Action Plan: Reducing Unintended Teen Births

Summary

New Mexico has seen significant declines in teen births, dropping 41 percent from 2013 to 2018, yet rates remain among the highest in the nation. Hispanic women, women ages 18 and 19 years, and 13 counties account for the majority of teen births. Although teenage parents may flourish or struggle depending on particular circumstances, teen parenting, on average, is closely connected to educational, economic, and health challenges. As a result, the 1,659 teen births in New Mexico in 2019 cost the state an estimated $15.7 million in a year.[i]

Economic and educational opportunities, as well as access to reproductive healthcare, impact the choices that adolescents make about whether and when to become parents. While building economic opportunity is a long-term challenge, more immediate work can focus on ensuring delivery of evidence-based sexual health education and youth development programs, increasing access to reproductive healthcare, and providing support to pregnant and parenting teens.

In 2018, New Mexico had the seventh highest teen birth rate in the country, with unintended teen births in 2019 costing the state an estimated $15.7 million in 2019.

This action plan proposes an ambitious yet achievable goal to reduce unintended teen births in New Mexico and narrow the gap between state and national rates. Targeted state funding of evidence-based programs can bolster local community engagement and regular monitoring of progress will help refine action to reach the goal.

Action Plan

Program Evaluation Unit
Legislative Finance Committee
December 8, 2020

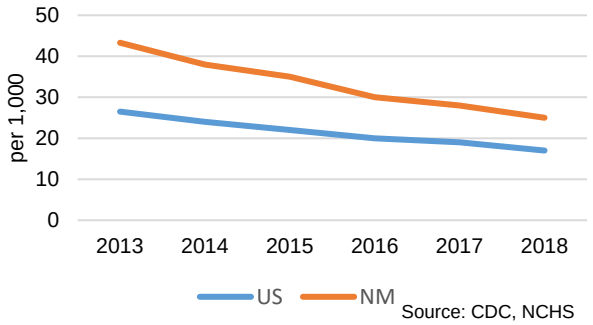
NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

The Issue: Unintended Teen Births Can Disrupt the Lives of Families and Cost an Estimated $15.7 million in 2019

Planning a pregnancy improves outcomes and opportunities for both parent and child, yet the majority of teen pregnancies are unintended. While teen birth rates are declining, New Mexico's rates remain higher than national averages. Teen births are most prevalent among Hispanic women, followed by Native Americans, and women 18 and 19 years old account for nearly three-quarters of teen births. Geography also plays a role, with counties in the Northwest and Southeast regions of the state accounting for the majority of teen births. In FY20, $4.9 million of state and federal funds supported pregnancy prevention programs in New Mexico.

Teen parenting is associated with educational, economic, and health challenges for the parent and child. Unintended pregnancies can disrupt the lives of the families involved and create significant social costs to the state, especially in the case of births to teenage parents. According to the Centers for Disease Control and Prevention (CDC), 77 percent of all teen pregnancies are unintended. Over the last three decades, New Mexico has consistently been among the seven states with the highest rates of teen births, with 24.4 per 1,000 women ages 15 to 19 in 2019.[ii]

Chart 1. New Mexico and US Teen Birth Rates



Source: CDC, NCHS

Although individual teenage parents may flourish or struggle depending on particular circumstances, on average, unintended teen parenting is associated with educational, economic, and health challenges. With only 50 percent of teen mothers graduating from high school on average, teen parents face decreased earning potential, and 63 percent of teen mothers receive public assistance within 12 months after giving births.[iii] [iv] These challenges affect not only adolescent parents but also their children. Compared with children born to older mothers, children of teen parents are more likely to drop out of high school, become teen parents themselves, enroll in Medicaid and the Children's Health Insurance Program, experience abuse and neglect, and, for sons, end up in the prison system.[v] By delaying pregnancy, however, these outcomes improve as adolescents pursue educational opportunity and acquire resources.

As a result, avoiding unintended teenage pregnancies can generate millions in annual public savings. Avoiding unintended pregnancies can improve outcomes and opportunities for individuals and also generate public savings. According to the bipartisan organization Power to Decide (formerly known as the National Campaign to Prevent Teen and Unplanned Pregnancy), unintended teen births in New Mexico in 2019 cost $15.7 million in one year. This includes costs associated with Medicaid spending from prenatal care, labor, delivery, postpartum care, and a year of infant care, in addition to spending on public assistance during pregnancy and one-year postpartum.[vi]

Table 1. Teen Birth Rates – New Mexico and United States (per 1,000)

	NM	US
2013	43.3	26.5
2018	25.3	17.4
% Decline from 2013 to 2018	41%	34%

Source: CDC, NCHS

Recognizing the importance of this issue in New Mexico, the Legislative Finance Committee published a report in 2015 exploring ways the state could expand evidence-based programs and services for teens. Recommendations from that report included setting a goal, prioritizing resources to high-need areas, and expanding access to the most effective forms of contraception. With teen birth rates declining nationally and in New Mexico, important progress has been made, but high teen births remain a significant issue.

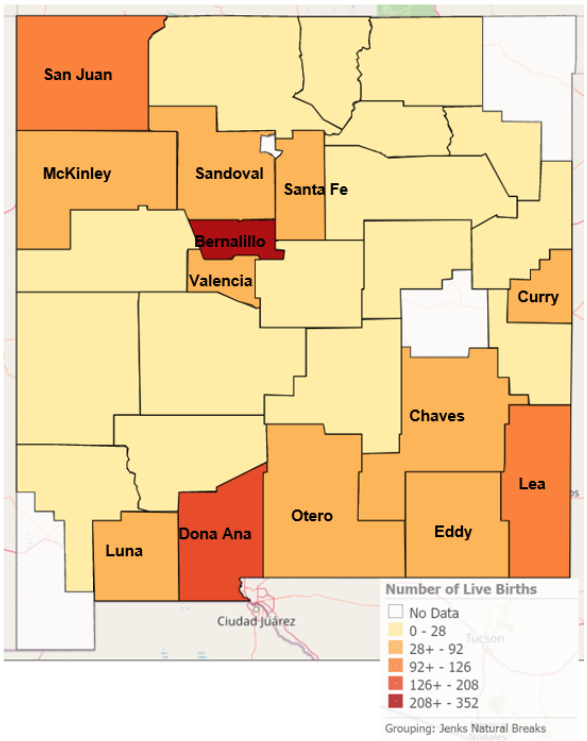
High statewide rates obscure differences by race and ethnicity, age, and geography.

In 2018, New Mexico had the seventh-highest teen birth rate in the country for adolescents 15 to 19 years old, but certain populations and geographies are affected more than others. Counties in the Northwest and Southeast have the highest numbers of teen births, and Hispanic teens account for a disproportionate number of those births. Statewide, older teens (ages 18 and 19) represent nearly three-quarters of births.

New Mexico's declining teen birth rate for adolescents 15 to 19 years old remains higher than national averages. From 2013 to 2018, the teen birth rate fell faster in New Mexico (a 41 percent decline) than across the country (a 34 percent decline), reducing the difference between the New Mexico and U.S. birth rates. This represents significant progress. However, in 2019, New Mexico's teen birth rate (24.4 per 1,000) remained higher than the provisional national average (16.6 per 1,000).[vii] Teen births are measured as the annual number of births to women ages 15 to 19 years per 1,000 women in that age group.

Teen births are concentrated in 13 counties in the Northwest and Southeast. While average statewide rates for adolescents 15 to 19 years old are high, local numbers vary signifcantly. In 2019, six of New Mexico's 33 counties reported a teen birth rate for adolescents 15 to 19 years old of zero or too small of a number to report. Of the remaining 27 counties, nine had rates ranging from 13.8 to 23.8 per 1,000, closer to the national average of 16.6 births per 1,000. However, six counties had rates significantly higher, ranging from 45.4 to 63.8 births per 1,000. Because much of the state is rural, counties with low population density have higher teen birth rates but still relatively low absolute numbers of teen births. For this report, therefore, high numbers of teen births (rather than rates) will be used to identify areas of need. Thirteen counties accounted for 87 percent of teen births in 2019: Bernalillo, Doña Ana, Lea, San Juan, Chaves, Otero, Santa Fe, Curry, Eddy, Sandoval, Valencia, Luna, and McKinley. (See Appendix A for numbers and rates of teen births by county in 2019).

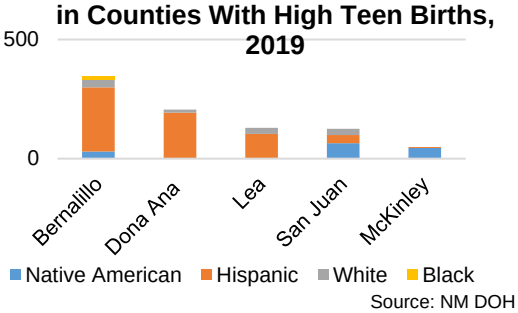
Figure 1. Adolescent Births in New Mexico by County 2019



Source: DOH

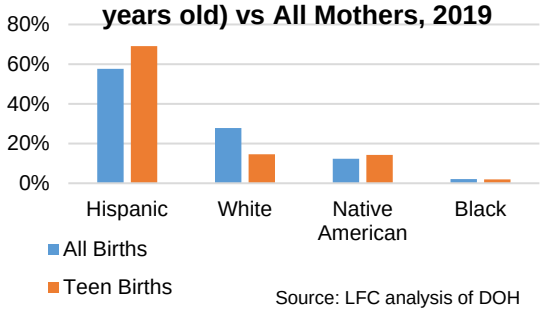
Hispanic women account for the majority of teen births for adolescents 15 to 19 years old in New Mexico. While births to Hispanic mothers represented 58 percent of all births in New Mexico in 2019, they represented 69 percent of teen births. The trend was flipped for white mothers, with 28 percent represented across all births and 15 percent represented among teen births. Nationally, Hispanic adolescents also have the highest rates of teen births. Among counties with significant numbers of teen births, Native American adolescents accounted for the majority of teen births in San Juan and McKinley counties. The Pew Trusts notes the racial and ethnic disparities are both a cause and consequence of poverty.

