	1.8	2.5	0.2	0.5	0.4	0.6	0.8	1.2
American Indian/Alaska Native alone	0.9	1.0	9.5	9.8	0.5	0.8	13.5	15.2	3.1	3.4
Asian alone	3.6	4.4	1.0	1.3	4.4	5.3	0.1	0.3	0.7	1.2
Native Hawaiian/Pacific Islander	0.1	0.2	0.1	0.1	0.0	0.0	0.1	0.2	0.1	0.1
Some other race alone	5.5	0.0	17.0	0.0	3.0	0.0	25.4	0.0	17.7	0.0
Two or more races	2.6	1.6	3.9	1.6	1.7	1.5	3.8	0.8	4.1	1.3
Hispanic/Latino (of any race)	12.5	15.2	42.1	44.0	11.7	13.6	72.9	72.2	49.0	49.5

Source: US Census

TABLE 3
Population Growth

Table 3 presents the growth (as percent change) and breakdown of the population by region and race and ethnicity in 2000 and 2006. Santa Fe County had the greatest population increase between 2000 and 2006 at 10.1% compared to the U.S. at 6.4%, New Mexico at 7.5% and Los Alamos at 3.7%. Rio Arriba had a

population decrease by -0.6%. While the actual size of the population for Native Americans is larger in Rio Arriba and Santa Fe Counties, Los Alamos had the greatest percent growth between 2000 and 2006. Los Alamos had a 20% increase of Hispanic/Latino, Santa Fe an increase by 11.2% and Rio Arriba a slight decrease by -1.5%.

Race/Ethnicity	USA			New Mexico			Los Alamos			Rio Arriba			Santa Fe		
	2000	2006	Percent Change	2000	2006	Percent Change	2000	2006	Percent Change	2000	2006	Percent Change	2000	2006	Percent Change
White	211,460,626	239,746,254	13.4	1,214,680	1,653,876	36.2	16,532	17,461	5.6	23,378	33,929	45.1	95,200	132,095	38.8
Black/African American	34,658,190	38,342,549	10.6	33,513	49,161	46.7	43	98	127.9	146	253	73.3	974	1,689	73.4
American Indian/Alaska Native	2,475,956	2,902,851	17.2	172,276	190,826	10.8	95	151	58.9	5,571	6,240	12.0	3,950	4,884	23.6
Asian	10,242,998	13,159,343	28.5	18,286	26,140	43.0	798	1,012	26.8	32	103	221.9	944	1,663	76.2
Native Hawaiian/Pacific Islander	398,835	528,818	32.6	1,248	2,655	112.7	0	6	0	57	78	36.8	80	178	122.5
Some other race	15,359,073	NA (variable change)		308,963	NA (variable change)		559	NA (variable change)		10,455	NA (variable change)		22,881	NA (variable change)	
Two or more races	6,826,228	4,718,669	-30.9	70,080	316	-54.4	316	294	-7.0	1,551	346	-77.7	5,263	1,898	-63.9
Total	281,421,906	299,398,484	6.4	1,819,046	1,954,599	7.5	18,343	19,022	3.7	41,190	40,949	-0.6	129,292	142,407	10.1
Hispanic or Latino (of any race)	5,305,818	45,504,311	28.9	765,386	860,024	12.4	2,155	2,587	20.0	30,025	29,565	-1.5	63,405	70,491	11.2

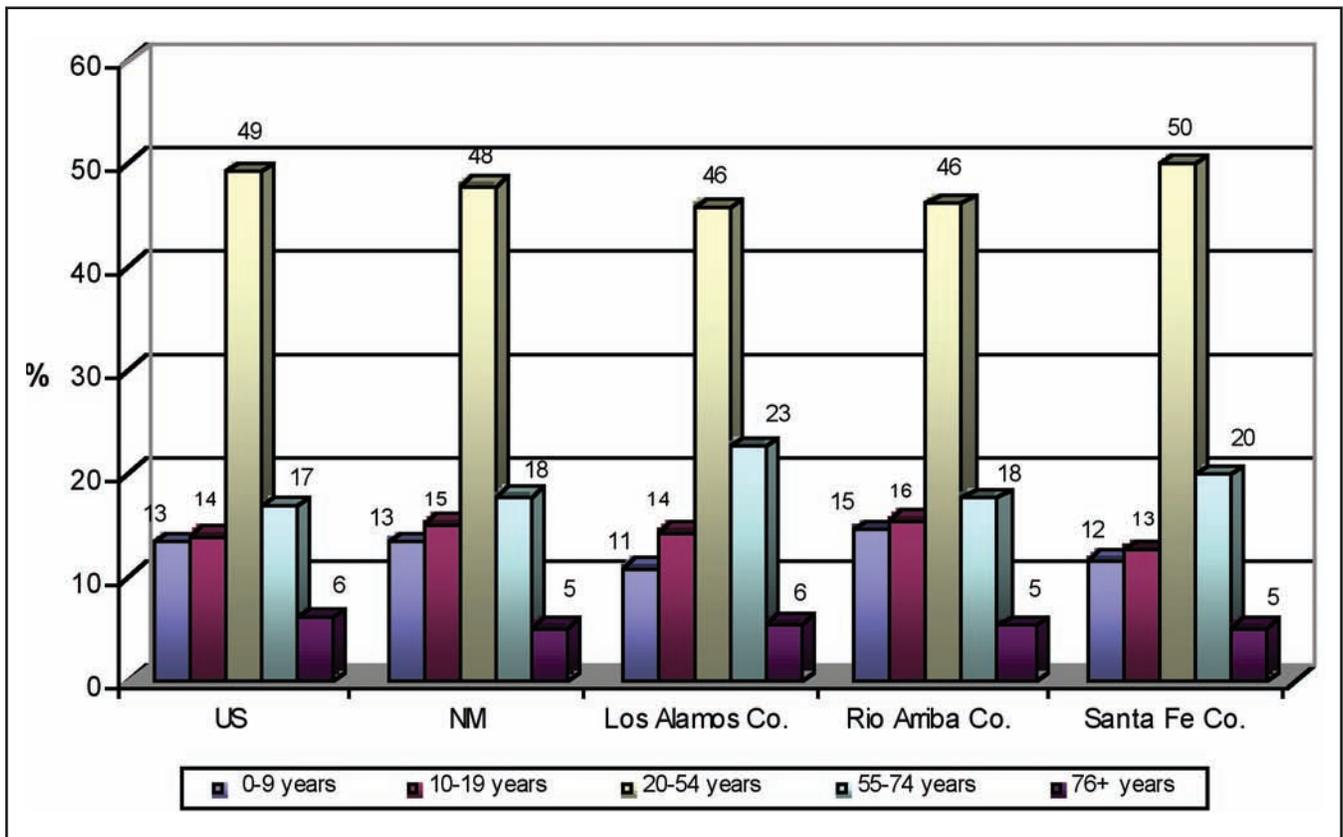
Source: US Census

Figure 4 shows the total population distribution by age group and the percent of total population that is 0–9 years, 10–19 years, 20–54 years, 55–74 years, and 76+ years (2005) for the US, NM, and three county area. Those that are 20–54 years of age comprise the largest proportion of the population. Los Alamos (23%) has a larger percent of 55–74 year olds than the U.S. (17%) and Rio Arriba (18%) and Santa Fe (20%). Rio Arriba has a larger percent of children and youth under age 19 at 31%

compared to the US (27%) and NM (28%), Los Alamos (25%) and Santa Fe (25%).

The aging of the 20–54 year old group will bring new demands on resources for long-term health care needs to the state and Northern New Mexico area. Children and youth pose a demand for home and school-based services that promote wellness such as exercise and good oral health and prevent disease such as obesity and substance abuse.

