

**CLOSING THE
HEALTH DISPARITY GAP
IN NEW MEXICO:
A ROADMAP FOR GRANTMAKING**

May 2006

Written by

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For



CON ALMA
Health Foundation, Inc.

The Heart and Soul of Health in New Mexico

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LETTER FROM ROBERT DESIDERIO, EXECUTIVE DIRECTOR

To the Members of the Board of Trustees and Community Advisory Committee of the Con Alma Health Foundation:

Con Alma Health Foundation, Inc. recognizes that relevant, accurate healthcare information is critical to addressing the complex health-related issues that we face in New Mexico. An assessment of the health status and access to quality health care for all New Mexicans, which captures their concerns and perceived barriers, is essential to protecting, promoting and preserving the health of New Mexicans.

This report will provide a basis for dialogue, not only within Con Alma, but within communities across our state. Its purpose is to assist the Con Alma Board of Trustees, Community Advisory Committees and the communities it serves in understanding the health issues facing New Mexico and thereafter to support grantmaking and responsive policy development. This assessment is a product of close collaboration between the Con Alma Grantmaking Committee and the Con Alma Community Advisory Committee. The completion of this report represents a milestone for the Con Alma Health Foundation and its ability to continue to improve the health of New Mexicans.

On behalf of Con Alma, I wish to thank Lisa Cacari Stone, Ph.D., health policy consultant and WK Kellogg Scholar in Health Disparities at the Harvard School of Public Health who contributed the vast majority of research, writing and editing of the report as a member of the Community Advisory Committee; and Deborah Boldt, M.P.A., for collecting the data and interviewing stakeholders to identify health issues and for her contribution of writing and editing the report; Nadine Tafoya, Member, Con Alma Board of Trustees, Alice Salcido, Chair and Jim Coates, Member, Con Alma Community Advisory Committee and Corazón Halasan, Community Epidemiologist, New Mexico Department of Health for reviewing and commenting on the report; and Dolores Roybal, Program Director; Michelle Gutierrez, Program Assistant; and Valorie Montoya, Con Alma's staff, for their excellent work in formatting and editing the report.

This report challenges us to engage in further dialogue around the findings that will lead towards effective solutions and improved health outcomes.

Sincerely,



Robert Desiderio, Executive Director
Con Alma Health Foundation

LETTER FROM FRANK SANCHEZ AND ELAINE MONTANO CO-CHAIRS, GRANTMAKING COMMITTEE

To the Members of the Board of Trustees and the Community Advisory Committee of the Con Alma Health Foundation:

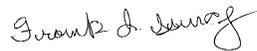
The findings from this report are very striking and informative. As Co-Chairs of the Con Alma Grant-making Committee, we urge you to give careful thought and consideration to the information contained within this report, especially how it relates to our grantmaking programs. We also seek your continued support and participation in this ongoing endeavor because this report will need to be periodically updated.

This report would not have been possible without the assistance of our community partners for their role in the data collection. We wish to thank the following organizations and individuals:

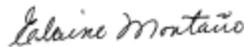
- New Mexico Department of Health: Michelle Lujan Grisham, Cabinet Secretary
- New Mexico Health Policy Commission: Patricio Larragoite, DDS, Executive Director
- New Mexico Human Services Department: Pamela Hyde, Cabinet Secretary
- New Mexico Voices for Children: Sara Beth Koplik, *Kids Count* Program Manager
- Dan Reyna, U.S.-Mexico Border Health Commissioner

We also wish to thank Dan Lopez, President, Board of Trustees, Alice Salcido, Chair, Community Advisory Committee and Robert J. Desiderio, Executive Director, Con Alma Health Foundation for their leadership and support.

Sincerely,



Frank Sanchez
Co-Chair



Elaine Montano
Co-Chair

INTRODUCTION: PRINCIPLES THAT GUIDE OUR GRANTMAKING

Con Alma Health Foundation, Inc. (CAHF) is New Mexico's largest health foundation. It was created in 2001 through the sale of Blue Cross and Blue Shield of New Mexico, a not for profit corporation. State law required that its non-charitable assets be set aside for a similar organization. The conversion provided charitable assets of more than \$20 million for the CAHF. This amount has steadily increased to nearly \$28 million through a profitable investment portfolio and development activities. In 2005, over \$1.5 million was distributed to qualified 501(c) (3) nonprofit, health-related, community-based organizations serving the residents of the state of New Mexico.

The vision of the CAHF is to remove barriers to good health for New Mexicans. The mission is to be aware of and respond to the health rights and needs of culturally and demographically diverse peoples and communities of New Mexico. Con Alma Health Foundation, Inc. seeks to improve the health status and access to health care services for all New Mexicans and advocates for health policies that address the health needs of all New Mexicans.

In order to achieve our mission and promote our core values in the types and quality of programs that are funded, CAHF must first understand the major factors that promote and threaten the health and well-being of New Mexicans.

This task is necessary because the need for support far outweighs available resources. Since its inception in 2001, the CAHF has awarded over \$3.5 million to 250 nonprofit organizations throughout New Mexico. Requests for funding have exceeded \$8 million.

The vision of Con Alma Health Foundation, Inc. is to remove barriers to good health for New Mexicans.

In 2003, CAHF established a focused funding priority with a call for proposals to bring positive, systemic change to pre-adolescent health issues in New Mexico. Proposals were invited from organizations that leveraged resources while honoring the basic values of providing service to diverse, underserved and rural populations. The target demographic was preadolescent children (below age 10). Activities included family, school, community and medical personnel. The target issues were youth risk behaviors (substance abuse, pregnancy, domestic violence, injury, etc.) and dental health.

During that same period, CAHF has also been a public policy advocate, promoting health policies including health insurance coverage for all New Mexicans. Additionally, CAHF has also been a change agent within philanthropy encouraging other New Mexican foundations to direct more of their resources toward eliminating health disparities and improving health policies.

This report adds to that track record by utilizing an evidence-based approach to grantmaking. It was developed as a decision-making tool to be used by the Foundation as it makes grants, contributions, and program-related investments to fulfill its mission. The purpose is to enhance the existing focus on programs serving youth. Along with additional information to help guide the Foundation's decisions in allocating the resources to the areas of greatest need so that Con Alma's philanthropic efforts have an optimal health impact.

The report synthesizes state and local data and information on the systems challenges and health disparities conditions in New Mexico. It is organized into the following six sections:

- **Understanding Health Disparities** - a multi-level framework for understanding causes of health disparities;
- **Socioeconomic Determinants of Health** - state characteristics by age, sex, race, income, employment, foreign-born, and disability;
- **Health Status** - overall health challenges and strengths in 2005 including key findings on the health of Native American, Hispanic/Latino, African American and Immigrant children;

- **Health Systems Issues** - a brief description of barriers people face in getting health care in New Mexico including health insurance coverage, shortage of health care providers, lack of cultural and linguistic workforce competencies, availability of preventative services, and rising costs of care;
- **Health Policy** - highlights of public initiatives taken to address health problems;
- **Grantmaking into Action** - recommendations of priorities for strategic planning and grant-making.

UNDERSTANDING HEALTH DISPARITIES

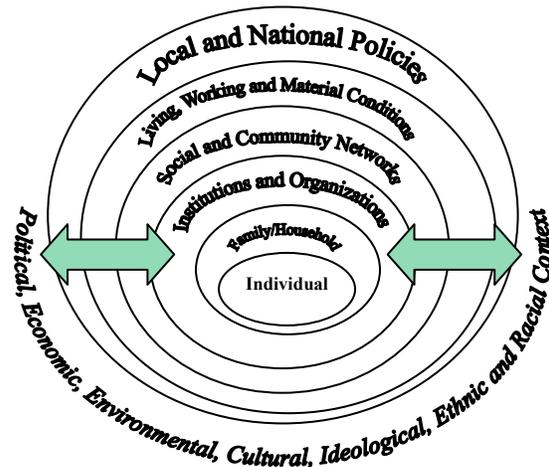
In the last decade, a growing body of research demonstrates that racial and ethnic disparities in health constitute a national crisis and is a growing public health challenge.^{1, 2, 3, 4, 5, 6, 7}

While health in the U.S. has improved overall, racial and ethnic minorities suffer higher rates of mortality and illness from asthma, diabetes, cancer, heart disease, and a range of other diseases compared to white Americans.⁸ They also tend to receive a lower quality of health-care than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled.⁹ According to the Kaiser Family Foundation, "eliminating these disparities is politically sensitive and challenging in part because their causes are intertwined with a contentious history of race relations in America."¹⁰ In New Mexico, the colonization of indigenous communities and U.S.-Mexico border politics has affected the health and well-being of generations of families. Nonetheless, solutions are possible and begin with understanding the web of factors producing inequalities in health.

Figure 1 illustrates that there are multiple dimensions which explain inequalities in health at the individual, family, institutional, social, and policy levels.¹¹

The six dimensions influencing health shown below explain that, at any given time, these factors interact to moderate health and well-being within a given political, economic, environmental, cultural, ideological, ethnic and racial context.

Figure 1. Socio-Ecological Model-



For example, an *individual's* income, education, employment, race/ethnicity, gender, age, and language are critical components explaining health differences and outcome. *Family* plays a role in mediating risks and can provide protective factors that influence adolescent substance use. *Individual and family* insurance status, primary language, and level of acculturation are among other factors which impact health. Equally important are the *institutions and organizations* that educate health professionals and deliver care. *Geographic location* (rural vs. urban), *neighborhood living* (community cohesion, violence) and *environmental and work conditions* are relevant to moderating health and well-being. Finally, local, state and national *policies* are instrumental in either tackling or exacerbating health disparities. For example, the state of residence of the child appears to influence the likelihood of receiving access to preventative care and other types of services due to the types of Medicaid eligibility and benefits, availability of resources and distribution of health care providers.