Chart 2. Race and Ethnicity of Teen Mothers (15 to 19 years old) in Counties With High Teen Births, 2019



Source: NM DOH

Chart 3. Race and Ethnicity of Adolescent Mothers (15 to 19 years old) vs All Mothers, 2019



Source: LFC analysis of DOH

Births to older teens represent nearly three-quarters of all teen births. Adolescent births are typically measured as births to girls ages 15 to 19 years old. However, when disaggregated further, data reveal that births to women 18 and 19 years old account for the majority of these births in New Mexico, 73 percent in 2019. While births to younger teens (15 to 17 years old) represent an acute challenge to high school completion and future success, older adolescents (18 and 19 years old) also face potential obstacles to pursuing postsecondary education or training. Different strategies can support young women at different ages, both by improving prevention and by supporting expecting and parenting young adults.

Federal and state funds support $4.9 million in pregnancy prevention programs annually.

Both state and federal funds support pregnancy prevention programs. In addition to state general fund allocations of $305 thousand in FY20, federal funds totaled $4.5 million from these sources: Teen Pregnancy Prevention grants (TPP), the Title X Family Planning Program of the Public Health Service Act, the Temporary Assistance for Needy Families Program, Title V Abstinence Education Grant Program (AEGP) and the State Personal Responsibility Education Program. Grants from the TPP program are awarded directly to providers, while other federal funds flow through the state. (See Appendix B for a full description of federal funds).

Table 2. State and Federal Funds Allocated to Teen Pregnancy Prevention, FY20

Funding Source	FY20
Federal Teen Pregnancy Prevention Grants (TPP)	$2,352,022
Federal Title X*	$1,127,000
Federal Temporary Assistance For Needy Families	$200,000
Federal Title V Funds	$551,650
Federal PREP Grant Funds	$295,871
Fee Revenue	$50,150
State General Fund	$305,379
Total	$4,882,072

*23 percent of total Title X grant to reflect share of teen clients

Source DOH and FFS

Contributing Factors and Potential Solutions To Reduce Unintended Teen Births

Both immediate and more systemic factors contribute to high rates of unintended teen births. In New Mexico, the Departments of Health (DOH), Public Education (PED), Early Childhood Education and Care (ECED), and Human Services (HSD) fund programs that address some of these contributing factors.

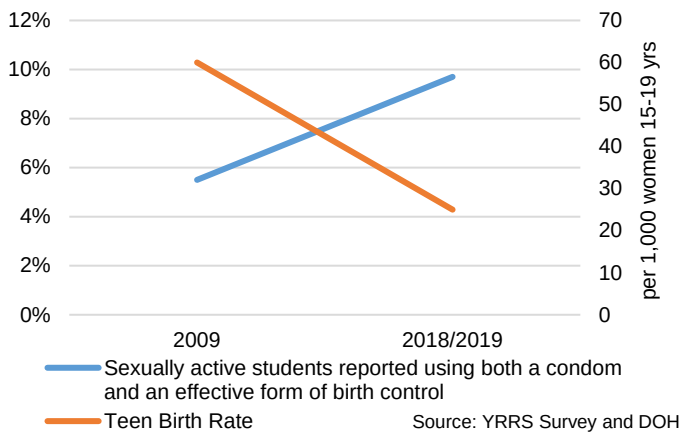
Both deeply rooted and more immediate factors contribute to high rates of unintended teen birth rates and require different solutions.

Socioeconomic factors may contribute to high rates of teen births while sexual activity and access to contraception and sexual health education also play a role. Programs that address access provide more immediate solutions, while more systemic change, outside the scope of this report, will be needed to address underlying socioeconomic inequities.

Income inequality is linked to teen births. Research suggests an association between teen births and low-income status. More specifically, the research looks at whether a family is underemployed, has low socioeconomic status, low education levels, or lives in a disadvantaged neighborhood or in an area of income inequality.[viii] Research has also found a link between income inequality and teen birth rates. A paper published by the National Bureau of Economic Research found that in places with higher income inequality, low-income girls are more likely to become teen parents.[ix] The findings added quantitative support to a long-standing ethnographic and sociological argument that despair and hopelessness contribute to rates of teen births.[x] [xi]The study found that a low-income teen girl living in an area of high-income inequality, where her desired economic and educational future seems inaccessible, might choose motherhood over pursuing her education or beginning a career. Interventions that address the "culture of despair"[xii] faced by low-income teen girls could help respond to this underlying root cause of teen births.

Declining sexual activity and increased contraceptive use contributed to declining teen birth rates. CDC attributes the declining national trend in teen births to decreased sexual activity among adolescents and increased use of contraception among those who are sexually active. In New Mexico, the data present a similar story. According to the Department of Health's *Youth Risk and Resiliency Survey* (YRRS), the percent of students in high school who reported being sexually active declined from 32.6 percent in 2009 to 25.2 percent

Chart 4. NM Teen Birth Rate and Sexually Active Adolescent Contraceptive Use



Source: YRRS Survey and DOH

in 2019. Additionally, those reporting using both a condom and another effective birth control method increased from 5.5 percent to 9.7 percent. Over the same period, the New Mexico teen birth rate declined.

Medically accurate, comprehensive sexual health education can contribute to a reduction in unintended teen births. A comprehensive approach to sexual health education includes developmentally appropriate, medically accurate, and inclusive information on human development, healthy relationships, decision-making, contraception, and disease prevention.[xiii] Comprehensive sexual health education can help reduce risky sexual behaviors and increase protective behaviors.[xiv] One study found teens who receive comprehensive sexual health education were 40 percent less likely to report a pregnancy than those who received no sex education and 50 percent less likely than someone who received abstinence-only education.[xv] The same study found comprehensive sexual health education does not increase sexual activity.

Agencies fund evidence-based programs to reduce teen births.

The Departments of Health (DOH), Public Education (PED), Early Childhood Education and Care, and Human Services (HSD) fund evidence-based programs or approaches identified by the Pew Trust's Results First Clearinghouse as being highly rated to address unintended teen pregnancy, sexual activity, sexual risk behaviors, contraceptive use, maternal health, birth outcomes, and parenting, among other things. These programs include youth development efforts (including the Teen Outreach Project and Adult Identity Mentoring), case management for pregnant and parenting teens (Graduation Reality and Dual-Role Skills or GRADS), home visiting for pregnant and parenting adults to promote infant and child health, school-based health centers (SBHC) and long-acting reversible contraceptive (LARC) access.

Table 3. Programs Shown to Reduce Teen Pregnancy

Program Name	Evidence Rating	In New Mexico?
Education-Based Initiatives		
Wyman's Teen Outreach Program (TOP)	Second highest Results First rating	Yes
Adult Identity Mentoring (Project AIM)	Highest Results First rating	Yes
Intensive case management for pregnant & parenting teens	Second highest Results First rating (note: GRADS as a model of this approach has not been evaluated)	Yes
Home visiting	Highest Results First rating	Yes
Reproductive Healthcare Initiatives		
School-based health clinics with reproductive health services	Second highest Results First rating	Yes
Long-acting reversible contraceptive access	Second Highest Results First rating	Yes

Source: Results First Clearinghouse Database

These agencies also collaborate to address sexual health education and access to reproductive healthcare. HSD and DOH both engaged with the Association of State and Territorial Health Officials' LARC learning community, as well as a state workgroup on the topic. And a recent federal opportunity, called "Leadership Exchange for Adolescent Health Promotion," provided an venue for PED's Safe and Healthy Schools and DOH's Office of Adolescent and School Health, among others, to collaboratively plan. The grant provided technical assistance for policy assessment, implementation, monitoring and evaluation specific to sexual health education, sexual health services, and safe and supportive environments.

Setting a Goal: New Mexico Could Reduce Unintended Teen Births by 41 percent by 2024

Setting an ambitious goal for reduced unintended teen births may help the state reach better outcomes. The state will also need to create a habit of accountability by regularly meeting with local partners to include their priorities, voices, and expertise. Action can then be targeted. A regularly updated scoreboard with relevant data on impact will help refine action and meet the goal.

Setting a goal helps improve outcomes.

Setting goals and creating a strategic plan can lead to improved organizational performance.[xvi] [xvii]Setting goals may be particularly effective when the goal is both ambitious and made public. Goal setting is a key component of State Stat, a process originally established in Baltimore as CitiStat and now used in multiple states to increase government accountability and success by using data and evidence to drive change. In a simplified version of this iterative process, data is first analyzed to identify a problem and set a goal. A habit of regular accountability is established to review data with relevant stakeholders and evidence-based action is taken to reach the goal. Data is monitored on a scoreboard to adjust and refine the goal as needed. Outcomes improve when solutions are data-driven.