FIGURE 4
Percent of Total Population, Distributions by Age Groups, 2005



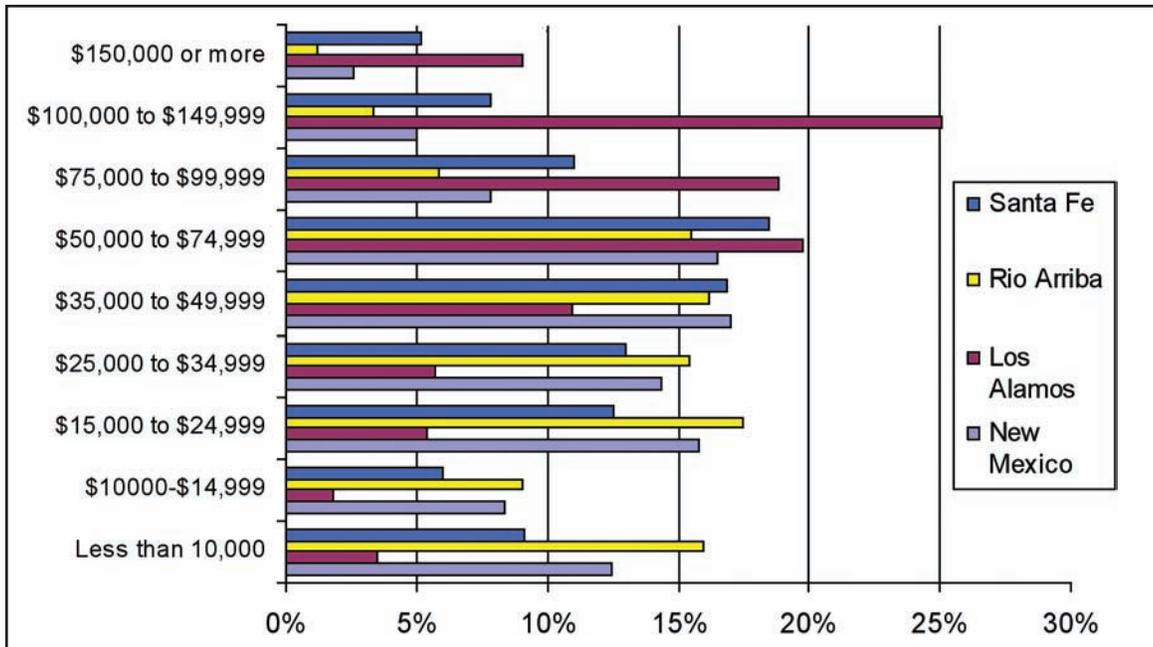
Source: US Census, ACS

Research shows that poverty is linked to ill health¹². Whereas, wealth fosters good health by providing people access to economic resources, medical care and quality of life options such as nutritious foods, better child care, safe neighborhoods with good schools, reliable transportation¹³.

Figure 5 shows Household Income as percent of those within each income category: less than 10K,

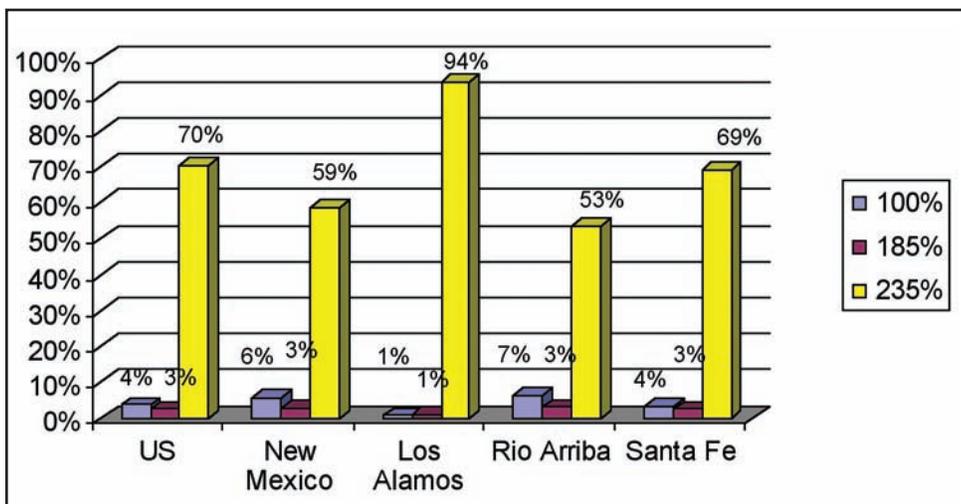
10K–14,999 and so on to \$150K and more for the US, NM, and Counties for 2000. Los Alamos income levels exceed NM and US with 9% of households earning more than \$150K, 25% of households with incomes between \$110K and \$149K, 19% earning between \$75K–\$99K and 20% earning between \$50K to \$74,999. Rio Arriba has the largest percent of households earning less than \$24,999 with 16% earning less than \$10K.

FIGURE 5
Household Income



Source: US Census, 2000

FIGURE 6
Household Incomes Below Poverty Levels



Source: US Census, 2000

Figure 6 illustrates the percent of households (all ages) living below 100%; 185%, and 235% of the federal poverty levels (FLP) for the US, NM, and three counties in 2000. Rio Arriba has 7% of households living below 100% poverty which is higher than the US (4%) and NM (6%), Santa Fe (4%) and Los Alamos (1%). Note: The FPL for a family of four in 2000 was \$17,050.

Rio Arriba has the greatest percent of families with children under age 18 who live below the poverty level. Table 4 illustrates the percent of children (Under Age 18) living in poverty by county for 2005.

TABLE 4
Percent of Children Under Age 18 Living in Poverty

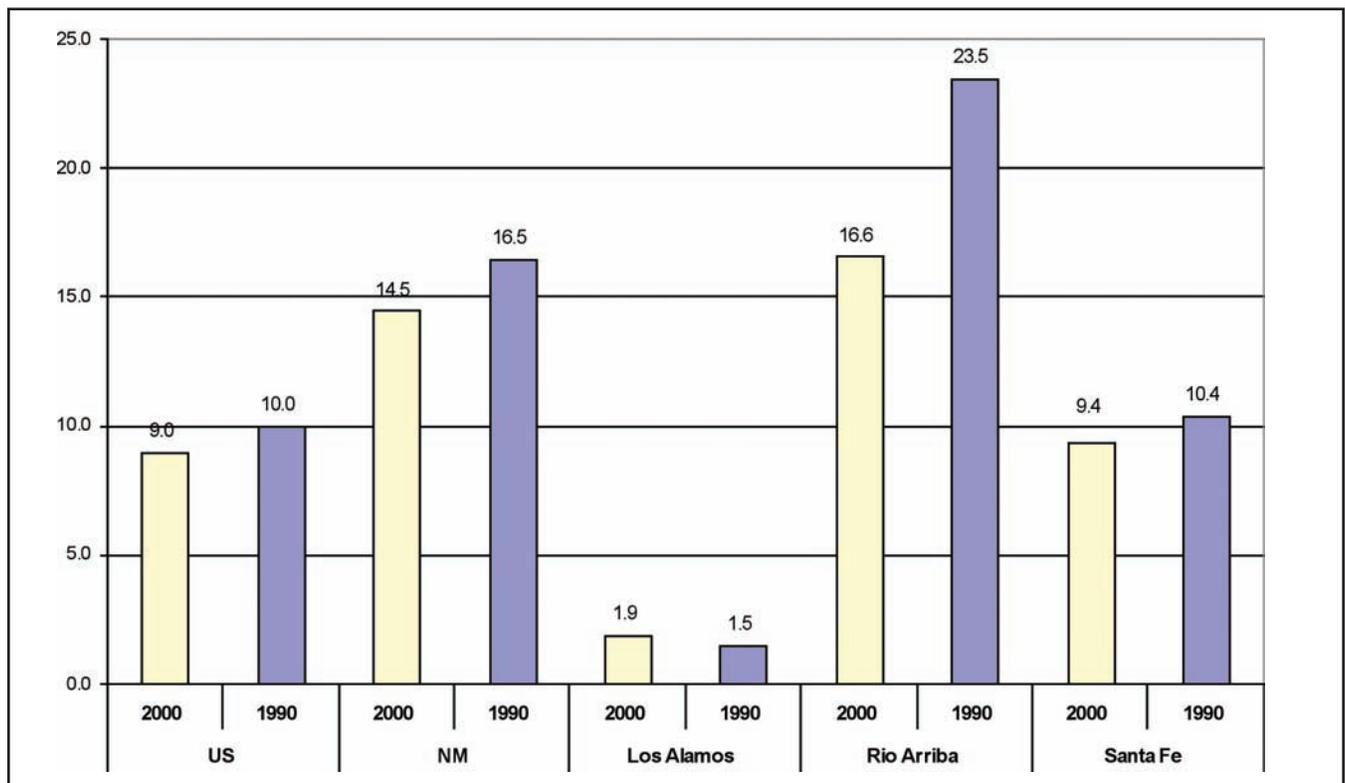
US	NM	Los Alamos	Rio Arriba	Santa Fe
18.5%	26.0	3.0	27.1	18.3

Source: ACS, 2005
Note: The poverty level for a family of four in 2005 was \$19,350.

Figure 7 shows the percent of families with children under 18 living below 100% of poverty for 1990 and 2000. The percent of families living below poverty declined for the US, NM, Rio Arriba and Santa Fe, but slightly increased in Los Alamos. While the centennial

census data are not directly comparable to the American Community Service updates as shown above, it is safe to estimate that the percent of families living in poverty has increased given the economic downturn of the nation.

FIGURE 7
Percent of Families with Children Living Below 100% Poverty Level

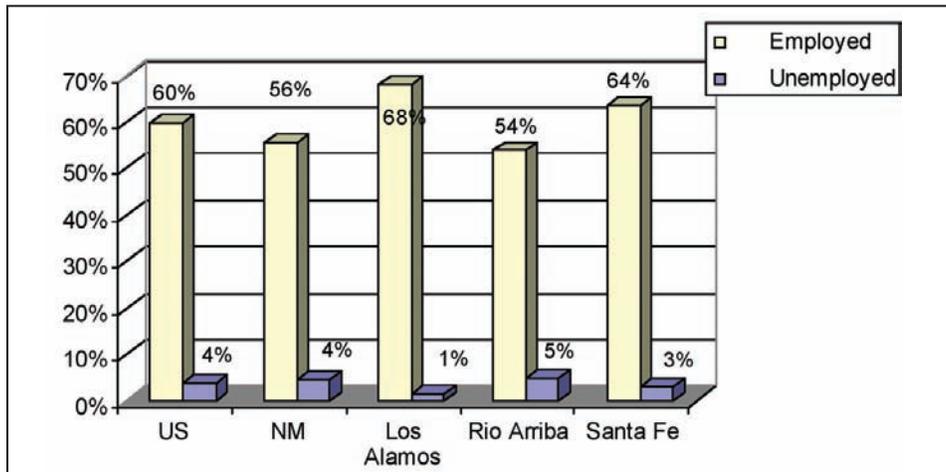


Source: US Census, 1990 & 2000

Work is linked to health via social resources, health care insurance coverage, hazardous or risky workplace conditions, and psychosocial characteristics of the work environment¹⁴.