The following two sections provide a snapshot of the socioeconomic factors and the health systems barriers that influence the health and well-being of racial and ethnic families and children in New Mexico.

SOCIOECONOMIC DETERMINANTS OF HEALTH

State socioeconomic and demographic data provide us with the basic information in predicting trends in health care needs for the general population. New Mexico is considered a young state, but in the next thirty years New Mexico will experience a large growth in the aging population. While it is estimated that 25 percent of adults have disabilities, this estimate is modest and policy makers should plan for community services for the aged and disabled. Fifty-five percent of the population is racial and ethnic minorities whose incomes are lower than the rest of the nation. New Mexico has a higher unemployment rate than the national average (7.3 percent compared to 5.8 percent in the U.S.) and is below the national average in educational attainment. The rate of those foreign-born is below the national averages.

AGE AND SEX

Between 1990 and 2000 New Mexico's population grew by 20.1 percent from 1.5 million to just over 1.8 million. In 2004, the female population was 50.8 percent and the male was 49.2 percent of the total population. The largest percent change from 1990 to 2000 was among those between 45 to 54 years, at 67 percent and among those 85 years and over, at 64 percent. By 2030, person's 65 years and older will comprise 26 percent of the state's population, while those over 85 years are expected to grow at a faster rate. Currently, New Mexico ranks 39th for the percentage of people age 65 or older and is projected to be 16th by 2010 and 4th by 2030. (Table A)

New Mexico has been considered a "young" state but can anticipate "the age wave." In 2000, 31 percent of the state's population was under 19 years of age, 13 percent between 20-54 years, less than 8 percent between 55 to 64 and 11 percent over age 65.

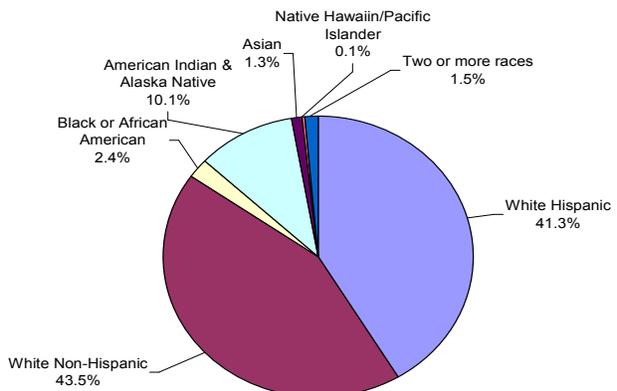
Table A. Age & Sex
Source: 1990 & 2000 U.S. Census Data

| | 2000 | 1990 | % change |
|-------------------------|-----------|-----------|----------|
| SOCIODEMOGRAPHIC | | | |
| TOTAL POPULATION | 1,819,046 | 1,515,069 | 20.1 |
| SEX & AGE | | | |
| Male | 894,317 | 745,253 | 20.0 |
| Female | 924,729 | 769,816 | 20.1 |
| Under 5 years | 130,628 | 125,878 | 3.8 |
| 5 to 9 years | 141,171 | 131,059 | 7.7 |
| 10 to 14 years | 147,309 | 121,632 | 21.1 |
| 15 to 19 years | 145,751 | 113,938 | 27.9 |
| 20 to 24 years | 121,291 | 106,058 | 14.4 |
| 25 to 34 years | 234,091 | 256,749 | -8.8 |
| 35 to 44 years | 282,009 | 227,717 | 23.8 |
| 45 to 54 years | 245,819 | 147,448 | 66.7 |
| 55 to 59 years | 87,140 | 62,038 | 40.5 |
| 60 to 64 years | 71,612 | 59,490 | 20.4 |
| 65 to 74 years | 117,745 | 97,607 | 20.6 |
| 75 to 84 years | 71,174 | 51,223 | 38.9 |
| 85 years and over | 23,306 | 14,232 | 63.8 |

RACE AND ETHNICITY

Contrary to the myth that New Mexico is a "tri-cultural" state, the composition of New Mexico's population is diverse. In 2004, people of color comprised 55 percent of the population of the state which was just over 1.9 million: Hispanic/Latinos at 41.3 percent, American Indian at 10.1 percent, African American at 2.4 percent and Asian American at 1.3 percent. white Non-Hispanics represented 785,113 or 43.4 percent of the state.

Figure 2. Source: U.S. Census Data
New Mexico Resident Population by Race & Ethnicity 2004



From 1990 to 2000, the American Indian population had a 29 percent growth and comprises just over 10 percent of the total population. Hispanic/Latinos reporting one race had a 32 percent change.

Table B. Race

Source: 1990 & 2000 U.S. Census Data

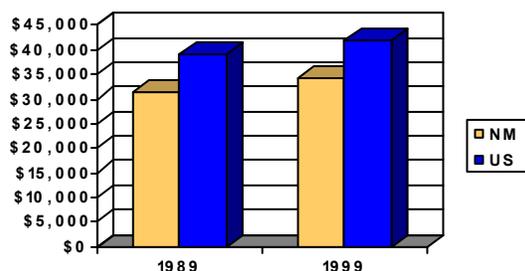
| | 2000 | 1990 | % change |
|--|-----------|-----------|----------|
| RACE | | | |
| White | 1,241,253 | 1,146,028 | 6.0 |
| Black or African American | 34,343 | 30,210 | 13.7 |
| American Indian and Alaska Native | 173,483 | 134,355 | 29.1 |
| Asian | 19,255 | 13,363 | 44.1 |
| Native Hawaiian and Other Pacific Islander | 1,503 | 761 | 97.5 |
| HISPANIC OR LATINO AND RACE | | | |
| Hispanic or Latino (of any race) | 765,386 | 579,224 | 32.1 |
| Mexican | 330,049 | 328,836 | 0.4 |
| Puerto Rican | 4,488 | 2,635 | 70.3 |
| Cuban | 2,588 | 903 | 186.6 |
| Other Hispanic or Latino | 428,261 | 246,850 | 73.5 |

INCOME AND POVERTY

New Mexico median household income was well below U.S. income in both 1989 and 1999. But there was some improvement by 1999, when the state income was 81.3 percent of the U.S. figure, a gain of 1.2 percentage points (Figure 3).

Figure 3. Median Household Income 1989 and 1999 - New Mexico and U.S. (in 1999 \$)

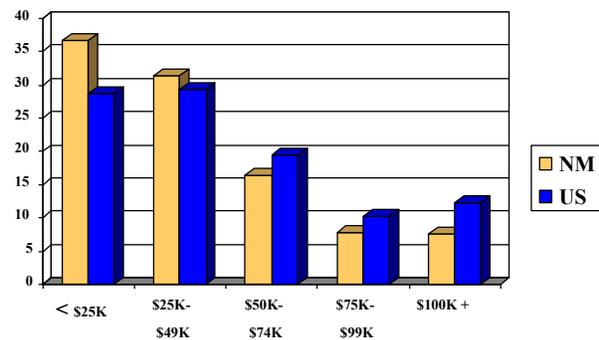
Source: U.S. Census Bureau & Bureau of Business and Economic Research (BBER), University of New Mexico



In the U.S., 42 percent of the households reported income of \$50,000 or more in 1999. This compares to just 32 percent in New Mexico. At the top end, there were 12.3 percent of U.S. households with \$100,000 or more income in 1999, vs. just 7.6 percent in New Mexico (Figure 4). There were a total of 678,032 New Mexico households in Census 2000.

Figure 4. Percent Household Income Distribution in 1999 - New Mexico and U.S.

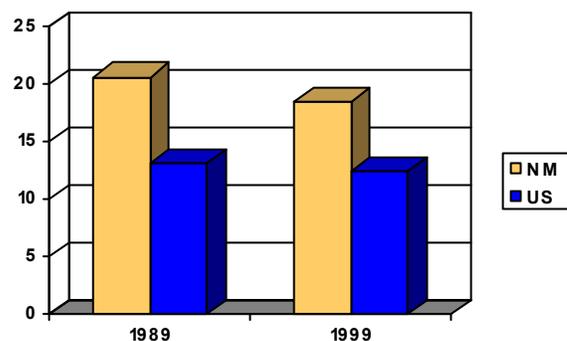
Source: U.S. Census Bureau & Bureau of Business and Economic Research (BBER), University of New Mexico



New Mexico's poverty rate fell from 20.6 percent in 1989 to 18.4 percent in 1999. Nationwide, the poverty rate declined from 13.1 percent to 12.4 percent (Figure 5). According to Census 2000, there were almost 329,000 New Mexicans, or 13.8 percent below the poverty level, an increase of 7.5 percent from 1989.¹²

Figure 5. Percent of Persons Below Poverty- New Mexico and U.S. 1989 and 1999

Source: U.S. Census Bureau & Bureau of Business and Economic Research (BBER),

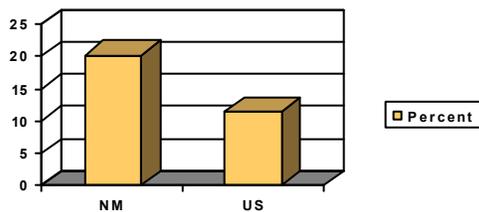


EMPLOYMENT

From 1990 to 2000, total employment growth (i.e., growth in the number of employed civilians and military combined) in New Mexico outpaced growth in the U.S. as a whole, 20.2 percent to 11.5 percent (Figure 6). The state added almost 130,200 workers as employment grew to 774,308 in 2000. The employment growth rates somewhat reflect total population growth. New Mexico's population increased 20.1 percent between 1990 and 2000. U.S. population grew 13.2 percent. Employment in the Armed Forces amounted to 11,192.

Figure 6. Percent Change in Total Employment (Includes employed civilians and Armed Forces). 1990-2000 New Mexico and U.S.