Reducing the teen birth rate (for 15 to 19 year olds) by 41 percent by 2024 would save the state $6.4 million. New Mexico has been steadily reducing the gap between the state's teen birth rate and national averages. If the trend from the last decade of an annual rate of decline of 8 percent continues in the future, New Mexico would slightly exceed the 2019 provisional national rate of 16.6 births per 1,000 girls by 2024.[xviii] However, with coordinated and targeted strategies across multiple agencies, New Mexico can outpace this 8 percent annual decline and aim for a more ambitious 10 percent annual decline. This would translate to a teen birth rate of 14.4 per 1,000 for adolescents ages 15 to 19 years old in 2024 or a reduction of 680 avoided unintended teen births. The Power to Decide organization estimates this would save New Mexico $6.4 million. [xix]

Identifying counties with high numbers, as well as lower than average declines, in teen births for adolescents 15 to 19 years old can help prioritize efforts. Thirteen counties accounted for 87 percent of teen births in New Mexico in 2019. While all of these counties saw average four-year rates of decline in teen births from 2014 to 2019, some counties had higher rates of decline than others. The national average annual rate of decline over this five-year period was 8 percent. Six of the counties with the highest teen births had average declines less than 8 percent. By focusing effective, evidence-based

Figure 2. Iterative Goal Setting Process

Source: Adapted from O'Malley 2019

Table 4. Teen Birth Rate Goal for New Mexico

	Teen Birth Rate	Teen Births
NM in 2019	24.4	1659
Target in 2024	14.4	979

Source: LFC analysis

Table 5. Counties with High Teen Births and High Rates of Declining Births

County	2019 Teen Births	YOY % change (four-year average)
Bernalillo	352	-9%
Dona Ana	208	-7%
San Juan	126	-9%
Lea	118	-4%
Eddy	92	-13%
McKinley	86	-23%
Chaves	84	-2%
Curry	72	-8%
Sandoval	69	-13%
Valencia	65	-2%
Santa Fe	64	-10%
Otero	52	-3%
Luna	51	-9%
U.S.		**-8%**

Source: LFC analysis of DOH data

solutions on these six counties, the state could make progress in reducing the overall teen birth rate.

There were also some bright spots over this period, with counties decreasing their teen birth rates faster than both the state and the nation. McKinley (at 23 percent) and Sandoval and Eddy (at 13 percent each) stand out as noteworthy examples.

DOH's current goal to reduce teen birth rates by 5 percent annually could be more ambitious and targeted. The teen birth rate is a DOH indicator for the health of the population for which the whole state is accountable. While DOH serves as the lead on the indicator, there is shared responsibility across agencies to provide a variety of services to help address the indicator. According to the requirements of the Accountability in Government Act, DOH has chosen two performance measures to evaluate its agencie's progress in reducing teen births. One is the number of teens that complete pregnancy prevention programs, and the other is the percent of teens seen in public health offices who received the most effective or moderately effective forms of contraception. In FY20, both measures surpassed the established targets. DOH could consider refining its performance measures to target areas of the state with higher teen births (see Table 5). Additionally, DOH has had a goal to reduce the teen birth rate by 5 percent annually. With significant declining teen birth rates, this goal has been met six out of the last eight years from 2012 to 2019. By targeting program expansion and partnering with local communities and other agencies to increase access to evidence-based care, the more ambitious goal could be met.

Table 6. DOH Indicator and Performance Measures Related to Teen Pregnancy Prevention

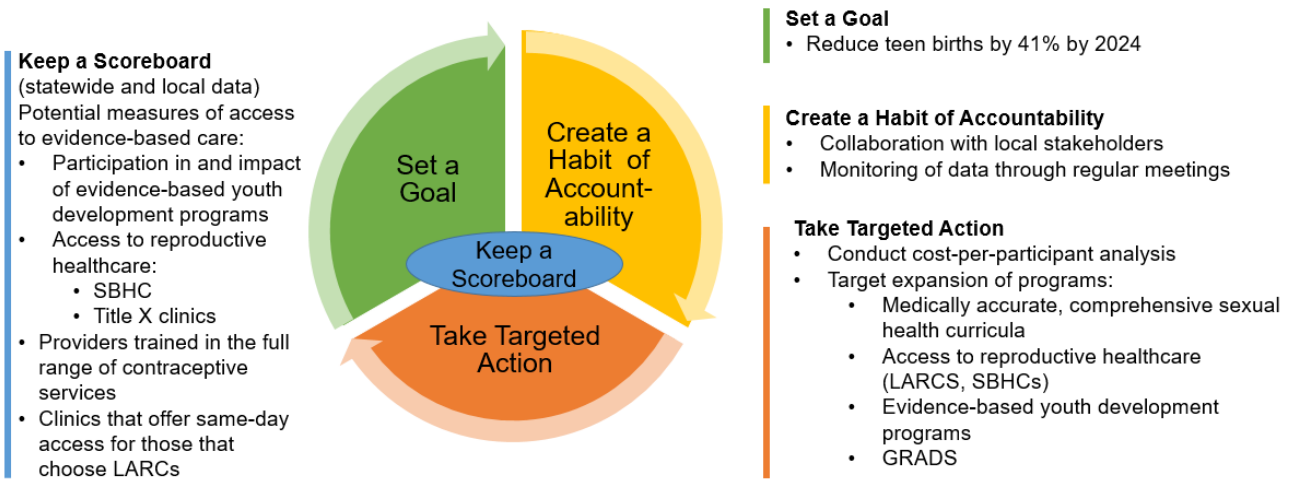
Population–based Indicator			
Number of births to teens per 1,000 females ages 15-19			
Performance Measures	**FY18 Baseline**	**FY20 Target**	**FY20**
Number of teens that successfully complete teen pregnancy prevention programming (includes TOP, Project AIM and ¡Cuídate!)	232	≥325	502
Percent of female clients ages 15-19 seen in NMDOH public health offices who are provided most or moderately effective contraceptives.	61%	≥62.5%	85.9%

Source: DOH FY2020 Interim Strategic Plan

Action Plan: to Reduce Unintended Teen Births, the State Needs to Create a Habit of Accountability and Increase Targeted Action

The iterative process outlined in Figure 3 can be used to reach the ambitious goal of reducing unintended teen births by 41 percent by 2024. After the goal is set, a regular habit of accountability should be established with state and local partners to include local priorities and voices in decision-making. The state can then take targeted action. This action begins with a cost-per-participant analysis of key programs and services, followed by expansion of these programs. These programs include use of evidence-based sexual health curricula, access to long-acting reversible contraceptives (LARCs) for those who want them, expansion of Graduation Reality and Dual-Role Skills (GRADS) program, and targeted increases in evidence-based youth development programs. Other programs can be assessed and added, including effective programs that support pregnant and parenting teens. As programs are expanded in specific counties and school districts, data on participation, access, and outcomes are fed into a scoreboard to monitor progress.

Figure 3. Iterative Action Plan to Reduce Unplanned Teen Births



Source: Adapted from O'Malley 2019

To create a habit of accountability, state agencies should partner with local stakeholders and keep a scoreboard.

Investment from state agencies alone will not bend the curve on unintended teen births but should happen in collaboration with community partners that can identify local priorities and help monitor data. The state could partner with stakeholders in those counties with high teen births and slower than average

declines in teen births (see Table 5). Potential partners could include local public health offices to help prioritize resources, school districts to convey local priorities, healthcare providers (including hospitals, school-based health centers, Title X clinics) to share information about access, youth-led organizations to include input from teens about their needs and preferences, and parents to share their values and concerns. Other important voices could come from nonprofit organizations, public officials, religious groups, and other community members who have a stake in improving health outcomes for teens. These partners could form local collaboratives to identify their own goals, create targeted action plans, and monitor data to help refine and reach their goal. State investment in evidence-based programs, as well as expertise from epidemiologists, could support these collaboratives for a successful public-private partnership through a habit of regular accountability.

A scoreboard should be used to track access to evidence-based care and services. Potential measures of access include: participation in and impact of evidence-based youth development programs at a local level, access to reproductive healthcare (including Title X clinics and school-based health centers), providers trained in the full range of contraceptive services, clinics that offer sameday access for those that choose LARCs.

A cost-per-participant analysis of key programs could help DOH target expansion of services and reduce unintended teen births.

With a clear and ambitious goal established, New Mexico can focus on delivering evidence-based programs and services to counties lacking access and with high numbers of teen births. A first step for DOH will be to conduct a cost-per-participant analysis to project targeted expansion of programs. While DOH is not the only agency involved in these programs, they could serve as the lead.

DOH does not project costs associated with the expansion of evidence-based programs. DOH has focused on the issue of teen pregnancy at a strategic level. However, the agency could conduct cost projections associated with the expansion of specific programs to establish a rationale for increased investments in areas of the state needing services.

Based on available data, LFC analyzed the following five programs to project estimated costs associated with their expansion: evidence-based comprehensive sexual health education, increased access to LARCs for those who want them, GRADS, Wyman's Teen Outreach Program (TOP) and Adult Identity Mentoring (Project AIM). These programs are discussed in further detail in the following sections of the action plan. For each program, the following information was collected: cost per participant, estimated number of current participants, and efficacy in reducing unintended teen births. Expansion targets ranging from 19 percent to 26 percent were applied across the programs. Together, the programs could serve 1,322 additional adolescents at a total cost of $324 thousand or an average of $245 per participant. Based on the assumptions of efficacy associated with each program, these expanded interventions could help avoid 680 unintended teen births, which would result

Case Study: Lea County's Roadmap to Reduce Teen Pregnancy

Local goal setting and planning to reduce unintended teen births is happening in Lea County. In 2016, a group of representatives from the hospital, philanthropIc organizations, public health offices, and other community stakeholders recognized the role that teen births played in the county's high rates of poverty and low levels of educational achievement and decided to set a goal: by 2018, reduce the birth rate for 15- to 17-year-olds by 30 percent. While the birth rate for women 15 to 19 years old remains high in Lea County, the goal-setting and prioritizing efforts seem to have made a difference for the younger women ages 15 to 17 years old: The birth rate for the younger teens dropped by nearly half, outpacing the statewide rate of decline.

While the group has had some success increasing access to reproductive care, with a new school-based health center and implementing youth development programs, comprehensive sexual health education is not broadly implemented in schools across the county and remains a strategy of the group. In the course of using data to monitor outcomes, the group identified rising rates of sexually transmitted infections and is now hoping to address that issue as well.

in public savings of $6.4 million per year, according to the Power to Decide organization. Many of these programs have additional positive outcomes associated with them that are not captured in this analysis. These include improved academic performance and health outcomes. DOH could consider performing similar cost-per-participant projections for these, as well as other programs, to help target resources. (See Appendix C for the underlying assumptions associated with this analysis).