Figure 8 shows employment by percent of those 16 and over in civilian labor force that are employed and unemployed for US, NM and counties for 2000. Rio Arriba had the highest unemployment rate (5%) compared to Santa Fe (3%), Los Alamos (1%), NM (4%) and US (4%).

FIGURE 8
Civilian Labor Force Sixteen and Over

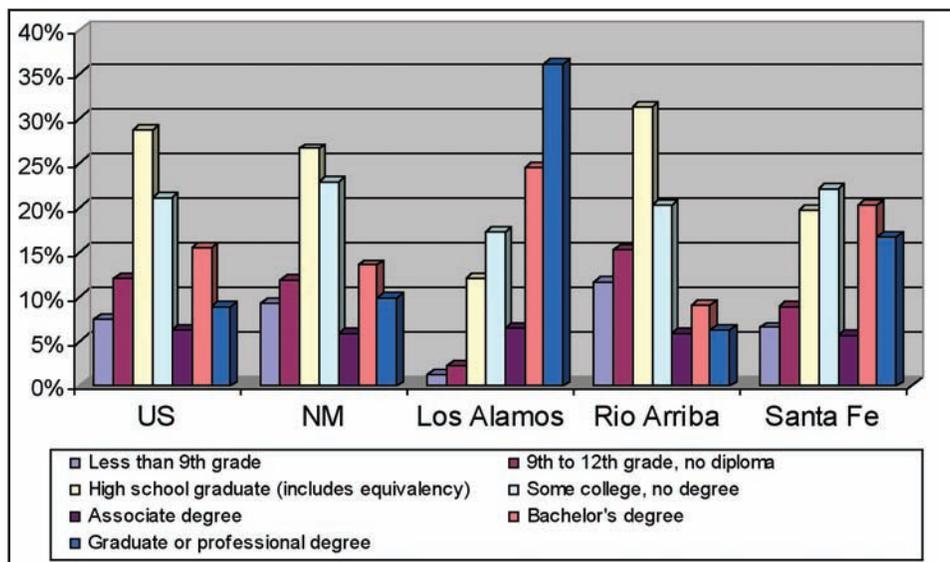


Source: US Census, 2000

Education is tightly linked with income and wealth which in turn are tightly linked with health. For example, more schooling yields opportunities for more rewarding jobs with healthier working conditions¹⁵. Figure 9 and Table 5 describe the education levels by percent of total population 25 years and over with-less than 9th grade, 9–12th grade, high school, some college no degree,

associate degree, bachelor's degree, graduate or professional degree for US, NM and counties. Los Alamos has the highest educated population with 36% graduate or professional degrees and 24% with bachelor's degrees. Rio Arriba has lower educational attainment with 27% of the population who have less than a 12th grade education compared to Santa Fe at 16% and Los Alamos at 3%.

FIGURE 9
Educational Attainment for Individuals 25 Years and Older



Source: US Census, 2000

TABLE 5

	US	NM	Los Alamos	Rio Arriba	Santa Fe
Less than 9th grade	8%	9%	1%	12%	7%
9th to 12th grade, no diploma	12%	12%	2%	15%	9%
High school graduate <i>(includes equivalency)</i>	29%	27%	12%	31%	20%
Some college, no degree	21%	23%	17%	20%	22%
Associate degree	6%	6%	6%	6%	6%
Bachelor's degree	16%	14%	24%	9%	20%
Graduate or professional degree	9%	10%	36%	6%	17%

Source: US Census

TABLE 6

	District Drop-Out Rate
NM	3.6%
Española	6.8%
Los Alamos	1.0%
Pojoaque	1.4%
Santa Fe	4.2%

Source: NMPED, 2005–2006

High school drop-out rate is the percent of high school students who drop out each year between 9th and 12th grade. According to the New Mexico Public Education Department, Rio Arriba County ranks number two in the state after Quay County which has the highest rate at 9.1%. Santa Fe County has the 5th highest drop out rate at 5.1%, while Los Alamos County ranks 24th out of 33 counties. **Table 6** shows high school drop-out rates by **school districts** for grades 9–12. Española School District had the highest rate in 2005–06 at 6.8% followed by Santa Fe at 4.2%.

TABLE 7

Housing Tenure	US			NM			Los Alamos			Rio Arriba			Santa Fe		
	2000	1990	% Change 90-00	2000	1990	% Change 90-00	2000	1990	% Change 90-00	2000	1990	% Change 90-00	2000	1990	% Change 90-00
Owner-occupied housing units	69,815,753	59,024,811	18.3	474,445	365,965	29.6	5,894	5,367	9.8	12,281	9,218	33.2	35,985	25,621	40.5
Renter-occupied housing units	35,664,348	32,922,599	8.3	203,526	176,744	15.2	1,603	1,846	-13.2	2,763	2,243	23.2	16,497	12,219	35

Source: US Census

Table 7, Housing Tenure, shows the percent change of total owner occupied and percent renter occupied for the US, NM and counties from 1990 to 2000. Rio Arriba (33.2%) and Santa Fe (40.5%) had higher growth in owner occupied vs. renter occupied housing than Los Alamos (9.8%).

Research demonstrates that socio-economic conditions and context matter for health. Health and health disparities are embedded in larger historical, geographic, sociocultural, economic and political contexts¹⁶. Research demonstrates that factors such as domestic violence, access to transportation, language barriers, immigration status, health literacy, social discrimination, aging and disability, are important intersecting issues that impact differences in health status and access to care. These intersecting issues matter over the course of a person's life and across generations of families.

Participants in the non-profit and faith-based focus group in Rio Arriba and the funders focus group repeatedly discussed the significance of defining health broadly to include the factors that are considered "root causes" of ill-health and well-being such as income, poverty, education, relationship to and land ownership, and cultural traditions. For example, one funder shared:

“We must look at the broader socio-determinants of health such as drug abuse, education, drop-out, suicides, and institutions like employment. I look at education. I look at schools. I look at all these cycles of poverty like violence. It's much broader. It's how we define health. How do these affect people? How do these influence generational cycles, like heroine overdose in the pueblos?”

A representative from a non-profit/faith-based organization expanded on the cycle of poverty and lack of education and their impact on children's well-being:

“We have to go to the root causes of medical issues; a lot of it is poverty. It's a cyclical process. For example, in our organization we get kids when they are already damaged. They come in at a point to where they need help, we have to help them. But then we have to throw them back into the hopper. It is a revolving door, we are just spinning wheels. Poverty is basic along with lack of education. We need to keep kids focused along with academics.”

As one participant reiterated, “A web of variables contribute to a child's growth and development.” Among these “web of variables” that influence health were two frequently discussed issues by the participants in Rio Arriba and the funders: 1) **hunger/food insecurity**; and 2) **lack of transportation in rural areas**. One participant explained the costs and challenges of traveling long-distances for service providers:

“For home visitors the biggest cost of serving new parents and infants is transportation. Our workers have to travel to visit families in Dulce, Jicarilla and the Apache nation. It takes them all day to drive there from Espanola. We work with rural clinics, and this has created a need to budget and fund raise for transportation, New Mexico is a rural state.”

Other participants shared how food insecurity and hunger affected families with children and elderly alike:

“You hear recurrent stories such as the elderly having to choose between food and medicine. Espanola provides transportation for elderly to their homes and in the course of that relationship with the clients one finds out folks need groceries. The elderly want to stay in-home with dignity and having the basics like food is critical.”

Another participant shared the harsh realities in the Rio Arriba area:

“Families need basic sustenance; many do not have enough food. We provide a food depot and have a bag of groceries for families once per month. Some families have nothing to eat, at first I was surprised to learn that some families had not eaten for four days.”

Other factors that impact health are language and culture. Both play a pivotal role for communities in Northern New Mexico and for persons who are limited English proficient (Native Americans, Hispanics and immigrants).