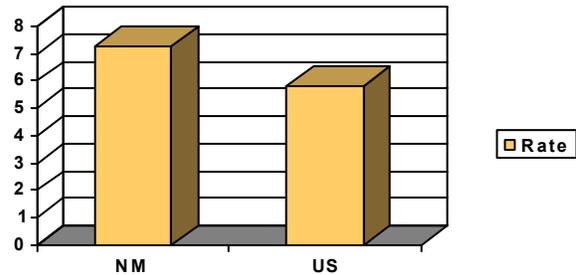
Source: U.S. Census Bureau & Bureau of Business and Economic Research (BBER), University of New Mexico



According to Census 2000, New Mexico's unemployment rate stood at 7.3 percent compared to 5.8% in the U.S. In New Mexico, 60,324 persons were classified as unemployed in 2000 (Figure 7). New Mexico ranks 16th in the nation, but locally unemployment varies greatly, with Luna (10 percent), Mora (9.8 percent), Guadalupe (8.1 percent), McKinley (7.70 percent), Taos (7.10 percent), San Miguel (7.0 percent), Catron (6.60 percent), Grant (6.40 percent), Rio Arriba (6.20 percent), Chaves and Colfax (6.10 percent) having the highest unemployment rates.¹³

Figure 7. Unemployment Rate 2000 - New Mexico and U.S.

Source: U.S. Census Bureau & Bureau of Business and Economic Research (BBER), University of New Mexico

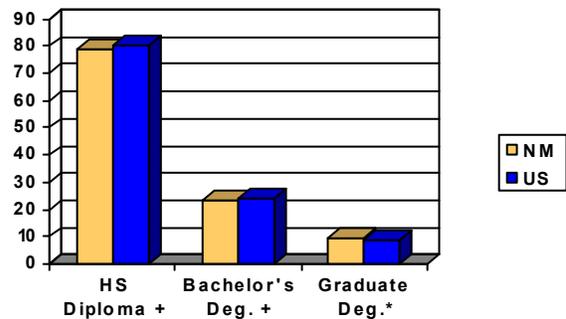


EDUCATION

New Mexico ranked slightly below the national percentages of persons 25 years and older with: high school diplomas (78.9 percent -NM vs. 80.4 percent U.S.); Bachelor's or higher level degrees (23.5 percent compared to 24.4 percent in the nation) (Figure 8).

Figure 8. Educational Attainment in 2000 Percent of Persons 25 Years and Over By Type of Diploma/Degree- New Mexico and U.S. (includes professional degree)

Source: U.S. Census Bureau & Bureau of Business and Economic Research (BBER), University of New Mexico



From 1990-2000 New Mexico has seen improvement in overall educational attainment for person 25 years and over, with the highest percent change among persons with graduate or professional degrees (46 percent).

Table C. Educational Attainment
Source: 1990 & 2000 U.S. Census Data

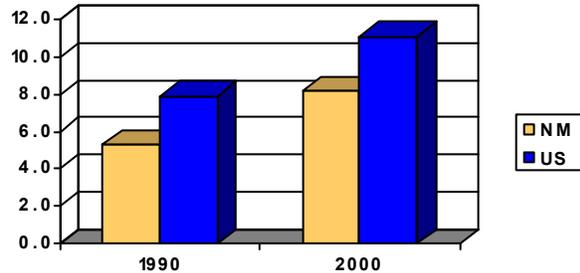
| EDUCATIONAL ATTAINMENT | 2000 | 1990 | % change |
|---|------------------|----------------|-------------|
| Population 25 years and over | 1,134,801 | 922,590 | 23.0 |
| Less than 9th grade | 104,985 | 105,362 | -0.4 |
| 9th to 12th grade, no diploma | 134,996 | 124,612 | 8.3 |
| High school graduate (includes equivalency) | 301,746 | 264,943 | 13.9 |
| Some college, no degree | 259,924 | 192,835 | 34.8 |
| Associate degree | 67,001 | 46,502 | 44.1 |
| Bachelor's degree | 154,372 | 111,957 | 37.9 |
| Graduate or professional degree | 111,777 | 76,379 | 46.3 |
| Percent high school graduate or higher | 78.9 | 75.1 | - |
| Percent bachelor's degree or higher | 23.5 | 20.4 | - |

FOREIGN-BORN

The percentage of New Mexicans that were foreign born increased between the censuses, rising from 5.3 percent of the population to 8.2 percent. There are now more than 149,600 New Mexicans that are foreign born. Nationally, the foreign-born population was proportionately larger in both censuses: 7.9 percent in 1990 and 11.1 percent in 2000. Among the 50 states and the District of Columbia, New Mexico had the 18th highest percentage of foreign-born persons in 2000. This was down from a rank of 16th in 1990. (Figure 9)

Figure 9. Percent Foreign-Born Population 1990 and 2000 - New Mexico and U.S.

Source: U.S. Census Bureau & Bureau of Business and Economic Research (BBER), University of New Mexico



DISABILITY

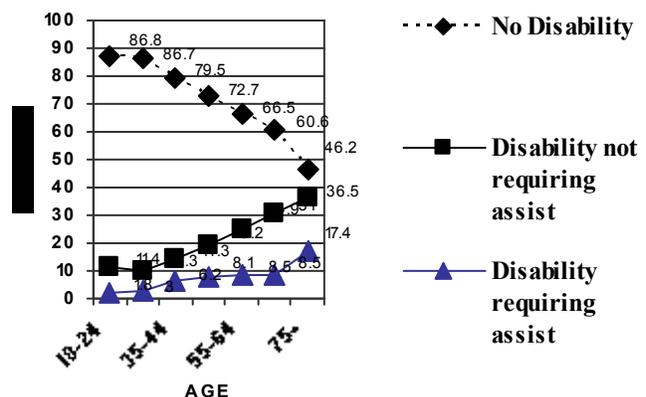
Twenty-five percent, or 300,000 of adult, non-institutionalized New Mexicans reported having a disability. Age is an important factor in disability, with older age groups clearly having a higher burden of disability than younger age groups (Figure 10).

Among those with disabilities requiring assistance, Hispanic/Latinos have the highest need at 7.3 percent, followed by white Non-Hispanic at 6.4 percent, and Native Americans at 4.6 percent.

Between 1,800 and 3,000 New Mexican's have a dual diagnosis of mental retardation/developmental disabilities (MR/DD) and mental illness.¹⁴

Figure 10. Disability status, by age.

Source: BRFSS, NM DOH. 1998-2000.



OVERALL HEALTH STATUS

Is New Mexico making progress? In 2005, New Mexico ranked 38th out of the 50 states on a nationally recognized, annual ranking of health. Since 1990, New Mexico has ranked between 35th and 48th in the US, with an average ranking of 44th. Challenges to the state include limited access to adequate prenatal care, high rate of uninsured population, and a high percentage of children in poverty. Progress made or strengths include: low rate of cardiovascular deaths, low rate of cancer deaths and high immunization coverage. What follows is a summary of key findings of overall health status from both the United Health Foundation¹⁵ and New Mexico Department of Health's most recent report, "The State of Health in New Mexico."¹⁶

STRENGTHS

Strengths include a low rate of cardiovascular deaths at 272.1 deaths per 100,000 population, a low rate of cancer deaths at 178.6 deaths per 100,000 population, high immunization coverage with 83.5 percent of children ages 19 to 35 months receiving complete immunizations, a low prevalence of obesity at 21.4 percent of the *total* population and a low total mortality rate at 817.7 deaths per 100,000 population.

CHALLENGES

Overall challenges include **limited access to adequate prenatal care** with 58.4 percent of pregnant women receiving adequate prenatal care, a **high rate of uninsured** population at 21.0 percent, a **high rate of motor vehicle deaths** at 2.3 deaths per 100,000,000 miles driven and a **high percentage of children in poverty** at 23.4 percent of persons under age 18. **Teen birth rates** have been declining in New Mexico for many years. Despite the declining rates, New Mexico ranks third highest in the nation for teen pregnancy. Most young teen mothers are less likely to get or stay married or complete high school. They are also more likely to be poor and require public

assistance. Their infants are at risk for a number of health problems including low birth weight, neonatal death, and Sudden Infant Death Syndrome.

Nationally, **childhood obesity** is a growing health epidemic. Currently, 9,000,000 children have this chronic condition, and it's putting them at high risk for diabetes, high blood pressure, and other preventable diseases. In addition, obese children frequently grow up to become obese adults, and they impose at least 11 billion dollars in medical costs on the nation each year.¹⁷ Childhood obesity is the direct result of too much food and too little physical activity. One of the results is the epidemic now plaguing the nation. Children watch over 40,000 food advertisements on television a year – one food commercial every minute, urging them to eat large helpings of candy, snacks, fast foods and cereal high in sugar. Excessive caloric intake without adequate physical activity leads to unhealthy weight gain, especially in people who are at-risk due to heredity.

Diabetes is a condition that is linked both to obesity and to genetics. Death rates for diabetes in New Mexico vary greatly by race and ethnicity with higher American Indian rates than those for either Hispanic/Latino whites or non-Hispanic whites.

Suicide rates for both adults and youth in New Mexico are considerably higher than those for the U.S. The reasons for suicide are complex, but may include depression, lack of access to medical services, alcohol and substance abuse, and access to firearms. Suicide rates are higher in rural, western states for reasons that are not clear. Suicide among young persons may be related to stress, confusion, and depression from situations occurring in their families, schools, and communities. Such feelings can overwhelm young people and lead them to consider suicide as a "solution." Few schools and communities have suicide prevention plans that include screening, referral, and crisis intervention programs.

Suicide rates increase with age and are very high among those 65 years of age and older, because older adults are more likely to be suffering from physical illness and be divorced or widowed.