Table 7. Cost per participant projections for selected reproductive health and education programs

Program	Cost per participant	Current # of Adolescents Served	Potential Expansion	Expansion Participants	Incremental Costs	Potential Reduction in Unintended Teen Pregnancies
Evidence-based sexual health education	$0	3914	26%	1018	$0	509
Increased access to LARC for those who want them	$900	515	19%	98	$8,814	97
GRADS	$1,600	417	24%	100	$160,136	14
Youth Development Programs						
TOP	$1,558	306	24%	73	$114,419.52	39
Project AIM	$1,201	167	20%	33	$40,120	21
TOTAL				**1322**	**$323,490**	**680**
Cost/person					**$245**	

Note: See Appendix H for underlying assumptions. Does not represent unduplicated count

Source: LFC analysis

Targeted expansion of comprehensive sexual health education, reproductive healthcare, and programs that reduce repeat teen births will help decrease unintended teen births.

Evidence-based comprehensive sexual health education is not taught in the majority of schools in New Mexico. Additionally, adolescents face barriers to accessing reproductive healthcare, including contraceptives. These barriers include: proximity to providers, confidentiality and cost of services, and provider knowledge about LARCs. School-based health centers offer reproductive healthcare but not all are trained in how to use LARCs. While recent increases in Medicaid reimbursement rates are promising, the price of LARCs remains high. Lastly, by providing wrap-around support and case management to pregnant and parenting teens, New Mexico can reduce the number of repeat teen births.

Evidence-based curricula on sexual health education are not used in 85 percent of surveyed schools in New Mexico. Three laws govern the instruction of sexual health education to K-12 students in public schools in New Mexico. The laws do not explicitly require medically accurate information is taught nor is a specific curriculum required or recommended.

A study published in 2019 in the *Journal of School Health* reported on a survey

of 122 secondary school educators, school nurses, and administrators in New Mexico. The study found 15 percent of respondents reported using an evidence-based curriculum and 65 percent used a "self-developed curriculum." However, evidence-based sexual health education programs have been proven to be effective at impacting a number of sexual-health-related outcomes.[xx] Ninety percent of surveyed participants were unaware if there was any assessment of how sexual health instruction was implemented. Surveyed participants represented 69 percent of all districts and represented a mix of urban and rural counties.

Who teaches sexual health education also matters. The report found that external organizations provide sexual health instruction to 49 percent of those surveyed. While community partners can provide a level of expertise in discussing sexual health issues that perhaps health teachers might not possess, New Mexico currently does not have any required criteria for schools to use when selecting these partners. Therefore, content can be driven by community partner bias rather than medically accurate information.

Lastly, sexual health education classes could be a place where students learn about their legal rights to access reproductive healthcare at Title X clinics without parental consent and their rights to confidential reproductive healthcare as protectecd by both state and federal laws. Raising awareness could help increase access to these services.

DOH does not consider local reproductive healthcare need when allocating funds to school-based health centers. Because most of New Mexico is federally designated as a primary care shortage area, SBHCs serve as a critical locus of integrated healthcare for adolescents, offering not just primary care but also behavioral and reproductive healthcare (See Appendix E for a map of the primary care shortage areas statewide).

DOH, through the Office of School and Adolescent Health, funds 54 SBHCs statewide. An additional 25 operate in the state but do not receive DOH funding. DOH funding includes operational support based on hours of operation and size of student population served. Additional funding is available if a SBHC provides services designated for health provider shortage areas. Funding grew 10 percent from FY16 to FY20, with nearly $4 million distributed in FY20. Reproductive healthcare visits to SBHCs modestly increased from 12 percent in 2016 to 16 percent in 2020. While utilization data based on type of visit is collected, SBHCs do not report on funding by type of visit and, therefore, how much is spent on reproductive healthcare at SBHCs is unknown.

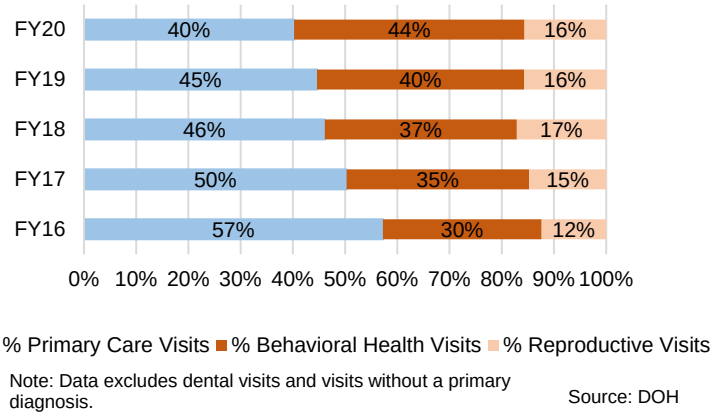
Table 8. Laws that Govern Sexual Health Education and Access to Confidential Reproductive Healthcare in New Mexico

NM Statute	Description
Sexual Health Education	
NMAC 6.12.2.10	Districts must provide instruction on ways to reduce risk of getting HIV/AIDS
NMAC 6.29.6.8	Health education topics for students K-12 must adhere to the standards and benchmarks. Includes "opt-out" rule for parents.
NMSA 1978 Section 22-13-1.1	Students must complete a course in health education that is alignment with the standards and benchmarks in order to graduate from high school.
Access to Reproductive Healthcare	
24-1-13.1 NMSA 1978	Any person regardless of age can consent to examination and treamtment by a licensed physician for a sexually transmitted disease
24-1-13.1 NMSA 1978	A female minor can consent to prenatal, delivery and postnatal care.
24-8-5 NMSA 1978	Neither the state nor any provider can subject a person to a requirement as a prerequisite for receipt of family planning services (exceptions do not address age of client)
24-10-2 NMSA 1978	In emergency conditions any person standing in locus parentis to a minor can provide consent to hospitlalization, medical attention or surgery after reasonable efforts have been made to contact a parent
(federal law) 42C.F.R.59.5 (a)(4)	Title X services must be available to all minor age clients without the need for parental consent.

Source: NM Laws

DOH could consider local need for reproductive health services when allocating funds to better target services in areas with higher need. This consideration could be used as an incentive or as a part of core funding. Local need could be determined based on school-level data on sexual activity from the *Youth Risk and Resiliency Survey* and county-level data on adolescent births from New Mexico's Indicator-Based Information System. To account for yearly variation, a multi-year average could be used. Lastly, DOH should require SBHCs to collect data on the costs associated with reproductive healthcare visits.

Chart 5. Primary Care, Behavioral Health and Reprductive Health Vistis At SBHC, FY16-20



Note: Data excludes dental visits and visits without a primary diagnosis.

Source: DOH

Ensuring confidentiality of reproductive healthcare services to adolescents remains a challenge. Confidential reproductive healthcare is important because it encourages access to services. An article in the peer-reviewed journal *Perspectives on Sexual and Reproductive Health* found that mandating parental involvement for teenagers seeking reproductive healthcare could lead to increased rates of teen births.

Ensuring confidential reproductive healthcare to adolescents can be impeded when explanations of benefits (EOB) or summary of payment forms from insurers are sent home to parents and reveal information about contraceptive use. Suppressing confidential reproductive healthcare use on the EOB continues to be a challenge in New Mexico. Massachusetts addressed this issue through legislation allowing insurers to send forms directly to patients rather than a primary policyholder and include only general information about sensitive visits. Additionally, patients can choose their preferred address for where billing and benefits information is sent. New Mexico's Legislature should consider ways to suppress confidential healthcare information on billing forms.

Use of LARCs increased 500 percent for adolescent girls served at Title X clinics from 2014 to 2018. LARCs, including implants and intrauterine devices, are highly effective, reversible forms of contraception that can provide years of pregnancy prevention.[xxi] [xxii] LARCs were identified in the 2015 LFC report on reducing unintended teen pregnancy as an effective yet expensive and underutilized method of contraception. Access to LARCs has

Table 9. DOH Funding to SBHC
(in millions)

FY16	FY17	FY18	FY19	FY20
$3.6	$3.2	$3.3	$3.3	$4

Source: DOH

Covid-19 and Teen Births

Initial evidence suggests the pandemic could limit access to reproductive healthcare services, but it is too soon to assess impacts on birth rates. School-based health centers and public health clinics are important access points for reproductive healthcare for adolescents. With school closures and Public Health Offices primarily pivoting attention to the pandemic, it remains unstudied but likely that contraceptive access has been limited.

improved significantly since then. According to an October 2019 update from the multi-stakeholder LARC workgroup, 39 of 54 DOH public health offices offer LARCs, and 30 percent of female teen clients served at Title X clinic sites choose LARCs as their primary contraceptive method, up from 5 percent in 2013. Because a LARC is inserted in a woman's arm or uterus, the risk of user error associated with other forms of birth control is removed. LARCs have been found to be 99 percent effective in reducing unintended births.

