Report
to
The LEGISLATIVE FINANCE COMMITTEE

Department of Health
Effective Practices to Reduce Teen Pregnancy, Including the Use of School-Based Health Centers
May 13, 2015

Report #15-07

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EXECUTIVE SUMMARY

New Mexico's teen birth rate is consistently the highest or near highest in the nation, though the state's teen birth rate has declined over the last decade. In 2013, adolescents gave birth to 2,980 children in New Mexico. Statistically, these children are more likely to live in poverty, enter school behind their peers, experience maltreatment, and become incarcerated than children born to older parents. Long-term, these children will cost taxpayers $84 million due to costs to Medicaid associated with their births, increased reliance on public assistance, and poor educational outcomes, suggests LFC analysis.

Previous evaluations have highlighted efforts in the state to improve outcomes for children through interventions in early childhood and the state's public education system. The legislature has responded by making significant investments in these interventions, including home visiting, child care assistance, PreK, and K-3 Plus. However, children born into poverty continue to experience negative outcomes, and teen births are associated with poverty. Children born to teen parents account for 11 percent of all births in New Mexico and are at risk of not completing school, among other negative outcomes.

This study aims to build upon existing evaluations by identifying and analyzing teen birth characteristics and trends in New Mexico, reviewing teen pregnancy prevention efforts in the state, and identifying evidence-based approaches to reduce risky adolescent behaviors.

Analysis suggests teen births are concentrated in certain areas of risk, including geographic regions, older teen populations, and among teens who have already become parents. As a result, evidence-based interventions targeted to these teens and geographic regions could produce significant population-level improvements. While not all school districts report implementing the state's health education standards, the Department of Health is supporting evidence-based education programs. Overall, however, efforts are not coordinated across agencies or always targeted to populations exhibiting the greatest risk.

Additionally, the evaluation found existing interventions and funds may be leveraged to increase access to the most effective forms of clinical pregnancy prevention methods. Opportunities to provide training and technical assistance to providers may increase access to the most effective forms of teen pregnancy prevention among high-risk populations. Examples in other states suggest coordinated and comprehensive prevention efforts can accelerate declines in births to teens, and New Mexico may look to these states for effective policy options.

Report recommendations include developing a comprehensive and coordinated teen pregnancy prevention strategy, providing training and technical assistance to providers, and implementing best practices related to the most effective clinical prevention methods. Additionally, the report recommends the Legislature continue to prioritize investments in the programs that improve outcomes for teen parents and their children.

In 2013, 2,980 adolescents between the ages of 10 and 19 gave birth in New Mexico.

In 2013, New Mexico ranked second among all states for teen birth rate.

The LFC estimates infants born to teen mothers in FY13 cost Medicaid an estimated $9.1 million during their first year of life.

KEY FINDINGS

Teen pregnancy continues to be associated with negative outcomes, producing substantial costs to the state. The teen birth rate in New Mexico has declined by 35 percent over the last decade, though New Mexico has the second highest teen pregnancy rate nationally. Since 2005, the number of births to teens between the ages of 10 and 19 in New Mexico has declined from 4,469 in 2005 to 2,980 in 2013, the most recent year for which data is available. Despite these declines, however, teen births are associated with negative outcomes for children and parents and thus deserve the state's attention.

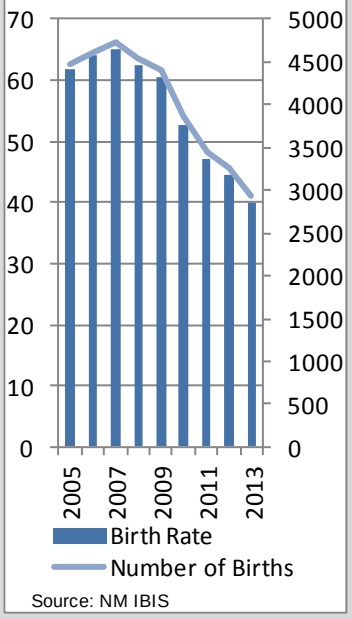
Negative outcomes associated with teen births cost New Mexico an estimated $84 million annually in New Mexico. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, teen childbearing in the United State cost tax payers at least $9.4 billion in 2010. In 2013, 2,980 babies in New Mexico were born to teen mothers, and the National Campaign to Prevent Teen and Unplanned Pregnancy estimates the average annual cost to taxpayers associated with a child born to a teen mother is $1,682. Assuming the cost estimates provided by the National Campaign to Prevent Teen and Unplanned Pregnancy, this cohort of children will cost New Mexico roughly $5 million annually for 15 years. All children and born to teen parents cost the state roughly $75 million annually, assuming the 2013 number of children born to teen parents remains constant.