If a person's primary language is embedded in a rich culture that is not rooted in the English language, then he/she will have difficulty communicating with and trusting his/her provider. Thus, language access has a significant impact on health outcomes since the quality of the medical encounter influences comprehension of critical health messages, as well as adherence to health-promotion and disease prevention interventions.¹⁷

A few participants from the funders group and Los Alamos and Rio Arriba non-profit/faith-based groups expressed concern on the population growth of transitory migrants and immigrants who come to the Northern New Mexico area. They mostly commented on whether immigrants were able to afford and/or receive services through the hospitals and clinics, on the issue of being fearful of seeking services, and being financially strapped and isolated. One funder explained:

“I think about our immigrant population, people are unable to afford to live here, they have to live in a trailer park in Tesuque. It's about the socio-determinants of health, immigrants, legal or illegal, or an immigrant with a PhD in physics. It's another country in terms of access for undocumented in terms of food and health services. They are not reporting domestic violence out of fear.”

Another participant expanded on how being an immigrant and having language barriers impact access to health care:

“The quiet immigrant population is marginalized. For those whose first language is one other than English, self advocacy is difficult despite the laws. So, providers that can do services in Spanish have limited availability or may be placed here temporarily. When the Spanish services are there they get accessed.”

The following data provide a snapshot of the kind of demographic changes the three county area and New Mexico have experienced with regards to language change and the percent of persons who are foreign-born.

Table 8 illustrates the percent change between 1990 and 2000 of the total population that speaks a language other than English, speaks English less than very well, and for Spanish-speaks English less than very well in the US, NM and three counties. New Mexico (24.9%) has a smaller % change of the population who speaks a language other than English compared to the U.S. (47.5%). Los Alamos (27.5%) and Santa Fe (25.4%) had a greater percent change among persons who reported they speak a language other than English compared to Rio Arriba (11.8%). Among those who speak Spanish, 35.6% reported speaking English less than “very well” in Santa Fe which is higher than the state, Los Alamos and Rio Arriba, but lower than the US change of 65.5%.

Table 9 shows the percent change of native born and foreign born for the US, NM and counties from 1990 to 2000. Rio Arriba (248.9%) and Santa Fe (223.4%) had the greatest growth of foreign-born population compared to Los Alamos (46.7%), NM (85.8%) and the US (57.4%). It is important to note that the majority of New Mexico's residents are US born (86% statewide, 94% Los Alamos, 96% Rio Arriba, and 90% Santa Fe). While foreign-born residents comprise a small portion of the population in Northern New Mexico, their growth presents new challenges and opportunities to the receiving communities and health care systems.

TABLE 8

	US			NM			Los Alamos			Rio Arriba			Santa Fe		
	2000	1990	% Change 90-00	2000	1990	% Change 90-00	2000	1990	% Change 90-00	2000	1990	% Change 90-00	2000	1990	% Change 90-00
Population 5 years and over	262,375,152	230,445,777	13.9%	1,689,910	1,390,048	21.6	17,275	16,999	1.6	38,419	31,229	23.0	121,557	91,923	32.2
Language other than English ¹¹	46,951,595	31,844,979	47.4	616,964	493,999	24.9	1,987	1,559	27.5	25,303	22,639	11.8	44,859	35,762	25.4
Speak English less than "very well"	21,320,407	13,982,502	52.5	201,055	159,620	26.0	561	439	27.8	6,341	7,065	-10.2	13,205	9,554	38.2
Spanish	28,101,052	17,345,064	62.0	485,681	388,186	25.1	1,000	1,091	-8.3	22,992	20,150	14.1	40,137	33,134	21.1
Speak English less than "very well"	13,751,256	8,309,995	65.5	158,629	119,705	32.5	220	292	-24.7	5,999	6,491	-7.6	12,243	9,032	35.6

Source: US Census

TABLE 9

	US			NM			Los Alamos			Rio Arriba			Santa Fe		
	2000	1990	% Change 90-00	2000	1990	% Change 90-00	2000	1990	% Change 90-00	2000	1990	% Change 90-00	2000	1990	% Change 90-00
Total Population	281,421,906	248,709,873	13.2	1,819,046	1,515,069	20.1	18,343	18,115	1.3	41,190	34,365	19.9	129,292	98,928	30.7
US Born	46,951,595	31,844,979	47.4	616,964	493,999	24.9	1,987	1,559	27.5	25,303	22,639	11.8	44,859	35,762	25.4
Foreign Born	21,320,407	13,982,502	52.5	201,055	159,620	26.0	561	439	27.8	6,341	7,065	-10.2	13,205	9,554	38.2

Source: US Census

Health Conditions

The most common health priorities discussed by focus group participants were substance use (alcohol use, alcoholism and drug abuse, prescription drugs), teen pregnancy, diabetes, obesity including childhood obesity, child and adolescent mental health. Among these, teen pregnancy and substance abuse and alcoholism were identified as the most pressing health issues.

Table 10 describes the birth and fertility rates for women and for teens ages 15–17.

New Mexico's **birth rate** (number of child births per 1,000 people per year) has been consistently higher than the national rate. In 2005, Rio Arriba had a higher birth rate (16.5) than NM (14.6) and the US (14). The birth rates in Santa Fe (11.6) and Los Alamos (9.8) were lower than Rio Arriba.

New Mexico's **fertility rate** (number of child births per 1,000 women of ages 15–44) has been consistently higher than the US rate. In 2005, New Mexico's rate was 71.3 compared to the US at 66.3. However, Rio Arriba has higher rates of childbearing at 84.6 than Santa Fe at 59.4 and Los Alamos at 57.3.

New Mexico consistently has one of the highest **teen birth rates** at 34.3 compared to the US rate of 22 in 2006. Although our rates are declining, the reduction is slower and less significant than other states and the nation. State data demonstrate that Hispanic teen girls comprise nearly 50% of the female teen population in

New Mexico; however, they represent approximately 70% of births to teens.

From 2004 to 2006, Rio Arriba had the **highest teen birth rate** at 40.5 which is higher than the state rate at 35.7 and significantly higher than Santa Fe at 27.3 and Los Alamos at 5.1. Adolescent pregnancy rates are cyclically connected to poverty levels. Poor adolescents are more likely to give birth, and mothers who gave birth as teenagers are more likely to be poor¹⁸. Other risks factors for teen pregnancy are: early school failure, early behavioral problems and distressed families.

While the teen pregnancy rate is low for **Los Alamos**, providers, non-profits and faith-based community members express concern about teen pregnancy and the need for parenting support. One focus group participant was especially concerned about the early age of deliveries presenting in the hospital, "we had two fourteen year olds that delivered recently." Another shared that "promiscuity that we see in the ninth grades and higher is a parenting issue." A commonly shared solution was to have early interventions such as creating opportunities for lifestyle development and to increase parental support and supervision.

Rio Arriba focus group participants expressed that cyclical patterns of poverty, low educational achievement, lack of family support lead to lack of confidence and self-esteem and are root causes of teen pregnancy. One participant explained:

TABLE 10
Maternal & Child Health

Health Indicator	US	NM	Los Alamos	Rio Arriba	Santa Fe
Total Births: 2005, Rate per 1,000	14	14.6	9.8	16.5	11.6
Fertility Rate: 2005, Rate per 1,000 women ages 15–44	66.3	71.3	57.3	84.6	59.4
Births to teens: 2004–06, Rolling 3 year average, 15–17 olds (IBIS, DOH)	—	35.7	5.1	40.5	27.3

Source: NM DOH

“Most teen pregnancy happens because kids are failing in schools. They are not feeling confident, they feel they are being passed by once again. But rather than blaming the school system which is overpopulated and understaffed, we have to educate parents on how to be advocates for their children. Educating parents on the reality of being a parent, lack of support and dysfunction are early evidence of substance and alcohol abuse and sexual abuse, so they are wanting to have a baby, that need of ‘I feel loved.’ It is very complex.”

Finally, while not a common theme across focus groups, an alternative perspective was offered for teen pregnancy by one non-profit participant:

“There’s another theory about teen pregnancy, in most low income communities of color, middle age is 14–17 years old, especially for the males who die earlier due to many causes such as violence or go to jail. So, young women must get a partner before they die or go to jail. As a society, we need to deal with this somehow and reach children at an early age. We keep trying to solve those that get pregnant, but we need to look at those kids who didn’t get pregnant. How do they to make it through? How can we build on the mechanisms that help kids make it?”

Leading Causes of Death

The trends for leading causes of death for New Mexico, Los Alamos, Rio Arriba and Santa Fe Counties are shown in Table 11. The causes of death are age-adjusted and reported as deaths per 100,000 population for 2003–2005.

Challenges for Rio Arriba include the higher rates in nine of the eleven leading causes of death compared to Los Alamos and Santa Fe: 883.2 for all causes, 177.69 for diseases of the heart, 160.28 for cancer deaths, 106.65 for unintentional injuries, 49.88 for diabetes, 32.15 for chronic liver disease and cirrhosis, 23.26 for suicide, 22.55 for homicide, and 16.41 for flu and pneumonia. The death rates for Rio Arriba are higher than the New Mexico state rates in seven of the eleven causes of death.

Challenges for Los Alamos include the highest rates of circulatory, cerebrovascular diseases at 26.69 and 34.25 for chronic lower respiratory diseases.

Santa Fe ranks second to Rio Arriba with moderate rates of unintentional injury (accidents) at 58.98 for flu and pneumonia at a rate of 11.93. Santa Fe ranks second to Los Alamos for chronic lower respiratory diseases at 36.11.