OTHER CHALLENGES

Behavioral Health

According to the New Mexico Behavioral Health Needs Assessment (2002), over 400,000 individuals in New Mexico have substance abuse/dependence or mental disorders. While this number may seem high, it represents about 22 percent of the state's total population.¹⁸ Each of these individuals has family members that are affected directly or indirectly by their abuse/dependence or disorder.

- Approximately 25-35 percent of those New Mexicans with substance use and disorders will need services from the publicly funded system of care.
- It is estimated that in New Mexico, 19,025 youth and 131,112 adults (including individuals in the state's jails and prisons) have substance use disorders.

According to focus group participants,¹⁹ populations most in need of additional services are:

- Children/adolescents, including infants to school age and adolescents especially females) transitioning into adulthood,³ and their families;
- Persons with co-occurring disorders (mental illness and substance abuse or mental illness and developmental disabilities); and
- Persons with special cultural needs (e.g., Spanish-speaking, Mexican immigrants, American Indians, etc.).
- Persons with mental illness who are in need of follow-up care after being released to the community.

There are considerable regional variations in service access and utilization patterns in New Mexico. There is no evident pattern or logic to the variations in service access and resource allocation, nor does there appear to be an explicit policy goal driving these variations. All regions have a high utilization of inpatient and residential care compared to the more desirable and effective community-based service modalities.

All five regions in New Mexico have significant unmet needs. The needs of rural areas in Region 1 (Northwest), Region 3 (Southwest) and Region 4 (Southeast) as well as the far Northeast corner of Region 2 are significantly more pronounced than the needs of urban areas surrounding Santa Fe, Albuquerque, and Las Cruces, especially when capacity to meet needs is compared to the special demographic and socioeconomic factors of each region.

Typically, mental health providers rely on government contracts for a major source of funding, despite significant cuts in recent years. As new policies further narrow the eligibility to access health and human services, it is possible that fewer public dollars will be available to support these programs. Funding provided for health and substance abuse services in New Mexico is currently inadequate to meet the behavioral health needs of New Mexico's residents. In addition, there are inadequate numbers of licensed practitioners in New Mexico as a whole, but particularly outside Albuquerque and Santa Fe.

Many of New Mexico's families suffer from high levels of divorce, physical and drug abuse and domestic violence. Children from these families suffer from severe trauma and psychological problems that are manifested in anxiety, depression, attention deficit and social interactions.

Programs that support young children's healthy mental development can reduce the prevalence of developmental and behavioral disorders that have high costs and long-term consequences for health, education, child welfare, and juvenile justice systems—and for children's futures.

A recommended funding priority would be to provide grants that address the issue of mental health, specifically:

- Regional planning involving all systems' managers and stakeholders;
- In-home and wrap-around services for children and their families, including therapeutic foster care where needed;

- Culturally specific services for American Indians, recent Mexican immigrants, and monolingual Hispanic individuals and families;
- School-based behavioral health clinics and services.

Border Health

If the **U.S.-Mexico border area** were its own state, it would rank **last in access** to health care; **second in death rates** due to **hepatitis**; **third** in deaths related to **diabetes**; **last** in per capita **income**; and **first** in the percentage of **uninsured**. Environmental issues are a growing concern among New Mexico's counties bordering Mexico. The four most frequently cited issues facing these communities are water and air quality, availability of clean water, and sewage and sanitation.²⁰

The **border area** has a **higher shortage of health professionals** than other non-border counties.

- Physicians: border rate is 60 percent lower than the non-border counties
- Nurses: border rate is 23 percent lower than the non-border counties
- Dentists: border rate is 55 percent lower than the non-border counties

The environmental health status of southern New Mexico's border region (Doña Ana, Luna, Hidalgo, Grant, Otero and Sierra counties) varies by county, with a wide range of issues impacting area residents. In many communities rapid population growth and economic development are stressing the environment. This has led to an increased concern with how the environment impacts health with the four most frequently cited issues facing these communities.

Many New Mexico border residents are not familiar with the connection between health and the environment. As a result, preventable illnesses occur because of personal behaviors that result in contamination of the environment or exposure to environmental agents.

The majority of the region relies on ground water for its domestic water needs. Many of these sources contain arsenic at levels that will not meet the newly proposed EPA standards. Long-term exposure to arsenic is known to cause circulatory system problems, gastrointestinal irritations and skin diseases such as cancer.

Border area residents perceive air quality as an issue affecting their health. In a survey of 781 residents from the six border counties, 9 percent of the participants had a family member diagnosed with asthma and 37 percent associated dust with respiratory problems.²¹ One of the major contributors of airborne dust is from regional windstorms. These dust storms routinely cause ascendances of the EPA air quality standards for particulate matter (PM10).²²

The agricultural industry in New Mexico's border counties employs a large number of farm workers to work on farms, dairies and in processing plants. This industry poses a number of hazards that put workers at risk of exposure to pesticides and other agro-chemicals, as well as injuries and sun and heat exposure.²³ Although there are laws in place to protect agricultural workers, there are limited resources to ensure that the laws are enforced.

In order to address community concerns and existing environmental health issues facing the New Mexico border counties, organizations working with households in Colonia communities need support for a wide variety of projects. It is recommended that Con Alma also support organizations that conduct training with local promotoras on environmental health topics.

HEALTH DISPARITIES : KEY FINDINGS

Among New Mexico's public health challenges identified in this report, understanding how gender, race/ethnicity, education level and income impact health status is one of the most complex. Interactions among these can help explain why some people are healthier than others.²⁴ The following data provides key findings with respect to who is likely to suffer the greatest burden of health disparities in New Mexico: Native Americans, Hispanic/Latinos, African Americans, and Immigrant Children. The future of the health of our state will be determined to a large extent by how effectively we prioritize and respond to the health needs of our racially and ethnically diverse children today. Priorities for grantmaking should consider these health challenges within each group variation, including geographic variation and gender differences.

NATIVE AMERICAN

The social consequences of U.S. policies and practices of genocide, slavery and forced assimilation have created an intergenerational phenomena impacting health called historical trauma.²⁵ It has been documented that historical trauma and oppression, along with chronic under-funding of the Indian Health Services have had a detrimental impact on the health and well-being of indigenous peoples.^{26, 27, 28} For example, studies have concluded that:

- Native Americans are 770 percent more likely to die from alcoholism, 420 percent more likely to die from diabetes and 52 percent more likely to die from pneumonia or influenza than the rest of the United States, including white and minority populations.
- Native Americans have the highest prevalence of Type 2 diabetes in the world, which is a significant threat to Native children.
- Heart disease is the number one cause of death among Native Americans. Rates of

cardiovascular disease are two times higher for Native Americans than that of the general population.

- Cancer is the second leading cause of death for Native American women and the leading cause of death for Alaskan Native woman.
- Depression is the most serious emerging health disorder in the Native American population. There are only 101 mental health professionals available per 100,000 Native Americans, compared with 173 mental health personnel per 100,000 whites.
- From 1995-2000, infant mortality was 33 percent higher among American Indian and Alaskan Native children than other children. Sudden Infant Death Syndrome (SIDS) was the leading cause of infant death among children born to American Indian and Alaska Native mothers who live in Urban Indian Health Organization service areas.

In order to gain a better understanding of the health of New Mexico's Native American population, The New Mexico Voices for Children published a special report²⁹ which shows that:

- Children under eighteen represent 41 percent of the Native American population.
- Forty percent of all Native American children live under the federal poverty level. Among white, non-Hispanics, this rate is 12 percent.
- The median income of Native American families is half that of white non-Hispanics in New Mexico.
- However, 69 percent of children living on tribal land are bilingual, and of those, more than 60 percent speak English fluently.

Native Americans are composed of diverse sub-groups with distinct languages, customs and beliefs and are located in both rural and urban communities. Populations within tribal communities range from less than 200 individuals at Picuris Pueblo to over 67,000 people living on the Navajo Nation in New Mexico. Figure 11 shows the concentration of the Native American and Tribal communities state-wide.³⁰

Figure 11. Tribal Communities in New Mexico

Source: NM Voices for Children



According to the New Mexico Department of Health Report which measured health disparities,^{31, 32, 33} in general, Native Americans experience the worst rates, and white Non-Hispanics experience the best rates. Native Americans suffered the highest rates of diabetes death, pneumonia/influenza death, alcohol-related death, motor vehicle injury death, shigellosis, adolescent driving under the influence, adolescent illicit drug use, and adolescent overweight status; they also had a large increase in the adult smoking rate. Native Americans experienced the greatest disparity changes for pneumonia/influenza death and diabetes death, for which disparities increased, and hepatitis A and shigellosis, for which disparities decreased.

HISPANIC/LATINOS

Currently, Hispanic/Latinos/Latinas comprise over 42 percent of the New Mexico’s total population. New Mexico’s Hispanics³⁴ have had a unique history of colonization, which has born the mestizo culture (or mixed race) consisting of Spanish and Indigenous roots. This rich, yet tragic complexity of history dates back to the occupation of New Mexico³⁵ by the Spaniards up through contemporary economic and immigration policies and contentious U.S.-Mexico border relations.

Today, New Mexican Hispanic/Latinos choose to identify and name themselves in many ways: Hispanos or Spanish Americans, Latinos, Chicanos, Mexicanos. More recently, the state has received newcomers from Puerto Rico, Cuba and other Central American countries. Demographic factors such as per capita income, education levels, and proficiency in English vary widely among native-born Hispanics, Mexicans, Cubans, Puerto Ricans and other Latinos living in the U.S.-Mexican border area.