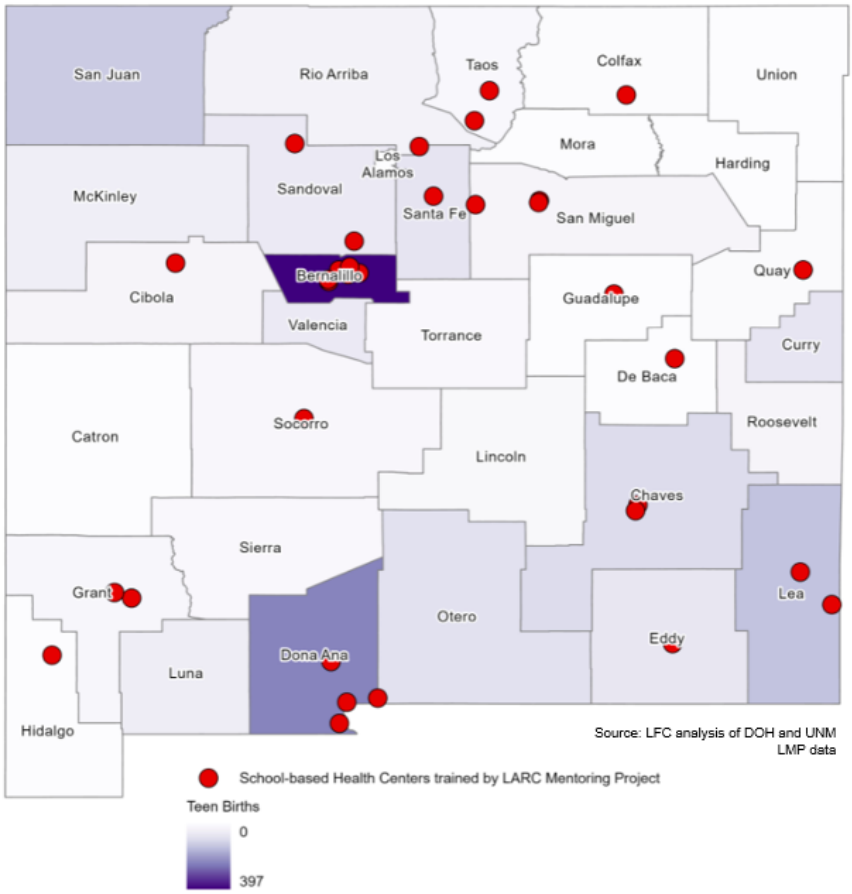
While growing in popularity, LARCs remain a less common and relatively expensive form of contraception. In recognition of their efficacy and high price, HSD unbundled the cost of the device from the cost of the office visit (the "encounter") such that providers could bill and be reimbursed for each separately. Additionally, effective January 1, 2020, HSD announced an increase in reimbursement rates associated with the insertion and removal of LARCs for Medicaid-eligible women. These rates were approved and funded during the 2019 legislative session.

The unintended pregnancy rate could be halved through counseling on and access to LARCs. A cluster-randomized trial in 40 reproductive health clinics across the nation, conducted by the University of California at San Francisco Beyond the Bill program from 2011 to 2013, found that education and counseling on LARCs increased provider knowledge and, in turn, women at intervention sites ages 18 to 25 were half as likely to have an unintended pregnancy, according to results published *The Lancet*. In 2018, 73 percent of adolescent births in New Mexico were to teens ages 18 and 19. UNM's LARC Mentoring Program (LMP) participated in the UCSF study, as well as the New Mexico LARC workgroup, and continues to provide statewide training and counseling in a full range of contraceptive methods and billing procedures to entire clinical teams, including clinicians, educators, front desk staff, clinic managers, and billing experts. The LARC workgroup and the LMP work to ensure counseling on contraceptive options is non-coercive and that providers offer women a range of options that suit their needs and preferences. Providers at Title X clinics, SBHCs and other locations also employ a shared decision making model when counseling and offer a range of contraceptive options in a non-coercive approach.

Targeted training of school-based healthcare center staff in LARC use could further increase access to contraceptive care. Most DOH-funded SBHCs provide reproductive healthcare to adolescents, with 86 percent of them providing at least one reproductive visit in FY13 and 14.[xxiii] However, not all SBHCs are trained in the counseling, use, and billing of LARCs. In Texas, the Health and Human Services Commission began ranking regions of the state by LARC use and planned to use mobile medical programs to increase access.

DOH indicates access is constrained due to a shortage of staff. Staff training in how to counsel and bill for LARCs also appears to be an issue. Of the 13 counties with the highest teen births in New Mexico in 2018, five of them do not have a single SBHC trained by the LARC Mentoring Program in the counseling and use of LARCs. In addition to training already practicing providers, the program is also working to embed this training in medical and nursing school pre-service training.

Figure 4. Teen Births in NM Counties and School-based Health Centers Trained in Long-acting Reversible Contraceptives - 2018



The high price of LARCs makes it difficult for clinics to stock devices and make same-day insertion available to adolescents. The cost of LARC devices varies greatly by brand and is reimbursed at different rates depending on whether the healthcare provider is a Federally Qualified Healthcare Center, a critical access hospital, a Title X clinic or fee-for-service Medicaid provider, among other designations. Some providers maintain a stock of LARCs within their clinic. While this allows for same-day insertion, it can also pose accounting challenges because the device's cost is high and stocked LARCs can represent financial loss if scheduled appointments are canceled or patients change their minds. Alternatively, some clinics order the device from a pharmacy on request by a patient, avoiding having to float the cost of the device but also delaying access for the patient.

In 2019, the Texas Medical Association's Committee on Reproductive, Women's and Perinatal Health explored the possibility of bulk purchasing LARCs and allowing physicians to bulk order the devices on a quarterly basis at no charge. The group cited how vaccines are ordered through the Vaccines for Children program run by the CDC as a potential model for the program. While HSD and DOH are exploring pilot programs to address LARC stocking and storage needs, a state-funded bulk purchasing program for LARCs similar to the CDC vaccine program could be studied to help alleviate the financial

costs faced by providers and to increase access for adolescents. (See Appendix F for reimbursements for LARC devices and procedures).

Repeat births accounted for 15 percent of teen births in 2019, and the GRADS program successfully reduces their incidence. The New Mexico GRADS program provides wraparound services to pregnant and parenting teens in schools. These services are funded from the state general fund and with federal TANF funds and can include classroom intervention, case management, links to childcare and healthcare, and support for young fathers. In the 2019-2020 school year, 15 New Mexico counties had programs in 23 schools or sites serving 834 pregnant and parenting youth.

In addition to supporting pregnant and parenting teens to graduate and have healthy babies, GRADs also seeks to address the incidence of repeat births. In 2018, 15 percent of all teen births were to mothers having their second or subsequent birth, a "repeat birth." CDC notes repeat births limit opportunities for both mother and child, making it more difficult for the mother to graduate from school or get a job and even resulting in premature or low birthweight babies.

In 2017, GRADS students had rates of repeat pregnancies 12 percent lower on average than countywide rates of repeat births. In 2018, the GRADS rate was 13 percent lower on average than countywide rates. With repeat births accounting for 265 of teen births in 2018, the GRADS program represents a promising intervention to support parenting teens to delay a repeat pregnancy. (See Appendix G for additional data on repeat births for GRADS participants versus statewide).

Case Study: Pregnancy Prevention Program Designed for Native Americans

Respecting the Circle of Life is an evidence-based STD/HIV and pregnancy prevention program for Native American youth ages 11 to 19 and their parents or a trusted adult. The Johns Hopkins Center for American Indian Health worked with Native American community members to develop the program delivered over nine sessions. A randomized control trial found the program significantly impacts factors associated with pregnancy prevention among Native adolescents. The program is currently run in Native communities in Minnesota and Arizona and could be delivered in New Mexico.

Evidence-based youth development programs should be expanded in counties with high rates of teen births.

Since FY19, the Family Planning Program of DOH has funded three youth development programs: TOP, Project AIM, and Teen Connection Program (TCP). TOP and Project AIM receive the second and highest evidence ratings, respectively, in the Results First Clearinghouse Database. Additionally, in FY20, New Mexico was chosen as a state in which to pilot TCP, a newer evidence-based program also developed by Wyman's but not yet included in the Results First Clearinghouse Database. These youth development programs primarily offer educational programming but also can include service-learning projects for youth. Among other positive outcomes, they aim to reduce unintended teen pregnancies. (See Appendix D for descriptions of these programs and the New Mexico contractors that implement them.)

DOH contracts should target all of the highest need counties with youth development programs. From FY17 to FY20, DOH allocated $3.7 million through contracts to providers in nine counties to offer TOP, Project AIM, and TCP (a fourth program called Cuídate was funded in 2017 and 2018 and, therefore, is also included in this analysis but was not funded in 2019 or 2020). While these programs provide important youth development curricula and could have positive impacts on communities, they are serving only five of the 13 counties that accounted for 87 percent of all teen births in 2019. While DOH

cannot require counties with high teen births to implement such programs, the department could help these counties identify important health outcomes, including teen births, and then offer such programs as successful solutions. (See Appendix D for more detailed tables on state and federal funding and local providers of the programs).

In addition to educational programs, DOH funds clinical family planning services. According to DOH, in 2019, nearly 3,000 teens received such services at Public Health Offices and outreach sites such as primary care clinics and SBHC. Girls ages 15 to 19 received 95 percent of services at these sites.

Table 10. Counties with Highest Teen Births and Youth Development Funding and Participants

County	Teen Births 2019	FY17-20 DOH Funding	FY17-20 Program Participants
Bernalillo	352	$122,550	48
Dona Ana	208		
San Juan	126	$312,450	73
Lea	118		
Eddy	92	$202,600	75
McKinley	86		
Chaves	84		
Curry	72		
Sandoval	69		
Valencia	65	$403,200	174
Santa Fe	64	$881,300	450*
Otero	52		
Luna	51		773

Note: Funding and program participants include Santa Fe and Rio Arriba counties because some contracted providers work in both counties.

Source: LFC analysis of DOH data

Programs that effectively support pregnant and parenting teens could be expanded to improve their opportunities.

While this action plan sets a goal to reduce unintended teen births through increasing access to evidence-based programs, the state also funds effective programs to help pregnant and parenting teens graduate from high school, have positive birth outcomes for their children, and learn about the importance of early childhood development through home visits from paraprofessionals. The state could expand funding for these programs to improve outcomes for more teen parents.