TABLE 11

Leading Causes of Death by Age-adjusted Rate, Deaths Per 100,000 Population, 2003–05

	US	NM	Los Alamos	Rio Arriba	Santa Fe
All Causes: 2005	798.8	770.3	523.4	883.2	647.6
Disease of the heart	–	174.72	148.68	177.69	141.45
Cancer Deaths (malignant neoplasms)	–	161.15	108.26	160.28	151.65
Unintentional Injury (Accidents)	–	60.82	32.13	106.65	58.98
Circulatory, Cerebrovascular diseases (stroke)	–	35.79	26.69	21.06	25.36
Respiratory, Chronic lower respiratory diseases	–	46.81	37.32	34.25	36.11
Diabetes Mellitus	24.6	33.54	25.15	49.88	25.47
Chronic liver disease and cirrhosis	–	14.9	7.56	32.15	13.5
Injury, Intentional self-harm (suicide)	–	18.1	21.45	23.26	19.06
Injury, Assault (homicide)	–	8.38	11.54	22.55	3.99
Respiratory, Influenza and pneumonia	–	17.78	11.59	16.41	11.93

Source: NM DOH

Infectious Diseases

Table 12 shows the actual cases and rates for infectious diseases for the three county area. Numbers for hepatitis were not available by county. The rates were not available for tuberculosis and sexually transmitted diseases (STD's) but the total diagnosed cases are reported. Since numbers and rates are not consistently reported and readily available at the county level, a brief description of statewide rates is provided below.

Table 12 notes that Santa Fe has the greatest challenges including a higher number of cases for STD's including chlamydia, gonorrhea and syphilis and the highest rate for the prevalence of HIV/AIDS.

Rio Arriba (103.36) had the second highest rate of HIV/AIDS per 100,000 persons.

Chlamydia is the most common sexually transmitted infection in the United States. From 2001 through 2006, New Mexico has ranked among the top seven states nationally for incidence of chlamydia. The majority of cases occur among females ages 15–24. The trend for this age group and ethnicity is illustrated in Table 13.

Overall trends show that HIV/AIDS continued to be distributed disproportionately across New Mexico's population. Hispanics were more likely to be newly diagnosed than any other racial/ethnic group, and in 2006 accounted for one-half of all new HIV/AIDS cases. Although men who have sex with men (MSM) remained the most heavily impacted risk group, high-risk heterosexual contact has become a slowly increasing risk factor. Regional trends showed the following:

- Almost half (48%) of all new diagnoses occurred in the Albuquerque area; about two-thirds of these cases were among MSM.
- Northwestern and Southeastern New Mexico continued to report the largest proportions of cases among MSM and MSM who also inject drugs (MSM/IDU).
- The Southwestern region, covering Las Cruces and the U.S.-Mexico border area, had the largest proportion of cases among Hispanics (68%) and people who reported high risk heterosexual contact as a primary risk factor (20%).

TABLE 12
Infectious Diseases

	US	NM	Los Alamos	Rio Arriba	Santa Fe
Tuberculosis (2007 case rates per 100,000 population)	–	–	0	3.24	1.36
STD's: 2002, Total diagnosed cases (Note: 2003–2005 not included due to data lost/ not entered for Santa Fe)	–	–	–	–	–
Chlamydia	*	*	9	163	202
Gonorrhea	*	*	1	31	32
Syphilis	*	*	0	0	1
HIV/AIDS (Prevalence ¹⁹). Rates per 100,000.	*	111.10	35.15	103.36	212.33

Source: NM DOH

TABLE 13
Chlamydia

	2002–2004	2003–2005	2004–2006
African-American	2865.4	2918.1	3167.8
American Indian or Alaska Native	3075.8	2788.5	2621.6
Asian or Pacific Islander	549.4	410.3	293.1
Hispanic	3390.9	3511.2	3828.5
White	1556.1	1880.6	2249.3
New Mexico	3241.2	3256.1	3385.8
United States	2591.9	2663.9	2743.7

Source: NM DOH, STD program

Chronic Diseases

Table 14 shows the prevalence rate of chronic disease conditions (described as the number of people who currently have the condition) and the incidence (refers to the annual number of new people who have a case of the condition).

Challenges for Rio Arriba include higher rates for diabetes (10.7) and obesity (20.5) than Los Alamos and Santa Fe.

Santa Fe has the highest incidence rate of cancer at 477.4 which exceeds the state rate of 415.0, Los Alamos at 443.3 and Rio Arriba at 378.7.

Los Alamos follows Santa Fe with a cancer incidence rate of 443.3 and an adult obesity rate of 20.5.

Adult asthma rates were not available by county but were reported by Region. The Region II area which includes Los Alamos, Rio Arriba and Santa Fe is lower than the state for both current (8.1 vs. 8.9) and lifetime rates (11.4 vs. 14.5).

TABLE 14
Chronic Diseases

	US	NM	Los Alamos	Rio Arriba	Santa Fe
Diabetes: 2004, Prevalence among Adults, Percent		9.2	8.8	10.7	9.6
Cardiovascular disease (stroke hospitalization rate per 1,000 age-adjusted, Ages 65+, Medicare Beneficiaries, 1995–2002)	17.2	12.89	11.0	11.0	12.0
Cancer (all) 1995–2004 average annual incidence rate, age adjusted per 100,000	–	415.0	443.3	378.7	477.4
Asthma: 2005 (adult lifetime-% said that a doctor or other health care professional told them at some point in their life that they had asthma)	12.6	14.5	11.4 Region II		
Asthma: 2005 (adult current-% reported that they still had asthma)	8.0	8.9	8.1 Region II		
Obesity: 2004–06, Percent Adults	24.4	22	15.3	20.5	14.3

Source: NM DOH

Substance Abuse

Data in **Table 15** show the profile of substance abuse indicators for alcohol, drug use, and smoking.

Challenges for Rio Arriba include the most serious problems for six of the eight indicators in which data were reported: adult binge drinking (17.8%), adult chronic heavy drinking (6.2%), youth drinking and driving (22.3%), youth marijuana use (42%), youth cocaine, methamphetamine or inhalant use (14.1%) and adult smoking (25%).

Challenges for Santa Fe include higher youth binge drinking (48.2%), adult drinking and driving (2.3%), youth drinking and driving (22.2%), and youth smoking (33.8%).

Los Alamos has lower rates of alcohol, drug and tobacco problems compared to Rio Arriba, Santa Fe and the state.

For youth drinking and driving, the prevalence of past 30 day drinking and driving was highest in Rio Arriba, which ranked the sixth highest percent in the state followed by Santa Fe.

Youth marijuana use is highest in Santa Fe County which ranks as the third highest county in state. Rio Arriba is 9th highest. Youth drug use is associated with suicide, early unwanted pregnancy, school failure, delinquency, and sexually transmitted diseases.

Rio Arriba had the highest rate of adult smoking and Santa Fe the highest for youth smoking. Smoking is responsible for a significant proportion of deaths from numerous types of malignant neoplasms, from numerous cardiovascular diseases and from certain respiratory diseases.

TABLE 15
Substance Abuse (State Epi Profile, 2005)

	US	NM	Los Alamos	Rio Arriba	Santa Fe
Adult Binge Drinking: 2002, Percent Consumed 5 or more drinks at least once in previous 30 days	*	14.4	8.7	17.8	11.8
Youth Binge Drinking: 2003, Percent Consumed 5 or more drinks at least once in previous 30 days, all grades (9–12)	*	35.4	*N/A	42.0	48.2
Adult Chronic Heavy Drinking: 2002, Percent consumed > 2 drinks/day (Males); >1 drink/day (Females)	*	5.1	1.3	6.2	3.8
Adult Drinking & Driving: 2002, Percent consumed drove after drinking at least once in previous 30 days	*	2.0	1.9	N/A	2.3
Youth Drinking & Driving: 2003, Past 30 days		19.1	N/A	22.3	22.2
Youth Drug Use: 2003, Past 30 day Marijuana Use, all grades (9–12)	*	29	N/A	42	36.2
Youth Drug Use: 2003, Past 30 day Cocaine, Methamphetamine, or Inhalant Use, all grades (9–12)	*	13.9	N/A	14.1	13.2
Adult Smoking: 2002, have smoked \geq 100 cigarettes in life, and smoked in past month	*	21.2	12.6	25.0	17.7
Youth Smoking: 2003, Past 30 day Smoking, all grades (9–12)	*	30.2	N/A	32.8	33.8

Source: NM DOH

* N/A=Data Not Available

Health Systems & Policy

Health care costs and financing, health insurance coverage, access to health services, and the number of health professionals available are indicators of a health care systems capacity to care for its poor, uninsured and underinsured populations. Despite the critical role that health care plays, focus groups participants consistently expressed concern about barriers to accessing health care such as lack of insurance coverage including dental coverage, lack of preventative care, lack or late entry into prenatal, shortage of service providers, or lack of providers such as dentists and behavioral health providers (prevention, treatment and after care), long-waiting lists and access to and exchange of information, referrals and resources among community members but also providers.