Research on Hispanic/Latino health status demonstrates that the more acculturated Latinos become, their health tends to get worse. This is considered the “Latino paradox” and is explained as an irony about Hispanic/Latino immigrants because, as a group, they tend to be healthier on their arrival to this country than they are after a few years of life in the United States. Thus, funding health interventions that promote the health and well-being of Hispanic/Latino communities should take these sub-cultural variations and acculturation into consideration.

Other findings demonstrate that New Mexico Hispanic/Latinos are more likely to have been born in the U.S. than Hispanic/Latinos in other parts of the country.³⁶ Over 90 percent of Hispanic/Latinos in New Mexico are native.³⁷ The following U.S. Census data shows that the Hispanic/Latino population in New Mexico is younger than the rest of the nation and that they are highly concentrated in the border region:

- Hispanic/Latino population
 - in U.S.: 12.5 percent
 - in New Mexico: 43 percent
 - in NM border region: 52 percent
- Hispanic/Latino Youth population (under the age of 15)
 - in U.S.: 21 percent
 - in New Mexico: 31 percent
 - in NM border region: 31 percent

Economic, educational, and health conditions for Hispanic/Latinos in New Mexico have reached a crisis point despite the fact that they comprise a large proportion of the population and contribute to the rich culture, language, history and traditions of our state.

In New Mexico from 1997-1999, 34 percent of Hispanic/Latinos were living in poverty (persons who make less than 100 percent of the Federal Poverty Level which was \$13,290 for a family of three in 1999)³⁸ as compared to 16 percent whites. New Mexico's Hispanic/Latinos had a median family income of \$21,457 as compared to \$32,687 for whites, and \$37,035 for Blacks from 1997-1999.³⁹

For New Mexico, improving educational support both at the college and high school level are worthwhile investments for increasing earnings, escaping poverty, and having health insurance coverage:⁴⁰

- In 2000-2001, Hispanic/Latinos (6.7 percent) had the highest dropout rate of all ethnic groups in grades nine through twelve, followed by Native Americans (5.9 percent), African Americans (5.2 percent), whites (3.6 percent), then Asians with the lowest rate (2.4 percent);⁴¹

- In grades seven and eight, Hispanic/Latinos had the third highest dropout rates (0.9 percent) with Black children the highest (1.2 percent), and Native American second highest (1.1 percent);⁴² and
- Educational attainment for the 25 year + population that identified as Hispanic or Latino in New Mexico (2000 Census) was:⁴³
 - 18.3 percent with less than ninth grade;
 - 17.3 percent ninth to twelfth grade, no diploma;
 - 30.2 percent high school graduates;
 - 18.8 percent with some college, no degree;
 - 4.6 percent associates degree;
 - 6.9 percent Bachelor's degree; and
 - 4.0 percent with graduate or professional degree.

New Mexico's Health Status Disparities report found that "white Hispanics had the poorest perception of health and the highest rates of teen birth, drug-related death, firearm injury death, Chlamydia, and binge drinking."⁴⁴ They experienced the greatest disparity increases for teen births and hepatitis B, and the greatest disparity decrease for smoking."⁴⁵

AFRICAN AMERICAN

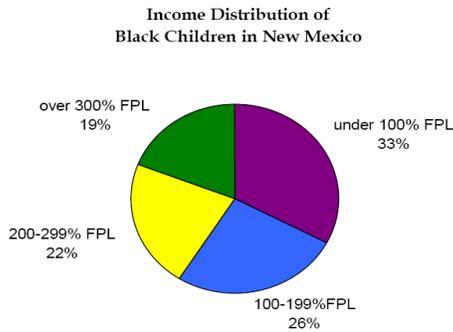
In New Mexico, the African American population is relatively small, comprising only two percent of the total populace. Despite their size, the African American community faces strong patterns of discrimination. The following data is from a special report on African American Children by the New Mexico Voices for Children.⁴⁶

African American children are approximately 2 percent of all children in New Mexico. Only four counties have higher figures. In Curry County, 8 percent of children are African American, in Bernalillo and Lea counties, the figure is 5 percent, while in Otero County 4 percent of all children are African American. In 2000, 21 of 33 counties had fewer than 100 African American children.⁴⁷

- This includes counties with the following towns: Deming, Espanola, Gallup, Las Vegas, Los Alamos, Silver City, Socorro, and Taos.

- Thirty-three percent of African American children live in poverty, but only 8 percent of families receive Temporary Assistance for Needy Families (TANF).
- Fifty-nine percent of African American children live under 200 percent of poverty, as compared to thirty-three percent of white children in New Mexico.⁴⁸

Figure 12. Source: *NM Voices for Children*

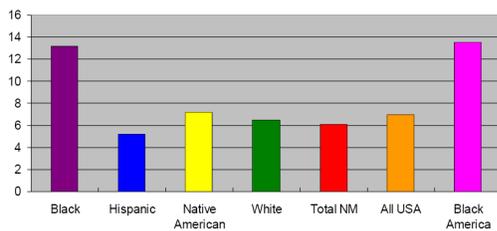


African American mothers work longer hours for less pay than all other mothers in New Mexico. Poverty levels remain high for African American families despite substantial hours of work.

African American babies face the highest infant mortality levels in New Mexico.

Figure 13. NM Infant Mortality by Race/Ethnicity

Source: *NM Voices for Children*
Infant Mortality



The death rate for African American males is 14.3 per 1,000 live births, while the female death rate is 12.0 per 1,000 live births in New Mexico. The lowest rate is found among Hispanic/Latina females, at 4.0 per 1,000 births.⁴⁹

CHILDREN OF IMMIGRANTS

Compared to other states, New Mexico has a lower population of “undocumented persons.” The estimated number of undocumented immigrants in New Mexico in 1996 was 37,000 and 40,000 in 2001.⁵⁰ Over three-fourths

(78 percent) of the immigrants admitted to New Mexico are from Mexico.

In 2000, at least 19,442 New Mexico children, or only 4 percent of all children, were foreign-born (that is, born outside of the U.S.) Eighty-three percent of immigrant children were Hispanic/Latino. Fourteen percent of foreign-born children are naturalized citizens and 86% are not US citizens. Forty-four percent of immigrant children are linguistically isolated as compared to 16 percent whites.⁵¹

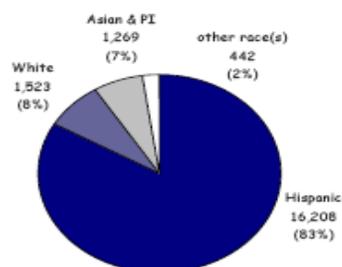
Seventy-three percent of New Mexico’s immigrant children are of Mexican ancestry. Roughly 1 percent of immigrant children trace their ancestry to Central America and 1 percent traces their ancestry to South America. Another 7 percent of New Mexico’s foreign-born children are Hispanic/Latinos of “other Spanish” ancestry. New Mexico’s Asian immigrant children represent a diverse array of ancestries including Vietnamese, Korean, and Indian. Thirty-five percent of Asian immigrant children in New Mexico are Chinese.⁵²

Eighty-nine percent of all immigrant children in New Mexico live with one or both parents. Nearly three-fourths (73 percent) live with two parents. Over eighty percent of children living with their parents have at least one working parent.

Families with a foreign-born Hispanic/Latino householders are more than twice as likely to be in poverty as those with a native-born householder.⁵³ Yet, despite the fact that most parents of immigrant children work, 42 percent of New Mexico’s foreign-born children live in poverty.

Figure 14. Source: *U.S. Census & NM Voices for Children*

Foreign Born Children in New Mexico (2000)



Accessing and paying for health services (preventative, specialty care, follow-up treatments, and hospitalizations) have become more problematic for immigrant families after the welfare reform⁵⁴ which created a bar on immigrants' access to Medicaid at the federal, state and local levels.⁵⁵ Local providers and advocates in New Mexico have reported that the new restrictions on federal and state health care benefits have exacerbated existing barriers in New Mexico.⁵⁶ As a result, immigrants delay seeking care until their problems become emergent and more expensive to treat.

Policies that deny health care and public benefits to non-citizens are likely to have broad spillover effects on citizen children who live in the great majority of immigrant families with mixed status. Denying health care to immigrant adults may diminish health outcomes for U.S. citizen children. According to an issues brief by New Mexico Voices for Children "Parents who obtain preventative healthcare for themselves are more likely to procure preventative care for their children.⁵⁷ Furthermore, if children have health insurance but their parents do not, they are less likely to receive preventative care than are children in families in which both children and adults are insured." Emergency care remains a regular source of care for many of those who have no regular physician and no health insurance, and they delay care due to real fears of deportation and language and cultural barriers.⁵⁸

HEALTH SYSTEMS ISSUES

The service needs of multicultural populations are of national and local interest, particularly because of the documented pattern of health care service inequities and potential negative consequences of these inequities for these populations. If, when, and how health care is delivered determines a person's health and well-being across the life-span.

When the health delivery system is lacking in many areas, the overall health of the public is compromised and the costs are greater. Lack of health insurance, access to preventative services (i.e., Cancer screening, regular dental check-ups), availability of primary and specialty health providers (doctors, nurses), affordable health care and products (i.e. prescription drugs), and culturally and linguistically appropriate services are critical determinants of health and well-being. When the system lacks, the health of the people suffer.

Insurance Coverage

According to the most recent figures available from the U.S. Census Bureau, nearly 46 million Americans - including more than 8 million children -have no health coverage. In New Mexico alone there are nearly 400,000 residents living without health insurance. The Institute of Medicine estimates that nearly 50 people die each day because they are uninsured and cannot get the medical care they need.