Pregnant and parenting teens who participated in the GRADS program experienced significantly higher graduation rates compared with national averages. CDC reports approximately 50 percent of teen mothers receive a high school diploma by 22 years of age. Participants of the GRADS program in New Mexico, however, had an average graduation rate of 80 percent for those participants entering as 12th graders and graduating that same academic year. While this is lower than the schoolwide 87 percent average graduation rate for 12th graders at those same schools, it is 30 percent better than the 50 percent national graduation rate for teen parents. Additionally, at 12 of the 22 schools analyzed, the graduation rate of GRADS students was better than that of 12th graders across the same schools.

Table 11. Average 12th Grade Graduation Rates in SY18-19 (GRADS students, Schoolwide, National Averages)

Graduation Rate for 12th Grade Participants of GRADS	Graduation Rate of 12th Grade Students at Schools with GRADS Programs	National Graduation Rate for Teen Mothers
80%	87%	50%

Note: The 12th grade graduation rate was calculated for incoming seniors in SY18-19 who graduated in the same school year. This does not consider confounding factors and does not compare pregnant and parenting teens not enrolled in GRADs but enrolled in school.

Source: PED

The GRADS program successfully helps reduce rates of low birth-weight babies. Low birth-weight babies, those born weighing less than 5 pounds, 8 ounces, can present addressable but challenging health and developmental problems. According to the Children's Hospital of Philadelphia, teen mothers are at an increased risk of delivering low birth-weight infants. According to data from DOH's Pregnancy Risk Assessment and Monitoring System, 10.6 percent of unintended births to women on Medicaid resulted in low birth-weight babies in 2015. While this data is not disaggregated by age, CDC notes 77 percent of teen births are unintended.

Given the prevalence of low birth-weight babies among teen parents, the GRADS program works to reduce its incidence. In 21 of 23 GRADS programs active during the 2019-2020 school year, the rate of low birth-weight births for teen mothers was 0 percent; while two sites had rates higher than countywide

averages. Engagement with pregnant teens to ensure healthy habits, including regular prenatal care, could be contributing to these outcomes.

Given the positive graduation and birth outcomes associated with students in the GRADS program, the Legislature should consider expanding funding for this program.

Efforts should focus on older teen parents in New Mexico. Teens ages 18 and 19 years old accounted for 73 percent of adolescent births in New Mexico in 2019. Access to family planning services and educational supports as well as infant and child care can ensure positive outcomes for these families. While additional data is needed to determine how many of these women hold high school diplomas and are pursuing higher education, programs that increase educational opportunities and access to family planning will help support these women. In Mississippi, a state with even higher rates of teen births than New Mexico as well as a disproportionate number of older teen births, the Legislature passed a bill that focused on higher education as a locus of support to prevent unintended pregnancies among older teens. The commissioner of higher education and the executive director of the state board of community colleges were charged with creating a plan to address the issue, including public awareness campaigns and increased access to health services. Arkansas and Louisiana passed similar legislation. A coordinated plan in New Mexico among higher education institutions and HSD could benefit these parenting teens.

More teen parents were served by home visiting in FY19 than FY14. Home visiting, a state program for new families that provides parental education and other supports through home visits from nurses and other paraprofessionals, can be particularly beneficial to teen parents. One outcome addressed by some home-visiting models is the amount of time between pregnancies. According to the Nurse Family Partnership (NFP) home-visiting program, closely spaced pregnancies are associated with poor birth outcomes (such as preterm birth, low birth-weight, and neonatal mortality). In studies of participants of NFP, women had longer intervals between the births of their first and second children. Programs such as these help a teen complete their education or pursue careers before becoming a parent again.

Table 12. Teen Parents Who Received Home Visiting in 2014 v 2019

Year	Teen Clients Served	Percent of All Home Visiting Clients	Teen Parents Served by Home Visiting as a Percent of All Births to Women Ages 15 to 19
FY14	230	12% (n=1,880)	8% (n=2,980)
FY19	438	8% (n=5,397)	25% (n=1724)

Source: HV Outcomes Reports

As teen birth rates declined in New Mexico from 2014 to 2019, more expecting and parenting teens were served by home-visiting programs (from 230 to 430 from FY14 to FY19) through expansion of the program generally. Targeting additional evidence-based home visiting could help reduce challenging outcomes for both parents and children. The evidence-based Family Spirit home-visiting program is culturally tailored to promote health and well-being among Native American families. It could be introduced in New Mexico to work with teen and older Native American families and, because it is evidence-based, would qualify for Medicaid funding.

Action Plan Summary

GOAL: DECREASE UNINTENDED TEEN BIRTHS BY 41 PERCENT BY 2024					
Action Plan Strategies					
		Improve Sexual Health Education	**Expand Educational Supports**	**Increase Access to Reproductive Healthcare**	**Target Resources**
Acting Stakeholder	**Legislature**	• Should consider revising laws to explicitly require medically accurate and comprehensive sexual health education.	• Should consider establishing a commission of representatives from the Higher Education Department, four-year institutions and community colleges to create a plan to support expectant and parenting students. • Should expand funding for GRADS in targeted areas of the state.		
	Department of Health			• Should include consideration of local need for reproductive healthcare in funding school-based health centers by monitoring data on adolescent births and access to reproductive healthcare.	• Should conduct a cost-per-participant analysis to target and rationalize resources in collaboration with HSD, PED, and ECECD and partner with local stakeholders to expand programs.
	Human Services Department			• Should conduct a cost study to determine the feasibility of purchasing LARCs in bulk on behalf of providers.	
	Public Education Department	• Should continue to develop regional communities of practice around sexual health education to promote evidence-based best practices in collaboration with DOH. • Should establish criteria based on evidence-based best practices on who can serve as a community partner to deliver sexual health education in alignment with medically accurate comprehensive requirements of sexual health education.			
	Early Childhood Education and Care Department		• Should add additional evidence-based home-visiting models that serve teen parents, such as Family Spirit, to the Medicaid-funded home-visiting program.		

APPENDICES

Appendix A: Rates and Numbers of Teen Births (ages 15 to 19 years old) in New Mexico 2019

Mother's County of Residence	Age-specific Birth Rate per 1,000 Women	Mother's County of Residence	Number of Births
Luna	63.8	Total	1,659
Quay	53.3	Bernalillo	352
Socorro	48.2	Dona Ana	208
Curry	47.5	San Juan	126
Eddy	46.4	Lea	118
Lea	45.4	Eddy	92
Chaves	36.4	McKinley	86
Guadalupe	35.8	Chaves	84
Cibola	34.8	Curry	72
Mora	32.5	Sandoval	69
McKinley	32.2	Valencia	65
Sierra	29.8	Santa Fe	64
Grant	29.3	Otero	52
San Juan	28.3	Luna	51
San Miguel	28	Cibola	28
Otero	27.4	Socorro	28
Valencia	27	San Miguel	26
Roosevelt	24.5	Grant	23
Total	24.4	Roosevelt	21
Dona Ana	23.8	Rio Arriba	18
Taos	22	Taos	17
Lincoln	20.1	Quay	14
Bernalillo	16.7	Lincoln	10
Torrance	16.6	Torrance	8
Santa Fe	15.8	Sierra	6
Rio Arriba	15.1	Guadalupe	5
Sandoval	14.7	Colfax	4
Colfax	13.8	Mora	4
Catron	0	Catron	0
Harding	0	Harding	0
De Baca	**	De Baca	**
Hidalgo	**	Hidalgo	**
Los Alamos	**	Los Alamos	**
Union	**	Union	**

**Count suppressed

Source: DOH

Appendix B: Federal Programs to Reduce Teen Pregnancy

Federal Title V and PREP

The federal State Abstinence Education Grant Program (AEGP), part of Title V, provides grant funds to states and territories for abstinence education, mentoring, counseling, and adult supervision. Grant funds are distributed based on the proportion of low-income children in the state or territory, and states must fund at least 43 percent of the project's total cost with non-federal resources. The AEGP promotes abstinence to prevent teen pregnancy among and targets particularly at-risk youth. Grantees must use evidence-based models to promote abstinence by strengthening beliefs supporting abstinence, increasing skills to negotiate abstinence and resist peer pressure, and educating young people about STIs. In FY20, New Mexico was allocated $429 thousand through the AEGP.

Through the State Personal Responsibility Education Program (PREP), the federal Family and Youth Services Bureau awards grants to state agencies to educate young people on both abstinence and contraception to prevent pregnancy and STIs, including HIV/AIDS. The program targets youth ages 10 to 19 who are homeless, in foster care, live in rural areas or areas with high teen birth rates, or come from racial or ethnic minority groups. The program also supports pregnant and parenting youth. PREP projects replicate effective, evidence-based program models or substantially incorporate elements of the project that have been proven to delay sexual activity, increase condom use, or reduce pregnancy among youth. Additionally, PREP projects offer services to address healthy relationships, positive adolescent development, financial literacy, parent-child communication skills, or healthy life skills. In FY20, New Mexico was allocated $326 thousand through the PREP.

Competitive Federal Teen Pregnancy Prevention Grants

The Teen Pregnancy Prevention (TPP) and the Pregnancy Assistance Fund offer funding to implement evidence-based programs; develop, replicate, and refine new innovative models; and support pregnant and parenting teens. In 2010, the U.S. Department of Health and Human Services (U.S. HHS) announced the award of $155 million in teen pregnancy prevention grants to states, nonprofit organizations, school districts, and others. One hundred million of this amount comes from a teen pregnancy prevention program appropriation by the Consolidated Appropriations Act of 2010, which replaced community-based grants for abstinence only education. Grantees are expected to replicate effective evidence-based program models or substantially incorporate elements of projects that have been proven to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth.