The lack of behavioral health providers was identified as a shortage crisis in the Northern New Mexico area. Across all four focus groups, participants were especially concerned about the availability of out-patient treatment and preventative mental health and substance abuse services for children, youth, young parents and families. One participant explains:

“We don’t have treatment available locally. For basic things like counseling, people are going out of county. The First Born® Program, Las Cumbres, and Teen Builders are doing some things in schools and offering prevention. But, there’s a huge gap in treatment services of any sort for youth, so in essence we are subsidizing the budgets of the El Paso and Memorial hospitals, and we are not providing the services they need locally. They are going to residential treatment out of county and state without their families, they are coming back and there is no follow-through, to the same environment they left. This is the worst possible behavioral health system for youth.”

In Rio Arriba, participants shared that they have encountered numerous systemic barriers to finding, accessing and getting data from Value Options Inc. Another participant explained:

“We also need more of case management in behavioral health, we’ve been trying to create centralized intake and referral service especially for youth to map out where gaps of services really are, we are getting push back from Value Options.”

Table 16 describes the health systems indicators for health care costs and insurance coverage in New Mexico.

TABLE 16
Health Care Costs & Insurance

Health System Indicator	US	NM
Per capita public health spending (2007)	\$162	\$113
Out-of-pocket costs (non-institutionalized under age 65)	—	\$669 (total population) \$858 (uninsured)
Uninsured- distribution of the nonelderly uninsured by age, (2005–2006), U.S. (2006)		
Total Uninsured (non-elderly)	18%	25%
Children	20%	25%
Adults	80%	75%
Poor (<100 FPL)	36%	36%
Near –Poor (100–199%)	29%	35%

Sources: Kaiser Family Foundation, Mathematica Policy Research, Inc.

New Mexico's per capita spending on health care (\$113) is far below the national average of \$162. **Out-of-pocket costs for New Mexicans is higher for persons who are uninsured (\$858 vs. \$669).** According to a 2007 report by Mathematica Policy Research, Inc., New Mexican's living in rural (non-Metropolitan Statistical Areas, MSA) communities spend a larger proportion of their medical dollars on hospital services (inpatient, outpatient, emergency room and prescription drugs) than the population living in urban areas of the state.

Health insurance coverage is a critical factor in making health care accessible to children and families living in Northern New Mexico. A total of 25% of New Mexicans are uninsured. Among the uninsured population, most are adults 19–30 (75% of the uninsured). Children comprise 25% of the uninsured. Hispanics comprise 43.5% of the uninsured population and Native Americans 13.3%. Non-Hispanic Whites represent 12.8% of the total uninsured population. Uninsurance rates are not available at the county level for New Mexico.

Research has consistently documented that lower educational levels, type of employment and income are key determinants of the high rates of non-insurance among low-income and minority populations, especially Hispanics and Native Americans. Differences in insurance coverage are also explained by country of origin, citizenship status and language. Research shows that the lack of insurance coverage is greater among foreign-born compared with U.S.-born Latinos, Spanish compared with English-speakers, recent arrivals compared to earlier immigrants, and non-citizens compared to citizens. Lack of health insurance has been shown to have a significant negative impact on individuals' health and financial well-being. The long-term consequences of being uninsured and lacking access to healthcare include diminished health and well-being for families and their children living in Northern New Mexico.

For many residents of Northern New Mexico, counties provide critical support and access to needed services to the local hospitals, primary health care, dental, pharmacy and behavioral health. **County indigent health care funds** are financed by locally imposed gross receipts taxes, under county control in terms of eligibility, covered services and reimbursement rates. Under the Indigent Hospital and County Health Care Act (CIF Act) and the County Local Option Gross Receipts Taxes Act, counties are given great latitude to determine how revenues from

the County Indigent Fund program are to be generated and collected. These funds also contribute to the County Supported Medicaid Fund and Sole Community Provider Hospital Fund. Each year the New Mexico Health Policy Commission collects data from the counties. Not all counties track and report data the same and in some instances there is missing data. Regardless, Table 17 provides a snapshot of the types of services Los Alamos, Rio Arriba and Santa Fe counties fund.

In 2007, county expenditures totaled \$15.7 million for Santa Fe, \$1.1 million in Rio Arriba and almost \$1 million in Los Alamos. A large proportion of county funds support the Sole Community Provider (\$9.2 million Santa Fe, \$627K Rio Arriba, and \$48K Los Alamos). The purpose of the Sole Community Provider Fund is to provide care to the indigent population by counties contributing state share dollars for the sole community hospitals which receive a federal match of approximately 3–1. Funds must be used by the hospital for direct patient care or services related to direct patient care. The fund recognizes certain hospitals, which because of isolated location, weather or travel conditions, or absence of other hospitals are the only source of inpatient hospital services reasonably available in a geographic area. Working with other governmental entities, the fund proceeds provide access to hospital services to as many clients as possible.

Hospitals which are designated as a "Sole Community Provider" receive an annual allocation from the Department of Health. The allocation includes both the Counties assessed amount plus the Federal Medicaid leveraged dollars. Both Los Alamos Medical Center (LAMC) and St. Vincent Hospital qualify as Sole Community Providers. Both hospitals serve Los Alamos County. Annually each qualified Sole Community Provider must get approval from each local public body in which services for residents are rendered. Under the Sole Community Provider status LAMC renders service to Los Alamos, Rio Arriba, Taos, and Santa Fe County residents. St. Vincent Hospital renders services to Los Alamos, Taos, Rio Arriba, San Miguel and Santa Fe County residents. The requests from each Sole Community Provider are forwarded to the Department of Health for use in developing the subsequent year budget allocation.

Designated Sole Community Provider hospitals must use these funds to provide care to the indigent population. Los Alamos County does not pay additional indigent funds to the hospitals until the allocated amount provided

by the state is exhausted. Additional claims are then paid through the County Indigent Health Care Fund if resources are available.

Counties have had significant flexibility and latitude in how to administer local funds for indigent health care, including eligibility determination. Counties determine the qualifying criteria for indigent services. This includes identifying income requirements, county residency requirements, and immigrant qualifications. As shown in Table 18 all three counties have a 90 day residency requirement in order to be eligible for county funded health services.

As of 2007, Los Alamos and Santa Fe Counties reimburse hospitals and providers for health services rendered to LEGAL immigrants while Rio Arriba does not.

Table 18 shows two indicators for health care access (immunization coverage and access to prenatal care). Los Alamos has the highest immunization compared to the other two counties and state (92.1%) while Santa Fe is the lowest (77.2%). Rio Arriba has the lowest access to prenatal care at 15.8% compared to Los Alamos at 2.6% and Santa Fe at 5.0%.

TABLE 17
County Financed Health Care & Eligibility Policy

Health Systems Indicator	Los Alamos	Rio Arriba	Santa Fe
County Financed Health Care			
Total Expenditures, Year Ending June 30, 2007	\$993,000	\$1,141,985	\$15,706,156
Base Sole Community Provider	48,260	626,651	9,235,436
Supplemental Sole Community Provider	272,011	373,069	–
County Supported Medicaid	471,924	–	2,696,485
Ambulance	3,057	–	20,385
University of NM Health Sciences Center	83	–	85,000
Out-of-County Hospital Non-UNMHSC	–	–	124,704
Primary Care/Specialty Care/ Community Health Center or Clinics	49,832	–	347,638
Dental	–	–	287,636
Pharmacy	45,828	–	112,467
Behavioral Health	21,671	–	350,202
County Eligibility Policy			
Residency requirement (number days)	90 days	90 days	90 days
Reimburse for LEGAL Immigrants Not US Citizens	Yes	No	Yes

Source: NM Health Policy Commission

TABLE 18
Health Care Access

Health System Indicator	NM	Los Alamos	Rio Arriba	Santa Fe
2005–2006-Immunization Coverage for 2 year olds	78.4	92.1	79.2	77.2
Percent of births with low or no prenatal care by county (all ages) 2005	13.0	2.6	15.8	5.0

Source: NM DOH

Tables 19 and 20 describe the availability of health care professionals in the three county area.

Traditionally, New Mexico has had a disproportionate amount of professional shortage areas and has struggled with recruitment, training and hiring a diverse workforce that is reflective of the composition of our communities. The lack of health providers that are linguistically and culturally competent is directly linked to unequal access and unequal health status²⁰.

New Mexico’s overall active physician to population ratio in 2001 was 1.74 physicians per 1,000 population while a national benchmark for an “adequate” supply was 1.78. On an FTE basis, there was a statewide improvement from 1.39 in 2001 to 1.54 in 2006. The national benchmark for an FTE basis is 2.42. **Table 19 shows that while none of New Mexico’s counties reached the national benchmark for an FTE at 2.42, Los Alamos FTE was 2.41, Santa Fe (1.83) and Rio Arriba (1.04).**

Table 20 shows the distribution of dental practitioners, nurses and licensed pharmacists in Northern New Mexico. The Health Resources and Services Administration (HRSA) indicates that preparing dentists to enter professional practice is an expensive, labor-intensive undertaking. Reported total expenditures for 4-year programs that educate dentists average \$312,040 per dental student equivalent (DSE) for public schools, \$232,888 for

private schools, and \$183,596 for private-state related schools. In 2006, New Mexico had a total of 812 active, licensed dental hygienists. Of those 812 dental hygienists, 50.49% were 25–44 years of age. Nearly 33% of dental hygienists were 45–54 years of age; 16.26% were 55–64; and 1.60% were 64–94.