The lack of health insurance coverage continues to be a growing public policy problem with serious negative consequences and economic costs not only for the uninsured themselves but for their families, the state they live in and the whole country.⁵⁹ Adequate access to health care services can significantly influence health care use and health outcomes. Without coverage, the uninsured (whether children, pregnant women, or other adults) received fewer services than their insured counterparts or no care at all.⁶⁰ Nationally and in New Mexico, racial and ethnic minority groups are much more likely than non-Hispanic whites to be uninsured, and are less likely to have job-based health insurance coverage. The U.S. Census estimates that 79 percent of New Mexicans had private or government health insurance coverage in 2004 and 21 percent did not have insurance coverage. In the U.S. 84 percent of all people were insured and 15.7 percent were uninsured. This ranks New Mexico as having one of the highest percent of uninsured in the Nation.

- The New Mexico Human Services Division (NMHSD) and Insure New Mexico! Council conducted a Household Survey in Fall 2004 and found the following about the uninsured:⁶¹

- Household income is a significant predictor of the likelihood that people will have health insurance. Among people residing in households below the poverty line, 34 percent do not have insurance. Among people who reside in households earning 185 percent of the federal poverty level, 30 percent do not have health insurance. Only 6 percent of the people residing in high-income households do not have health insurance.
- The age group most likely to have no health insurance is adults between the ages of 18 to 24, followed by adults between the ages 25 to 34. Thirty-one percent of adults 18 to 24 years old and 29 percent of adults 25-34 years old do not have insurance. Children are more likely than young adults to have insurance primarily because many children are covered by Medicaid/SCHIP.
- The education level of adults is a major predictor of whether they have access to health insurance coverage. For example, of the uninsured population, 39 percent have only some high school, while 9 percent are college graduates.
- Native Americans are least likely to have health insurance, although many Native Americans receive free/low cost health care from the Indian Health Service (IHS). Hispanic/Latinos are much less likely to be covered by a health plan than Anglos/whites. Specifically, 28 percent of Native Americans do not have health insurance, 23 percent of Hispanic/Latinos do not have health insurance and 11 percent of non-Hispanic whites do not have health insurance.
- People residing in the rural areas of the state are less likely to have health insurance than are city dwellers. Insurance penetration is lowest in the southern (one-third of Hispanic/Latinos lack insurance) and northwestern (nearly one-quarter of all residents lack insurance) parts of the state.
- The Northwestern part of the state is disproportionately Native American. Among the uninsured, 41 percent work multiple part-time jobs.

NATIVE AMERICANS

In another study conducted by the NMHSD and Insure New Mexico! Council found there are many financial, logistical, or cultural reasons why enrollment rates are not higher among this population.⁶² The following barriers to obtaining health insurance were identified by participants of eight focus groups:

- **Cost.** Low wages among Native Americans compounded by out-of-pocket monthly premiums and/or deductibles and co-pays make health insurance unobtainable for many.
- **IHS Connection/Federal Trust Responsibility.** High quality health care through IHS is an entitlement as promised by the federal government. This leads to the perception that health insurance lacks value because medical care is provided by IHS at no cost to the patient.
- **Cultural Barriers.** The concept of insurance engenders a form of thinking that may have a causal impact on the future, i.e., by purchasing health insurance, one is creating a negative energy that will cause an accident or illness to occur.
- **Trust.** This element is two-pronged: fear of trusting that the insurance company genuinely cares about the patient and fear of being mistreated by a non-IHS facility.
- **Age.** Healthy young people do not see the need to spend money on health insurance they feel they are highly unlikely to need.
- **Bureaucracy.** It is perceived that accessing care is too cumbersome, i.e. making appointments and choosing a doctor from a directory.
- **Understanding Insurance.** There is a lack of awareness and understanding of how health insurance works, in addition to the perception that health insurance has too much fine print and paperwork.

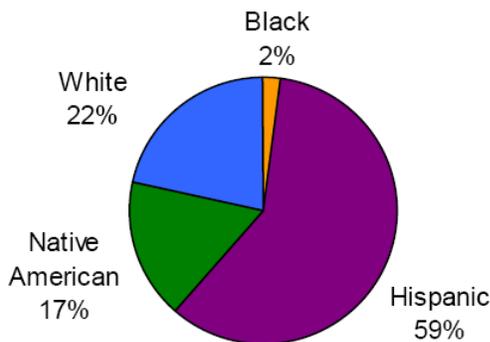
- **Lack of Education and Outreach by Insurance Companies.** Direct mail and large formal forums were perceived as ineffective for a population that prefers direct face-to-face education. Focus group participants recommended one-on-one education and providing information in Native languages.

New Mexico Voices for Children

According to a national report, lack of health insurance coverage is the most important factor to explain the differences in the health status of African Americans and Hispanic/Latinos as compared to Anglos.⁶³

Children of color have less access to primary medical care than do white children. People of color, in general, are less likely to have health insurance or to receive immunizations, routine cancer screenings and regular check-ups.

Figure 15. Source: *NM Voices for Children*
Percent of all Medicaid Enrollees under Age 21 by Race/Ethnicity



Health professional shortage areas & workforce supply

Historically, African Americans, Native Americans, Hispanic/Latinos were banned from most of the nation's health professions schools. For example, African Americans health care professionals, including nurses, physicians and dentists, primarily received their education from all-black schools. Racial segregation in the education and training of health professionals was present up until the civil rights era. Even as late as 1956, two years after the *Brown vs. Board of Education* decision that called for desegregation of the public school system, 7 out of 10 hospital administrators were opposed to integrating hospitals.

New Mexico shares this history and is facing a serious shortage of trained, culturally competent health professionals. Research has shown that a more diverse health workforce can improve access to health care services for underserved minority populations since minority providers typically provide more care for the poor and uninsured and practice in more areas with shortages of providers. Rural, geographically remote Hispanic/Latino and Native American communities in New Mexico experience some of the most significant health disparities in the nation.

New Mexico is one of the most racially and ethnically diverse states in the nation, but this diversity is not reflected among the health care workforce. The health and wellness of underserved people of color is adversely affected by the shortage of diverse health professionals. Having health professionals reflective of the ethnic communities they serve can increase the comfort level of patients and increase the likelihood that their cultural and linguistic needs will be met.

Statistics reveal that minority health professionals are more likely to practice in shortage areas, yet the relatively small number of Hispanic/Latinos and Native American students entering health programs makes recruiting and retaining Hispanic/Latinos and Native American health professionals a daunting challenge. Increasing the supply of qualified Hispanic/Latino and Native American health workers is an important strategy for underserved communities to access quality, culturally competent health services.

Recently, more efforts have been made at the state and university level to increase the number and diversity of health professionals serving our communities. Despite these efforts, New Mexico continues to suffer from an overall shortage of health professionals. The Health Policy Commission conducted a Physician Supply survey⁶⁴ in 2002 and found that of the state's 6,275 actively licensed allopathic and osteopathic physicians in 2002, only about half, excluding residents, are engaged in active practice in New Mexico. While 79 percent of practicing physicians reported no significant practice changes in the next 12 months, 21 percent reported that they were planning to make significant changes by retiring, leaving the state to continue their practice, reducing patient care hours or relocating to another part of the state.

The total number of New Mexico physicians per 1000 population (1.69) significantly lags behind the national benchmark (2.42). Of the 2,179 survey respondents actively practicing in New Mexico, 73 percent (1,583) are non-Hispanic white, 10 percent (212) are Hispanic/Latino, 6 percent (124) are Asian or Pacific Islander, 2 percent (35) are African American, 1 percent (19) are Native American or Alaskan native and 9 percent (206) did not answer.

A 2005 Study on the Impact of Nurse Staffing and Retention Issues on Workforce Development found that:⁶⁵ "It is well documented that New Mexico, along with the entire United States, is in the midst of a nursing shortage that will worsen by the year 2020." In a 2002 report, Projected Supply, Demand and Shortages of Registered Nurses: 2000-2010, the US Department of Health and Human Services' Health Resources and Services Administration (HRSA) predicts that the national nursing shortage will grow by 20 percent.

- Over 41% of New Mexico's RNs and 43 percent of LPNs are over the age 50, which is older than the national average of 46.2 years. This indicates that 43 percent of the workforce may need to be replaced over the next 15 years. Additionally, due to the growing elderly population, more nurses will be needed.
- Approximately 91 percent of the New Mexico nurse workforce is currently employed in nursing either full or part-time. The latest national data available, released by HRSA in 2002 for 2000, reported that 81.7 percent of nurses were employed in the nursing field.
- The 2002-2012 Occupational Outlook projections from the New Mexico Department of Labor (2004) predicts that the state will need an additional 4,520 RNs and 680 LPNs by 2012.

Efforts to increase the nursing workforce meets the mission of Con Alma by increasing patient access to health care through school nurses, maternal-child nurses in public health, home care, long-term care and acute care for the indigent and culturally diverse populations.

Linguistic & Cultural Access

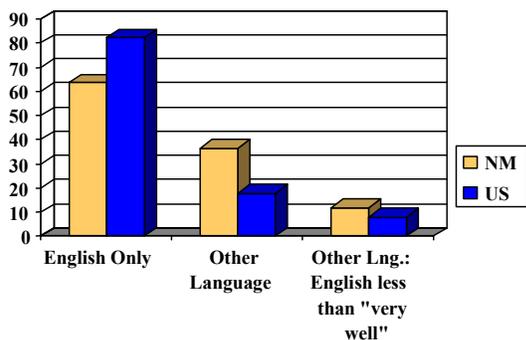
Language problems are one of the leading barriers to accessing and utilizing health care services among Hispanic/Latinos.^{66, 67, 68} Studies that examine the relationship between language and health care find that Spanish speakers are less likely than English-speaking Hispanic/Latinos to have a usual source of health care. Effective communication between patient and provider remains a barrier for language minorities despite federal laws, such as Title VI

Policy Guidance (Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 2000) which require government funded programs or services to ensure meaningful access to health and social services to persons with Limited English Proficiency (LEP).