Additionally, in 2013 the U.S. HHS awarded competitive Pregnancy Assistance Fund grants, totaling $21.6 million, to 17 states including New Mexico. These funds are intended to support pregnant and parenting teens and women continuing their educations. New Mexico received a $1.5 million federal grant from the U.S. HHS for the New Mexico Graduation Reality and Dual-role Skills (GRADS) program.

In FY15, the U.S. HHS announced additional grants to support capacity building, the replication of evidence-based teen pregnancy prevention programs, and efforts to scale evidence-based programs in communities with the greatest needs will be available.

Title X

This program of the federal Public Health Service Act is the only federal grant program dedicated to providing individuals with comprehensive family planning and related preventive health services. These services are provided through state, county, and local health departments, school-based health centers (SBHC), and other private nonprofits. Title X supports critical infrastructure needs that are not reimbursable under Medicaid or commercial insurance, such as staff salaries, individual patient education, community-level education and outreach, research and evaluation, and public education about family planning, women's health, and sexual issues.

Appendix B (continued): Federal Programs to Reduce Teen Pregnancy

Temporary Assistance for Needy Families (TANF)

Through TANF, the Federal government provides grants to states to assist, for a limited time, families with children when the parents or responsible relatives cannot provide for the family's basic needs program. States have broad flexibility to carry out the program within four goals: 1. To provide assistance to needy families so that children can be cared for in their own homes or the homes of relatives; 2. To end the dependency of needy parents on government benefits by promoting job preparation, work and marriage; 3. To prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and 4. To encourage the formation and maintenance of two-parent families.

Medicaid

Medicaid provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Jointly funded by states and the federal government, Medicaid is administered by states but must follow federal requirements. As of October, 2020, 740.7 thousand New Mexicans are enrolled in Medicaid. In order to expand access to family planning services, the federal government allows states to waive the regular income requirements so that women who do not qualify for full benefits still qualify for family planning services. In New Mexico, the waiver covers women up to 225% percent of the federal poverty level ($21,720 for a family of three, as of January, 2020)

Appendix C: Assumptions Underlying Cost Per Participant Projections for Six Programs Aimed at Addressing Teen Births

	Cost per participant	Current #s Served	Efficacy to reduce unintended adolescent births
Evidence-based sexual health education	The costs involve the cost of the curriculum and training. While some evidence-based programs are free and others come at a cost, the per-person costs are negligible.	▪ NM PED graduation data for 4-year cohort of 2019 reports 26,092 high school students were ever enrolled for one or more semesters during 4-year cohort. ▪ NMSA 1978 Section 22-13-1.1 states that NM students must complete a course in health education to graduate. ▪ Dickson et al study surveyed 122 educators in NM and found that 15% reported using evidence-based curricula. A conservative estimate, therefore, assumed that 15% of 26,092 received evidence-based sexual health education prior to graduation.	One study found that teens who participate in comprehensive sexual health education were at a 40% lower risk of reporting a pregnancy than those who received no sexual health education. See: Kohler PK, Manhart LE, Lafferty WE. Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. J Adolesc Health 42(4), 2008.
Increased LARC use	Calculated based on averages of the procedure and device costs of implants and IUDs. For the procedure cost, an average was taken of the cost of removal and insertion of an IUD and an implant. For the device cost, an average was taken of the 340B price available to FQHCs and critical access hospitals for all six LARC products available in NM. The federal government pays 90% of these costs (i.e. the FMAP).	The 2019 YRRS survey finds that 25.2% of students reported being sexually active. Of those, 10.7% reported using an IUD or implant (i.e. LARCs). There were 19,107 observations in the 2019 survey. Therefore, a conservative, estimated baseline of 515 teens currently using LARCS was used.	99% See: Birgisson et al. Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review)
Wyman's Teen Outreach Program (TOP)			53% lower risk of pregnancy Source: Child Trends, the Brookings Institute, Allen and Philihiber, 2001, Kilburn, 2014
Project AIM	Based on FY20 DOH funding and enrollment data. Total funding/total enrollment	Based on FY20 DOH data on program participation	In one study, 64% of AIM participants were not engaging in sexual intercourse after one year from the program. See: Clark LF, Miller KS, Nagy SS, Avery J, Roth DL, Liddon N, Mukherjee S. Adult identity mentoring: reducing sexual risk for African-American seventh grade students. J Adolesc Health. 2005 Oct;37(4):337. doi: 10.1016/j.jadohealth.2004.09.024. PMID: 16182145.
GRADS	Provided by GRADS program. Total Budget/Total Enrollment	GRADS enrollment data	GRADS reports a 1.2% incidence of repeat pregnancy in the AY2018-29. The statewide prevalence of repeat pregnancy was 15%, Therefore, a 14% rate of reducing repeat teen births was applied to this model.

Appendix D: DOH Funded Youth Development Programs & Funding Sources for These Programs

Youth Development Programs Funded by DOH

Program	Description
Teen Outreach Program (TOP) (developed by the nonprofit Wyman Center).	A nine-month youth development program, designed to prevent adolescent problem behaviors by developing health behaviors, life skills and a sense of purpose with children ages 12 to 18. The nonprofit Wyman Center is the developer of TOP. The curriculum combines service learning, adult support and guidance, and curriculum-based group activities. TOP participants receive at least 120 minutes of programming each week for a nine-month period throughout the school year to complete lessons in a variety of topics, including communication skills, understanding and clarifying values, relationships, goal-setting, decision-making, and adolescent health and sexual development. During the nine-month period, participants also complete 20 hours of Community Service Learning. In New Mexico, most teen participants complete the nine-month program with more than the minimum 20 required hours.
Adult Identity Mentoring (Project AIM)	A group-level youth development intervention designed to reduce sexual risk behaviors among youth ages 11-14 by providing them with the motivation to make safe choices and to address deeper barriers to sexual risk prevention (e.g., hopelessness, poverty, risk opportunities in low-income environments). The program consists of 12 fifty-minute sessions typically delivered in-school or in community based settings twice a week over six weeks.
Teen Connection Program (TCP) (developed by the nonprofit Wyman Center).	A semester-long program for 9th through 12th graders during which students meet weekly in small groups. The curriculum focuses on building positive relationships with peers and adults. Throughout the program teen participants learn and practice skills such as successful communication, resilience, and fostering successful relationships whether romantic in nature or platonic such as with peers and trusted adults.

State FY	TOP	Project AIM	¡Cuídate!	TCP
2018	$ 597,126	$ 172,200	$ 33,800	-
2019	$ 802,400	$ 200,600	-	-
2020	$ 802,400	$ 200,600	-	$49,900

Source: DOH

Year	Funding Source	TOP/AIM/TCP/¡Cuídate!
SFY2018	Title V	$460,052
	PREP	$319,400
	Revenue	$51,150
	Total	$830,602
SFY2019	Title V	$551,650
	PREP	$245,721
	State General Fund	$105,329
	Total	$902,700
SFY2020	Title V	$551,650
	PREP	$345,971
	State General Fund	$105,379
	Total	$1,003,000

Source: DOH

Appendix D (continued) DOH Funded Youth Development Programs & Funding Sources for These Programs

State and Federal Funds for TOP/AIM/TCP/¡Cuídate! by County

County	FY 18	FY 19	FY 20	Total
Bernalillo	$61,275	$ -	$ -	$61,275
Cibola	$107,927	$100,300	$100,300	$308,527
Eddy	$51,150	$50,150	$50,150	$151,450
Luna	$262,000	$300,900	$300,900	$863,800
Rio Arriba	$57,400	$200,600	$200,600	$458,600
San Juan	$131,150	$ 50,150	$ -	$181,300
San Miguel	$51,150	$50,150	$50,150	$151,450
Santa Fe	$57,400	$100,300	$150,200	$307,900
Valencia	$51,150	$150,450	$150,450	$352,050
Total	$830,602	$1,003,000	$1,002,750	$2,836,352