Dentists and dental hygienist rates per 1,000 population vary across counties. Los Alamos had the highest rate of dentists (.80) and dental hygienist (.80) followed by Santa Fe at .75 for dentists and .43 for dental hygienist. Rio Arriba had the lowest rates at .23 for each.

In New Mexico, the number of licensed registered nurses (RNs) increased by 3.44% from 15,164 in fiscal year 2006 (FY06) to 15,686 in FY07. The number of licensed practical nurses (LPNs) increased by 1.27% from 2,916 in FY06 to 2,953 in FY07. RN and LPN rates per 1,000 population vary widely across counties. **As shown in the table below, the rate of RNs per 1,000 population was highest in Los Alamos (7.84), followed by Santa Fe (7.58), whereas Rio Arriba was 4.80.**

In 2006, New Mexico had a total of 1,486 active licensed pharmacists. **Santa Fe had the highest rate of licensed pharmacists at .74 followed by Los Alamos at .50 and Rio Arriba at .30.**

TABLE 19
Availability of Health Care Professionals

Health Systems Indicator	Los Alamos	Rio Arriba	Santa Fe
Patient Care Physicians			
Total Active Patient Care FTE Physicians	48.0	45.4	269.4
Physician FTE 1,000/population	2.41	1.04	1.83

Source: NM Health Policy Commission

TABLE 20

Distribution of Health Care Professionals

Systems Capacity	Los Alamos			Rio Arriba			Santa Fe		
Distribution of Health Care Professionals by county (2006)	NM Active Licensed	% Total	Rate per 1,000 Population	NM Active Licensed	% Total	Rate per 1,000 Population	NM Active Licensed	% Total	Rate per 1,000 Population
Dentists	16	2%	0.80	10	1%	0.23	110	12%	0.75
Dental Hygienist	16	2%	0.80	10	1%	0.23	63	8%	0.43
Registered Nurses	156	1%	7.84	209	1%	4.80	1,118	7%	7.58
Practical Nurses by County	29	1%	1.46	60	2%	1.38	172	6%	1.17
Licensed Pharmacists	10	1%	0.50	13	1%	.30	109	7%	0.74

Source: NM Health Policy Commission

Summary

What matters for health in Northern New Mexico?

Race/ethnicity, age, income, poverty and wealth, education, type of work and social resources all matter for health. These factors influence access to social and economic resources over a person’s life, across generations of families and within entire communities. Non-medical factors such as housing, working conditions, affordable and nutritious food, transportation, language and culture all impact health and access to important health services and family supports.

The root causes of health occurring outside the health care system have had profound effects on the health

and well-being of children and families living in Rio Arriba, Los Alamos and Santa Fe Counties. While the numbers and narratives identify a number of poor health conditions, three priorities were consistently highlighted: 1) teen pregnancy; 2) substance abuse; and 3) alcoholism.

Health systems and policy issues that showed marked alarm included: barriers to accessing health care such as lack of insurance coverage, higher out-of-pocket costs for the uninsured, shortage of service providers such as dentists and behavioral health providers, long-waiting lists, lack of access to health information and resources across non-profits, providers and for community members.

Executive Summary Recommendations

The recommendations in this report draw from the priority health and health care needs identified by the secondary data analysis and the focus group discussions. Four focus groups were conducted with funders, non-profits and faith-based organizations, and health care providers in the three county area of Northern New Mexico. The co-moderator's questions were designed to elicit advice on how the NNMHGG should act to solve perceived health and health care issues and how to prioritize funding. Key themes discussed by focus group participants were synthesized and compared to the results of the data analysis (demographics, socio-determinants of health, health conditions, and health systems and policies). Next, these findings were compared to a recent review of the literature on interventions to reduce health disparities^{21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32}. Consistent with the findings and the literature, multifaceted interventions targeting different leverage points within and outside the health care system are highlighted below.

Recommendation 1. Expand the definition of health to include wellness and life opportunities

RECOMMENDATION 1-1 Recognize that health is influenced by factors outside the health care system.

- Build on community assets and embrace the notion of wellness.

RECOMMENDATION 1-2 Raise awareness and mobilize action to improve health through a broad range of interventions.

- Participate in public education campaigns conducted in partnership with public-health entities, private sector, universities and community-based organizations to encourage comprehensive approaches to address health inequalities among communities in Northern New Mexico.

- Reduce poverty through programs that focus on the educational attainment of children and youth. Education is the cornerstone to promoting and protecting intergenerational health and well-being. Education is also a vehicle for securing employment and attaining economic security, programs that prepare children early in life for school success and continue to support academic engagement are critical for future health.
- Promote public-private investments that protect mortgages and home ownership for low and middle income families.
- Promote workforce development, especially in the health professions at the K–12 and community college levels.
- Protect the rights of all to equally participate in the labor market through monitoring and compliance of federal Equal Employment Opportunity laws, the guarantee of minimum living wages and provision of employer sponsored health insurance.
- Invest in local farmer's markets and food banks that provide access to nutritional and affordable food to local residents, especially in rural areas.
- Foster public-private collaborations and alliances to address transportation issues in rural areas.

Recommendation 2. Improve health conditions

RECOMMENDATION 2-1 Expand and implement nutrition and health education programs.

- Make sure people have access to high quality nutritious foods at an affordable price, especially if it supports the local growers.
- Offer health education for healthy lifestyles and provide lifestyle counseling.

RECOMMENDATION 2-2 Build awareness of and strengthen investments in early prevention of infections (pneumonia and flu), diseases (HIV and STD's), chronic conditions (asthma, diabetes, obesity, heart disease) and risks behaviors (substance use, teenage pregnancy, unintentional injuries, violence) among private and public health systems and governments.

- Support science-based and culturally appropriate prevention strategies for children and youth at the individual, family, school and community levels (teenage pregnancy, youth drinking and driving, smoking and drug use).
- Advocate for government and private investments in preventative screenings and early detection of diseases and health risks at community health centers, hospitals and other health providers.
- Promote school and mobile health clinics and their capacities to offer comprehensive preventative services (immunizations, vaccinations, dental, behavioral health and physical health).
- Increase opportunities for free screenings and health, nutrition and wellness information at public accessible places beyond the health care system (i.e. Wal-Marts/grocery stores, community events, churches, etc.).

RECOMMENDATION 2-3 Focus state health care reform efforts and health disparities initiatives on culturally appropriate disease management efforts.

- Align efforts among state, tribal and local governments, managed care organizations, community health centers, hospital systems and public health entities to improve access to prescription drugs and other medical devices/tools that empower individuals to monitor and control their disease (i.e. HIV, diabetes).
- Foster the health literacy of patients to manage their health and promote cultural and language literacy among providers to assist diverse patients in understanding and managing their health conditions.

Recommendation 3. Strengthen the capacities of community-based organizations to improve health care access and solve problems

RECOMMENDATION 3-1 Help community-based organizations (CBOs) to develop a one-stop shop.

- Assist in developing a centralized assessment and referral.

RECOMMENDATION 3-2 Support and assist CBOs with streamlining electronic records.

- “My agency has actually started electronic record-keeping, having all our agencies go there, being able to transfer files across the board.”

RECOMMENDATION 3-3 Help non-profits improve communications and information exchange.

- “We need a resource book (maybe it exists), this would be helpful.”

RECOMMENDATION 3-4 It is important to build capacity of community-based organizations and supports to address health care and social needs.

- To strengthen family networks and in changing the outlook of that community.
- Expand drug counseling support systems.

RECOMMENDATION 3-5 Help build the capacity of organizations to provide services so they can be more effective.

- Offer grants in terms of systems change and development, collaboration and capacity building.
- Support the leaders in these organizations.
- Train non-profits to build those skills and support their efforts.

RECOMMENDATION 3-6 Build on the assets of community colleges and universities.

- Recruit students into health care professions.
- Tap into UNMHSC and the medical students there, we have a wonderful resource via the medical school.

RECOMMENDATION 3-7 Support mechanisms for enlarging the pool of health professionals to provide culturally competent care, particularly in underserved areas.

- Foster the regeneration of new talent into educational and training programs for health professionals through local leadership and community-based strategies.
- Collaborate with K–12, colleges and universities on innovative initiatives that promote the recruitment, training and hiring of local residents into the health professional schools (i.e. dentists, nurses, pharmacists, physicians).

RECOMMENDATION 3-8 Promote culturally and language appropriate services.

- Encourage health and social service providers to adopt and use the National Standards for Culturally and Linguistically Appropriate Services in Health Care.
- Work with the New Mexico Department of Health, Human Services, Children Youth and Families, IHS and tribes to explore innovative mechanisms for promoting language access (i.e. the use of federally funded Medicaid waiver and reimbursements to New Mexico for language access).
- Sponsor local health and behavioral care professionals, para-professionals and community health workers to participate in accredited medical interpreters training and train-the-trainer programs.