There are other health professional competencies that when lacking may inhibit access and the quality of care delivered such as: understanding of special health needs of Hispanic/Latinos across the life-span, cultural differences in lifestyle, knowledge of traditional medicine practices, variations in help seeking behaviors, awareness of behavioral health needs, and regional differences among Hispanic/Latino sub-populations.

In New Mexico, 63.5 percent of persons five years and older speak only English at home.⁶⁹ This was the 2nd smallest percentage among the 50 states and the District of Columbia. Only California had a smaller proportion. Nationally, 82.1 percent spoke only English at home. The Census 2000 questionnaire allowed those respondents that reported speaking another language to indicate how well they spoke English. In New Mexico, 11.9 percent spoke a language at home and spoke English less than “very well.” This is the 5th highest percentage in the country and compares to 8.1 percent for the nation as a whole.

Figure 16. Language Spoken at Home in 2000
Percent of Persons 5 Years & Over By
Language & Ability to Speak English -
New Mexico and U.S.
Source: U.S. Census



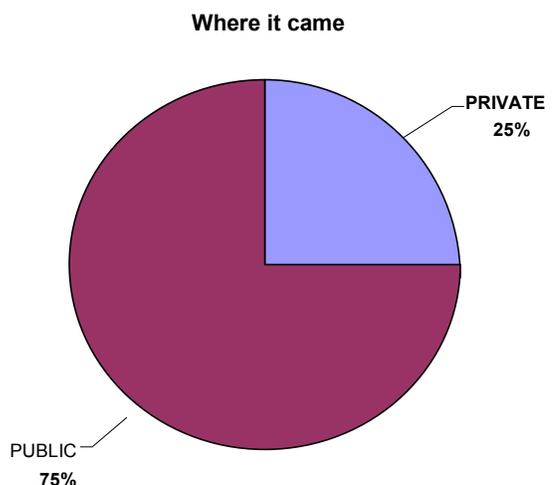
Health Care Financing

Federal budget cuts and the devolution of authority to finance health care has become a burden to the state of New Mexico. The economic consequences to the safety-net providers and especially to the communities they serve which are primarily racial and ethnic minorities are devastating. This section provides data on the growth in health care expenditures and Medicaid, increased uncompensated health care costs, and budget cuts to the Indian Health Services.

HEALTH EXPENDITURES 2002

In 2002, the estimated cost of providing health care to New Mexicans was \$7.8 billion. Approximately 75 percent of health care expenditures were publicly financed (\$5.8 billion).⁷⁰ Figure 17 shows expenditures for health care services by payer source for calendar year 2002. Approximately 75 percent, or \$5.8 billion, of the health care expenditure was publicly financed and 25 percent, or \$1.9 billion, was privately financed (Figure 17). This estimate is consistent with the 2004 study “Government Financed Healthcare in New Mexico,”⁷¹ which also found that in 1999, three quarters of New Mexico's \$6 billion health care expenditure was publicly financed. Compared to another estimate made in 1996,⁷² the portion that government contributed to New Mexico's health care spending was 51 percent. This represents a 7.8 percent annual growth rate in government-financed health care.⁷³

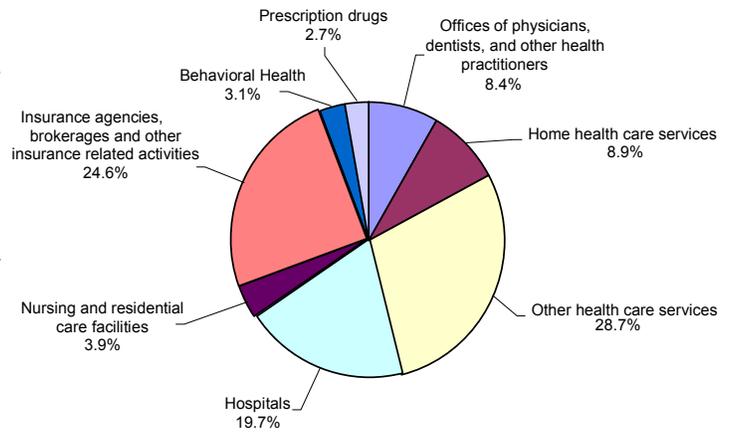
Figure 17. New Mexico Health Care Spending in



Of the \$7.8 billion in health care expenditures in 2002, the federal government paid \$4.97 billion or 64 percent. Total state and local spending was approximately \$872 million, or 11 percent. Of the \$778 million (10 percent) contributed by state government, \$432 million came from the state Medicaid share and \$293 million from the Department of Health. Counties covered about one percent of health care costs, or \$94 million. Of the \$1.9 billion contributed from private sources, 54 percent (\$1.1 billion) was paid by fully insured plans and 38 percent (\$741 million) was paid by self-insured plans.⁷⁴

Figure 18 shows that in 2002, the largest percentage of spending – almost 29 percent, or \$2.2 billion - went to other health care services, which includes ambulatory health care services (except offices of physicians, dentists and other health practitioners), outpatient care centers, medical and diagnostic laboratories, and other services that were not uniformly categorized by the New Mexico County Indigent Fund and Corrections Department.⁷⁵ The second-largest category covered insurance agencies, brokerages and other insurance-related activities at 25 percent (\$1.9 billion). Included in this category is the full amount expended to pay insurance claims for 2002. Hospitals accounted for 20 percent (\$1.5 billion) of the health care spending, followed by home health care services at 9 percent (\$692 million), offices of physicians, dentists and other health practitioners at 8.4 percent (\$653 million), nursing and residential care facilities at 3.9 percent (\$303 million), behavioral health at 3.1 percent (\$241 million) and prescription drugs at 2.7 percent (\$212 million).⁷⁶

**Figure 18. New Mexico Health Care Spending in 2002:
Where it Went**



INDIAN HEALTH SERVICES

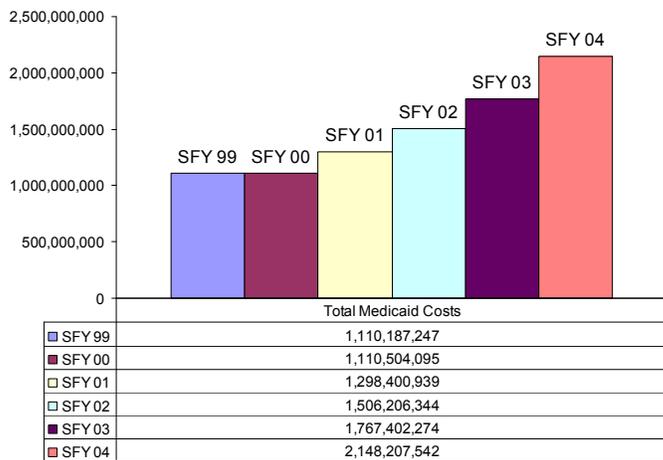
Of the \$7.8 billion spent on health care in New Mexico in 2002, \$228.2 million came from the Indian Health Services to the Albuquerque and Navajo Area offices.⁷⁷ Chronic under-funding of American Indian and Alaska Native health care by the federal government has weakened the capacity of the Indian Health Service, tribal governments and the urban Indian health delivery system to meet the health care needs of the American Indian and Alaskan Native population. The Indian Health Service (IHS) per capita expenditures for American Indians and Alaskan Natives are half of what is spent for Medicaid beneficiaries, a third of that spent by the Veterans Administration, and half of what the federal government spends on federal prisoners' health care.⁷⁸

As of March 2006, Congress has still failed to reauthorize the Indian Health Care Improvement Act (IHCA) which would make a series of improvements to the Indian health care delivery system.⁷⁹ The Department of Justice has an issue with provision of health care to Urban Indians expressing that Urban Indians are not included in the definition of what constitutes an "Indian" for the purposes of receiving care from health clinics, so would not face equality challenges as do federally recognized tribes.

MEDICAID

Medicaid growth in New Mexico has been similar to the national trend. In 1991, the total state and federal expenditures in Medicaid was approximately \$341 million of which the state contributed about \$88 million, or 25 percent. In SFY 2004, Medicaid expenditures exceeded \$2 billion, requiring a state contribution of over \$400 million (Figure 19).⁸⁰

Figure 19 --- Total Medicaid Expenditures, New Mexico 1999-2004 (HSD, MAD)



The University of New Mexico Health Sciences Center financial report presented at the Statewide Health Summit in December (2005) showed that the cost of uncompensated care in fiscal year 2005 was \$131,267,834 which is \$44,876,287 in excess of funds directly allocated for uncompensated care. The uncompensated care is provided by University of New Mexico Hospital (UNMH) and the School of Medicine (SOM) faculty, who are the doctors for UNMH. Additional public funds are needed to adequately address the current public mission. Funding to cover the current uncompensated care gap must be addressed, as well as support to build capacity for future needs.