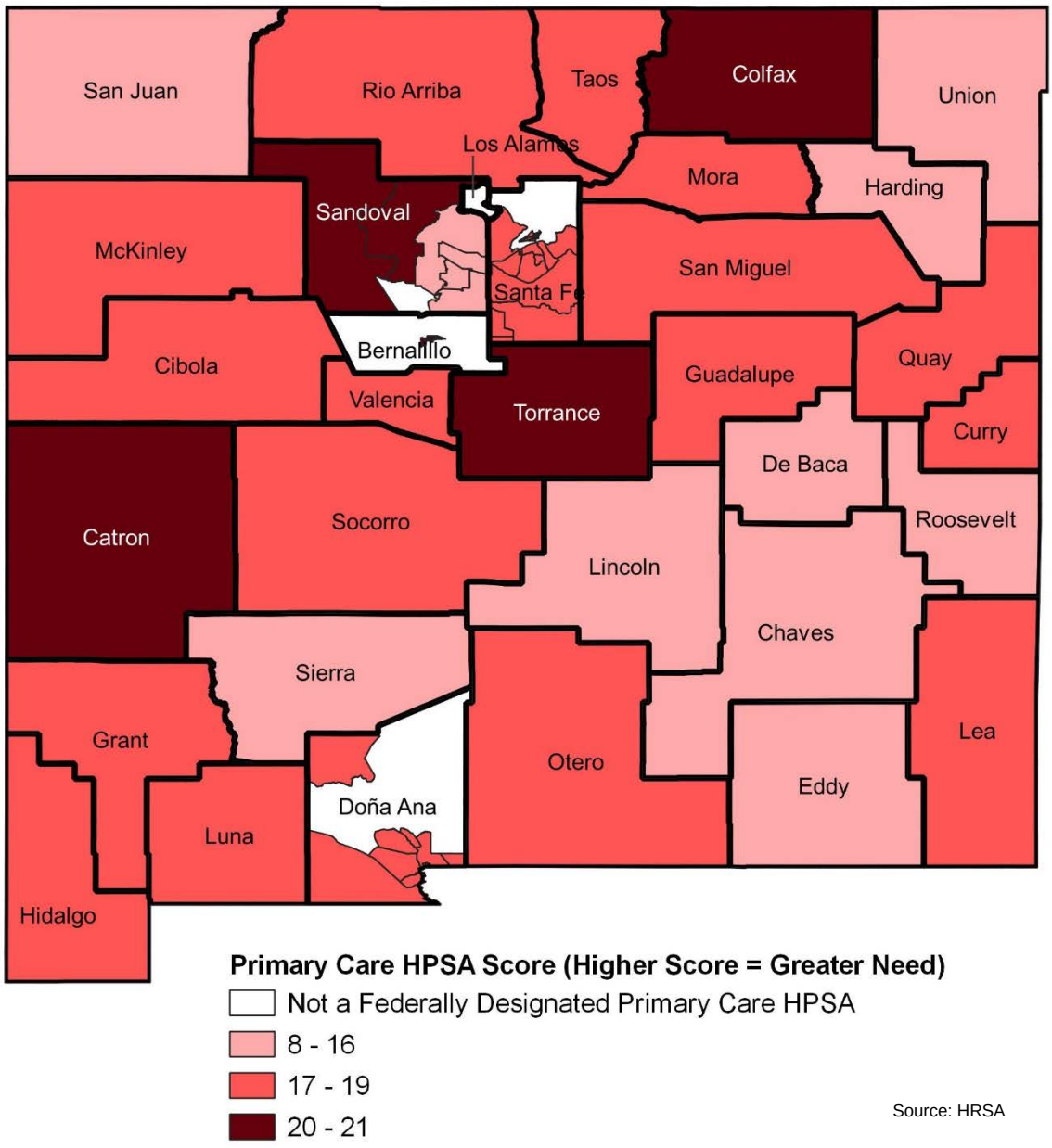
Source: DOH

Participants by Contractor, Curricula and County

Contractor	Curriculum	County	FY18	FY19	FY20	Total
Capacity Builders, Inc.	TOP	San Juan	13	6	0	19
Carlsbad Community Anti-Drug/Gang Coalition	TOP	Eddy	12	17	14	43
Las Clinicas Del Norte	TOP	Santa Fe	0	20	31	51
Luna County	TOP	Luna	100	100	100	300
Luna County	AIM	Luna	70	160	80	310
Navajo Prepatory School	TOP	San Juan	10	0	0	10
Planned Parenthood of the Rocky Mountains	¡Cuídate!	Bernalillo	21	0	0	21
Santa Fe Boys & Girls Club- Zona del Sol	AIM	Santa Fe	37	0	0	37
Santa Fe Boys & Girls Club in North Santa Fe & Rio Arriba Counties	AIM	Santa Fe & Rio Arriba	39	67	87	193
Santa Fe Boys & Girls Club in North Santa Fe & Rio Arriba Counties	TOP	Santa Fe & Rio Arriba	0	31	28	59
Santa Fe Boys & Girls Club in North Santa Fe & Rio Arriba Counties	TCP	Santa Fe & Rio Arriba	0	0	29	29
UNM Department of Pediatrics	TOP	Cibola	35	27	17	79
West Las Vegas Schools	TOP	San Miguel	45	38	41	124
Youth Development, Inc.	TOP	Valencia	25	47	75	147

Source: DOH

Appendix E: Federally Designated Primary Care Health Professional Shortage Areas in New Mexico



Source: HRSA

Appendix F: LARC Device and Procedure Reimbursement Rates

Manufacturer	Device	FDA-Approved Duration	Researched Extended Use	WAC	Title X 340B	NM FFS Medicaid Reimbursement
Merck	Nexplanon (implant)	3 years	Up to 5 years	$934.82	$399.00	$890.30
Cooper Surgical	Paraguard (Copper IUD)	10 years	Up to 12 years	$808.50	$244.73	$808.50
Bayer	Kyleena	5 years	N/A	$953.51	$568.28	$953.51
	Mirena	6 years	Up to 7 years	$953.51	$314.62	$953.51
	Skyla	3 years	N/A	$793.96	$448.93	$793.96
Abbive	Liletta	6 years	Up to 7 years	$749.40	$95.03	$625.00

Source: LARC Mentoring Project and NM State Pharmacy

Procedure Code	Current Medicaid FFS Reimbursement	New Medicaid FFS Rate Effective 1/1/20	Percentage Increase
11981- Insertion of LARC Implant	$149.34	$300.00	101%
11982-Removal of LARC Implant	$141.34	$282.68	100%
11983-Removal and reinsertion of LARC Implant	$256.46	$512.92	100%
58300-Insertion of Intrauterine Device	$119.07	$300.00	152%
58301-Removal of Intrauterine Device	$99.40	$198.80	100%

Source: HSD

Appendix G: Repeat Teen Births (ages 15 to 19 years old): County-Wide vs GRADS Students

	2017/SY16-17			2018/SY17-18		
County	**% Repeat Births**	**GRADS % Repeat Pregnancies**	**Difference**	**% Repeat Births**	**GRADS % Repeat Pregnancies**	**Difference**
Bernalillo	15%	8%	7%	16%	0%	16%
Chaves	16%	3%	13%	15%	7%	8%
Dona Ana	16%	2%	14%	13%	2%	10%
Lea	21%	0%	21%	18%	4%	14%
Luna	18%	0%	18%	22%	4%	18%
McKinley	16%	0%	16%	14%	10%	4%
San Juan	12%	2%	10%	14%	5%	9%
Sandoval	13%	3%	10%	8%	10%	-2%
Santa Fe	10%	2%	7%	18%	2%	16%
Socorro	0%	0%	0%	35%	0%	35%
Valencia	13%	0%	13%	10%	0%	10%

Source: LFC analysis of DOH and GRADS data

Note: Only counties with statistically stable #s as well as GRADS programs are included.

Selected End Notes

[i] See notes in endnote XV for additional details on this analysis.

[ii] New Mexico, Department of Health, Indicator-Based Information System.

[iii] Manlove, J. Lantos, H. Data Point: Half of 20- to 29- year-old women who have birth in their teens have a high school diploma. Child Trends. January, 11, 2018.

[iv] Dye, J. Participation of Mothers in Government Assistance Programs: 2004. Household Economic Studies: U.S. Census Bureau, May 2008.

[v] Sullentrop, Katy. "The Costs and Consequences of Teen Childbearing" The National Campaign to Prevent Teen and Unplanned Pregnancy, August 17, 2010.

[vi] The monetization calculations by the Power to Decide were used in the 2015 LFC report entitled, "Effective Practices to Reduce Teen Pregnancy, Including the Use of School-Based Health Centers", May 2015

[vii] The National Center for Health Statistics has only released a provisional 2019 national teen birth rate for adolescents aged 15 to 19 years old. While this number may be adjusted, the New Mexico rate will most likely remain higher than the national one.

[viii] Penman-Aguilar, A. Carter, M. Snead, M. Kourtis, A. "Socioeconomic Disadvantage as a Social Determinant of Teen Childbearing in the United States." Public Health Reports, 2013 Supplement, Vol. 128.

[ix] Kearney, M., Levine, P. Income Inequality and Early Non-Marital Childbearing: An Economic Exploration of the "Culture of Despair." National Bureau of Economic Research. Working Paper 17157. 2011 http://www.nber.org/papers/w17157

[x] Edin, K. Kefalas, M. (2005) Promises I Can Keep: Why Poor Women Put Motherhood Before Marriage. Berkeley, CA: University of California Press.

[xi] Wilson, W. (1987) The Truly Disadvantaged: The Inner City, the Underclass and Public Policy. Chicago: University of Chicago Press.

[xii] Kearney et al. "Income Inequality and Early Non-Marital Childbearing."

[xiii] Sexuality Information and Education Council of the United States (SIECUS) (2009). Comprehensive sex education: Fact sheet.

[xiv] Chin, H.B., Siple, T.A., Elder, R., Mercer, S.L., Chattopadhyay, SK., Jacob, V., Santelli, J. (2012) The effectiveness of group based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, human immunodeficiency virus, and sexually transmitted infections: Two systematic reviews for the guide to community preventive services. American Journal of Preventative Medicine, 42, 272-294.

[xv] Kohler PK, Manhart LE, Lafferty WE. Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. J Adolescent Health 42(4), 2008.

[xvi] Chan Su Jung & Geon Lee (2013) Goals, Strategic Planning, and Performance in Government Agencies, Public Management Review, 15:6, 787-815, DOI: 10.1080/14719037.2012.677212

[xvii] Epton, T., Currie, S., & Armitage, C. J. (2017). Unique effects of setting goals on behavior change: Systematic review and meta-analysis. *Journal of consulting and clinical psychology*, 85(12), 1182–1198.

[xviii] Projected adolescent birth rates were calculated by taking the five-year average of the year over year percent change in rates from 2013 – 2018 and applying that same decline to future years.

[xix] The Power to Decide organization estimates public savings based on: "Medicaid spending associated with prenatal care, labor, delivery, postpartum care, and a year of infant care, in addition to public assistance associated with pregnancy and/or the year following birth for those that receive benefits." For more information on this monetization calculation, see: https://powertodecide.org/what-we-do/information/why-it-matters/progress-pays

[xx] Kirby, Douglas. "Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Disease."

[xxi] Birgisson NE, Zhao Q, Secura GM, Madden T, Peipert JF. Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review. J Womens Health (Larchmt). 2015;24(5):349-353. doi:10.1089/jwh.2015.5191

[xxii] Secura G. Long-acting reversible contraception: a practical solution to reduce unintended pregnancy. Minerva Ginecol. 2013 Jun;65(3):271-7. PMID: 23689169.

[xxiii] Legislative Finance Committee report, Effective Practices to Reduce Teen Pregnancy, Including the Use of School-Based Health Centers, May 2015