RECOMMENDATION 3-9 Promote efforts that reduce discrimination, bias and misinformation among health providers and local health systems.

- Work with other public health stakeholders to disseminate clarifications of federal, state, county and tribal eligibility and benefits criteria for various classifications of immigrants, i.e. those who are legal but fall within a five-year bar for federally funded health care and unauthorized pregnant women and children).
- Encourage health professional training schools and universities and state licensing entities to incorporate anti-discrimination and internalized racism techniques into their cultural competency curriculums and licensing requirements.
- Encourage state quality improvement and pay-for-performance requirements and initiatives to include cultural and language competency indicators.

Recommendation 4. Engage community leaders in policy development and policy change efforts.

RECOMMENDATION 4-1 Assist in policy development that supports the capacities of non-profits.

- “Tap into the tag on motorcycle registrations which could be used to support community-based organizations.”
- “In terms of a policy, we could introduce a memorial and do away with the provisions that put a cap on insurance pools.”

RECOMMENDATION 4-2 Provide opportunities for residents in Northern New Mexico to build policy advocacy skills and to meaningfully engage in state health care reform initiatives (i.e. Hispanic/Latino, Native American, immigrants, people living with disabilities, youth and elders).

- Sponsor local forums that foster exchange of information and dialogue around key elements of health reform.

- Assist in fact-finding and gathering research on the impact of health care reform on communities in Northern New Mexico (i.e. take-up patterns via employer-sponsored coverage; innovative coverage for low income adults; state administrative obstacles to enrollment and retention; and incentives to promote innovative coverage initiatives that are culturally, linguistically and financially appropriate for various subgroups).
- Support community-based organizations and leaders in using media advocacy efforts to hold elected and appointed officials accountable to the use publicly financed health care including the flow of funds to managed care organizations.

Recommendation 5. Create innovative funding mechanisms

RECOMMENDATION 5-1 Move from being the one-shot funding to systemic change.

RECOMMENDATION 5-2 Avoid funding specific programs for specific agencies. Foundations could “tweak their funding mechanisms” so that collaborators are effective.

RECOMMENDATION 5-3 When programs are successful, continue funding those areas to sustain the improvement.

RECOMMENDATION 5-4 Small funders have a unique opportunity to be advocates.

RECOMMENDATION 5-5 Provide more sustained funding—multi-year funding leads to systemic change.

RECOMMENDATION 5-6 Foundations can play a role in convening people and coming together and sharing with each other.

RECOMMENDATION 5-7 Keep grant processes simple and streamlined.

Appendices

Appendix A: Data Sources

Demographics & Socio-Determinants of Health

- US Census
- Bureau of Business and Economic Research, University of New Mexico

Health Conditions

- IBIS, NM DOH
- NM State Epidemiological Profile (Substance Abuse by County, 2005)
- County Health Indicators (Health Status 2004)
- Youth Risks & Resiliency Survey (2005 by county)
- Behavioral Risks Factor Surveillance Survey, NM DOH, Centers for Disease Control
- 2003 County Health Profiles

Health Systems and Policy

- 2006 New Mexico Geographic Access Data System and Selected Health Professionals in New Mexico (Health Policy Commission)
- County Indigent Fund Report, 2007 (NM HPC)
- Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements)
- Kaiser Family Foundation

Appendix B: Focus Group Interview Guide

Thank you for coming today and taking time out from your busy schedule to provide feedback to the Northern New Mexico Health Grant Group (NNMHGG). My name is _____ and my co-moderator is _____. We are researchers and collectively have over 30 years of public health work in New Mexico. We have been asked by the (NNMHGG) to conduct focus groups.

Your input will be used as part of a report to guide grant-making. You can help us answer “What are the health priorities in Los Alamos, Rio Arriba & Northern Santa Fe counties?”

The NNMHGG/Con Alma Health Foundation has a small gift bag and water bottle in appreciation for your expertise and input.

The main themes from today will be incorporated into a final report BUT your name or your organization will not be used. Your identity is confidential so that you may feel free to express your opinions.

Please take the time to complete the short demographics sheet (2 pages, front and back), but do not place your name. This will be used to show the diverse kinds of participation and perspectives that gave input to the report.

Finally, the report will be available to anyone interested in the findings via the Con Alma Health Foundation website at www.conalma.org.

Before we get started, please briefly introduce yourself, name and type of work you do.

Thank you. Now let me quickly summarize the history of the NNMHGG and purpose of the report.

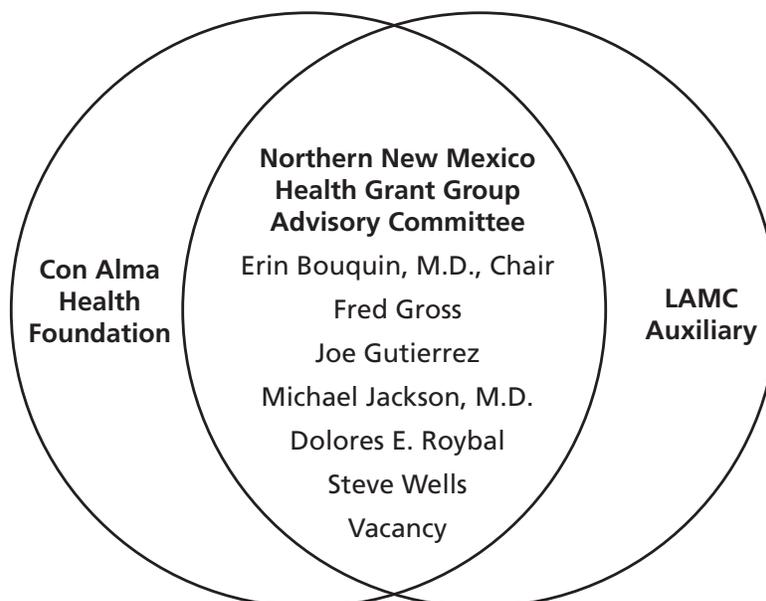
History

- May 2002 the LAMC sold
 - from Banner Health Systems (non-profit) to Province HealthCare (for-profit)
 - Proceeds from sale of LAMC set aside to serve unmet health care needs of Los Alamos, Rio Arriba and Northern Santa Fe counties
-

Grant Eligibility

- NNMHGG awards for non-continuing grants of \$20,000 or less:
 - serve the target geographic area
 - have at least one other funding source
 - funds cannot supplant or replace public or private funding, e.g., current salaries of project staff
 - 501(c)(3) status
 - address health needs left unmet by the sale of the Los Alamos Medical Center
-

Leadership



Purpose

- Report to guide grant-making
 - Cross-county comparison (Los Alamos, Santa Fe & Rio Arriba)
 - Four focus groups
 - 1 provider, 2 health & social services/faith-based, 1 funder
 - Secondary data collection
 - Socio-determinants of health
 - Health status
 - Health systems
-

Seeking Your Input

- What are the top health issues in Los Alamos, Rio Arriba & Northern Santa Fe Counties?
 - Advice on how the NNMHGG should act to solve issues and prioritize funding?
-

Are there any questions for clarification? Okay, let's get started.

From your perspective, **“What are the most pressing health needs in (Rio Arriba, Los Alamos, Northern Santa Fe) county?”** (1 hour)

- brain storm on top 3, jot down then discuss)
- after group brain-storms, have them give specific examples and/or stories to illustrate issues
- facilitators then summarize core themes based on the discussion

In thinking about these pressing health issues, **“What advice/ideas on how the NNMHGG might act to solve these issues and prioritize funding?”** (1/2 hour)

- Facilitators then summarize core themes based on discussion

Are there any closing comments?

Thank you for sharing your perspectives and for your commitment to the health of New Mexico's children, families and communities. A final report will be available on the Con Alma Health Foundation website at www.comalma.org.

References

- ¹ New Mexico Department of Health staff who assisted in identifying available public use data and provided review of data accuracy: Lois Haggard, PhD, Gay Romero, Susan Baum, MD, MPH, and Vicky Howell, PhD.
- ² Bureau of Business and Economic Research staff at the University of New Mexico who provided expert guidance on the type of Census data to use for the report: Karma A. Shore and Kevin Kargacin.
- ³ In this report, health is defined as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
- ⁴ Health care is the prevention, treatment, and management of illness and the preservation of mental and physical well being through the services offered by the medical, nursing, and allied health professions. According to the World Health Organization, health care embraces all the goods and services designed to promote health, including “preventive, curative and palliative interventions, whether directed to individuals or to populations” World Health Organization Report. (2000). Chapter 1: *Why do health systems matter?*. WHO.
- ⁵ Commission to Build a Healthier America, Robert Wood Johnson Foundation (RWJF).
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- ⁷ Berkman, L. F., & Kawachi, I. (2000). *Social Epidemiology*. New York: Oxford University Press.
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- ¹⁴ Commission to Build a Healthier America, RWJF. <http://www.commissiononhealth.org/>
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