UNCOMPENSATED CARE

In a state with a high proportion of uninsured residents, it is important to note that in 2002, the uncompensated care costs reported by the New Mexico Hospital and Health Systems Association was \$209 million and \$6.6 million for private practice dentists (Table D).⁸¹ Uncompensated care is a measure of hospital care provided by which *no payment* was received from the patient or the insurer.⁸²

Table D. Estimated Uncompensated Care Costs, 2002

| | |
|--|----------------------|
| New Mexico Hospital and Health Systems Association | \$209,000,000 |
| New Mexico Dentists | \$ 6,640,000 |
| TOTAL | \$215,640,000 |

STATE HEALTH POLICY : PAST, PRESENT & FUTURE TRENDS

Past - The rising costs of health care, federal reform efforts resulting in the devolution of increased decision-making and fiscal responsibility to the states, the growth in the number of uninsured and decreasing state budgets have posed tremendous challenges to state policymakers and donors.⁸³ A comprehensive review of state and federal health policy reform efforts in the past fifteen years found that New Mexico has kept pace with other states in implementing the following strategies in an attempt to improve health care coverage and address an increasing magnitude of provider issues:⁸⁴

- 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. These funds also contribute to the County Supported Medicaid Fund and Sole Community Provider Hospital Fund. The initial assessment for the County Supported Medicaid Fund was used by the state to expand Medicaid eligibility to pregnant women with incomes less than 185 percent of the Federal Poverty Level (FPL). Medicaid expansion in the mid-1990s provided coverage for all children less than 19 years of age in households with incomes less than 185 percent of the FPL. Implementation of the State Children's Health Insurance Program (SCHIP) expanded Medicaid to cover children with family incomes up to 235 percent of the FPL.
- The state also provides direct funding to community health centers for operations through the Rural Primary Health Care Act. Grants and low-interest loans for capital and infrastructure are funded by the Primary Care Capital Fund Act.
- The New Mexico Medical Insurance Pool, the state's high-risk pool, is financed through individual premiums and insurer assessments. The state implemented the Health Insurance Alliance to offer health insurance options for small employers. Modifications to the Small Group Rate and Renewability Act limited the use of rating factors and pre-existing conditions/exclusions, and the Minimum Healthcare Protection Act provided a limited health care benefit package.
- The Health Care Purchasing Act sought to consolidate the purchasing of health care coverage for state employees, public school employees and public retirees for greater efficiency and cost savings.
- Creation of the County Maternal and Child Health Plan Act encouraged counties to develop comprehensive, commu-

nity-based maternal and child health services to meet the needs of childbearing women and their families.

- The Patient Protection Act was established as protection for consumers and for providers in managed health care systems in order to ensure fair treatment of patients and delivery of good quality health care services.
- Numerous prescription drug coverage initiatives have been introduced or implemented to address the growing dependence on drug therapy and its cost.
- Medicaid and State Children's Health Insurance waivers were utilized to provide increased coverage, limit benefits and provide more flexible programs for their recipients.

Present - Governor Bill Richardson has proclaimed 2006 "The Year of the Child" and wants to assure that all New Mexico children, especially those ages 0-5, have an opportunity to obtain health insurance coverage. The Human Services Department plans to initiate an aggressive outreach campaign to target children and their families.

As a result of community advocacy efforts at a state-wide health summit sponsored by University of New Mexico Hospital, the Governor reversed his 6 month Medicaid Recertification back to 12 months. Beginning July 1, 2006, certification for income-related Medicaid eligibility for children and families will be 12-month certification period.

The executive and legislative leadership continue to engage in political wrangling on how to best address the high rates of insurance costs. Through the State Coverage Initiative program and other solution through Insure New Mexico!, the NMHSD is working with several public and private entities to reduce insurance costs for New Mexicans. This includes outreach to Native American individuals and employers.

To increase Medicaid enrollment, \$1 million was appropriated in State Fiscal Year 2006 to assist with enrolling eligible individuals into Medicaid, targeting Native American and Hispanic/Latino children.

For New Mexico, improving educational support of children is a valuable investment for increasing earning capacity, escaping poverty, and having health insurance coverage.⁸⁵ Investing in our children's education is good health policy.

Future Trends - The future challenges facing the state include the continued inequalities in health by race and ethnicity, growth of aging population, the increased prevalence of disability, the rising costs of long-term services and health care, and the state's limited fiscal viability.

Con Alma Health Foundation, Inc. (CAHF) has the opportunity to partner with other public and private entities in creating solutions to our health disparities crisis. This would enable us to assure that disparities are prioritized and addressed systematically through improved data collection of where health status disparities exist and where they are getting worse.

SOLUTIONS: GRANTMAKING IN ACTION

RECOMMENDATIONS FOR GRANT- MAKING AND BEYOND

While the report calls for a strengthening of resolve and resources to address health disparities, it is strongly recommended that CAHF continue to build on its track record of bringing positive, systemic change to pre-adolescent health issues in New Mexico.

The following two priority areas, *Invest in People* and *Invest in the System*, and their corresponding recommendations for grant-making and beyond, are based on the

evidence of disparities in New Mexico. They are adapted from best practices for interventions to address these disparities.^{86, 87, 88, 89, 90}

Additionally, CAHF includes assets that go *beyond* the dollars with which it makes grants, these are provided below as **Other Recommendations**. The energy and talent of its board and community advisory members, its staff and network of community-based organizations provide important non-cash assets to the community and add value to its grants. Non-cash recommendations that help to improve the effectiveness of CAHF and the communities it serves are also included under "Invest in the System."

INVEST IN PEOPLE

Strategy1: Youth and Workforce Development.

The data in the report emphasize the need to continue to address systemic change in pre-adolescent health in New Mexico as well as to build a committed and skilled health workforce for the future. This is particularly critical to rural communities and will require investment in human capital and other initiatives to develop people who will ultimately be the catalysts and engines of change.

Recommendations:

- Continue to fund nonprofit organizations that serve preadolescent children (below age 10) in activities that include family, school and communities in providing preventative health and oral health as well as reducing youth risk behaviors (obesity and diabetes, substance abuse, teen pregnancy, domestic violence, injury, etc.).
- Provide grants to nonprofit organizations that strive to eliminate health disparities by addressing the specific needs of the populations they serve, such as those that provide culturally and linguistically appropriate health promotion and disease prevention services.
- Provide grants to nonprofit organizations that recruit and train for entrance into the health workforce and that assist low-income residents with entrance into health care careers that offer livable wages, including such jobs as community health workers/promotoras, licensed vocational nurses, certified nursing assistants,

registered nurses, medical coders, in-home health support aides and medical, lab assistants, mental health workers and physicians. Include organizations that work upstream at middle and high schools to attract youth and inspire them to consider the health care industry.

- Provide grants to nonprofit organizations that utilize and evaluate indigenous models of health care that aim to reduce health disparities in health services access, quality of care and improve health conditions of racial and ethnic minorities. Innovative models for consideration are:
 - Community Health Workers/Promotores as liaisons between health care consumers and providers to promote “patient empowerment” among groups that traditionally lack access to adequate health care.
 - The role of traditional healers such as medicine men and women and curanderas/os in the prevention and treatment of the illness and promotion of holistic health for communities of color (both physical and behavioral health).
 - Provide grants to nonprofit organizations that support leadership development for people of color in the health professions and that advocate for public and institutional policies to promote diversity in the health professions. Involving local community members in advocacy efforts not only sharpens their leadership abilities, but it also leaves a team of motivated individuals who will be able to respond to new health issues as they emerge.

Strategy 2: Developing political and technical skills.

Local leaders across the state are essential for improving health and changing the system. However, certain ingredients must be present and certain skill sets developed for communities to be successful agents of change.⁹¹ Re-engaging people into the

discussion on the importance of health care and helping people to organize them so that they can act to meet their own needs are two critical components to success.

Recommendations:

- Provide support and strengthen nonprofit organizations that seek to improve the health of underserved populations through community organizing to build power in order to collectively effect change.
- Provide grants to nonprofit organizations that offer technical and capacity building skills through group training, one-on-one coaching, linkage with other resources, and infusion of information to address stated needs. This is essential to developing and strengthening organizations and communities. Improved organizational and individual capacity will last longer in the community than grant funds.
- Provide grants to nonprofit organizations for collaborations, such as partnerships between public health departments and community-based health programs for leadership development and training.
- Provide grants to organizations offering structured mentoring programs that address community health issues. Mentoring programs have the potential to tap underutilized community resources and strengthen social networks for children, youth and adults.

INVEST IN THE SYSTEM

While there are no easy answers to the problem of health disparities, Con Alma should continue to build on its track record of providing resources and engaging the community in the goal of eliminating inequalities in health care in New Mexico. Con Alma can serve as a catalyst for positive, systemic change in health care at all levels of the system. Thus, the following recommendations addresses "systems reform" and suggestions on where to invest the foundation's resources in order to better serve all New Mexicans.

Recommendations:

- Continue to provide support to small, innovative and promising programs that

develop new approaches to improving health access and that establish evidence of effective strategies and interventions specific to New Mexico. The development of new models of care and services for vulnerable populations, people who typically fall through the cracks in our health care system, is essential to Con Alma's mission.

- Continue to provide general operating support to nonprofit, health-related organizations to help underwrite the day-to-day administrative, infrastructure and overhead costs that enable them to carry out their mission. The valuable work accomplished by nonprofit organizations is rooted in their ability to meet basic organizational needs.
- Provide increased grants to coalitions, collaborations and local networks to organize systems level interventions and develop public policies that move toward achieving health insurance coverage for all New Mexicans, increasing access to and quality of health care and reducing health disparities.

Other Recommendations:

- Continue to leverage Con Alma funds by developing new community relationships and skills through cost-sharing partnerships with other foundations and governmental agencies.
- Continue to promote collaboration among advocacy organizations focused on different constituencies. Act as a link between grassroots community organizers and policy advocacy networks.

- Continue to conduct research on issues and bring attention to a problem or solution in the community through meetings, publications and training that provide instruction on how to advocate more effectively.
- Continue to participate in advocacy networks that pool their resources and ideas in order to influence improved health policy making process at state and local levels.
- Support programs that foster collaboration locally with residents, community-based organizations, educational institutions, unions, employers and public agencies to ensure a community-based perspective. Communities must be engaged in current discussions about causes of, and solutions to, social disparities in health.

While Con Alma Health Foundation, Inc. is the largest health care foundation in New Mexico, it cannot do everything. There are only so many issues that can be dealt with at a time, and no foundation can successfully address any of them unilaterally. Collaboration with other foundations and government agencies is a critical component of success. The amount of resources that Con Alma will put into any one issue will change over time as the environment changes. The only way to keep this in balance is by continually asking what are the most pressing issues, and how can we use our resources most effectively to make a difference.

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