A 2012 LFC evaluation titled, *Improving Outcomes for Pregnant Women and Infants Through Medicaid* found health outcomes for full-term infants cost Medicaid roughly $2,100 during the first year of life, while pre-term babies cost Medicaid an estimated average of $20 thousand in medical care during the first year of life. In FY13, 13 percent of all teen births were preterm. Using this assumption, infants born to teen mothers in FY13 cost Medicaid an estimated $9.1 million during their first year of life.

High numbers and rates of teen pregnancy tend to be concentrated in a few counties and among certain high-risk populations, suggesting targeted approaches to teen pregnancy reduction may produce significant statewide improvements. Statewide in 2013, roughly 11 percent of all births were to mothers between the ages of 13 and 19, though rates varied by county and exceed 15 percent in Lea, Roosevelt, Eddy, Quay, Socorro, and Luna counties. Eighteen and 19 year-old mothers account for 70 percent of all teen births in New Mexico. Roughly 17 percent of all teen births in New Mexico are to mothers who have already had a child.

New Mexico is implementing evidence-based teen pregnancy prevention programs, but efforts are inconsistent and not coordinated among agencies. New Mexico lacks a concrete, coordinated, and comprehensive state plan to reduce teen pregnancy. New Mexico has several established structures and programs for preventing teen pregnancy, including comprehensive health education standards developed and implemented by the Public Education Department (PED) and evidence-based prevention programs overseen by the Department of Health (DOH). Additionally, the work of individual non-profits suggests localized efforts to reduce teen

Number of Teen Births and Teen Birth Rate, FY05-FY13



Source: NM IBIS

Percent of NM Births that are Subsequent Births, 2013

Girls 15 to 17 Years Old	7%
Girls 18 to19 Years Old	21%

Source: DOH IBIS

The 2,980 children born in FY13 to teens will cost New Mexico roughly $5 million annually for the next 15 years.

pregnancy exist, but they are not coordinated or connected with other state efforts. Similarly, while DOH's efforts to implement evidence-based programs are promising, these efforts may be necessary, in part, because the state's public schools are not fully implementing the adopted health education standards.

New Mexico's educational standards require school districts teach multiple strategies to prevent teen pregnancy and reduce risky behaviors, but not all schools report implementing these standards. Half of surveyed charter and district high schools report they do not teach topics of pregnancy and sexually transmitted infection (STI) prevention included in the state's health education standards.

The New Mexico Department of Health is using teen pregnancy prevention funds to implement evidence-based approaches. An estimated $1.9 million was allocated to teen pregnancy prevention efforts in FY15 by the DOH Public Health Division. DOH reports the Teen Outreach Program, an evidence-based approach validated by the U.S. Office of Adolescent Health, is being implemented in 11 counties in New Mexico. The NM DOH Family Planning Program (FPP) promotes population-based strategies to reduce teen pregnancy, including youth development programs, adult/teen communication programs, and comprehensive health education programs.

Non-profits and other entities are also implementing local efforts to reduce teen pregnancy in high-risk communities**.** Several non-profits in New Mexico have received federal funds to validate or implement evidence-based teen pregnancy prevention programs among high-risk populations, but these grants will expire next year**.** In FY11, New Mexico received three federal grants totaling roughly $3 million from the U.S. Office of Adolescent Health for teen pregnancy prevention**.** The work of public schools, the DOH, and local non-profits demonstrate promising examples of efforts to prevent teen pregnancy. However, better coordination and collaboration could ensure communities exhibiting the greatest risks receive targeted interventions without duplicating efforts to maximize resource use.

Examples in other states suggest coordinated and targeted approaches to teen pregnancy prevention can accelerate reductions in teen births. The National Conference of State Legislatures (NCSL) recommends several options for states and localities to reduce teen pregnancy and the associated economic, social, and human costs. NCSL recommends policy-makers invest in evidence-based programs, including those identified by the federal Office of Adolescent Health. Additionally, NCSL recommends states target limited resources by focusing on geographic areas where teen birth rates are high or in areas that account for the majority of teen births in the state.

New Mexico has also made significant investments to reduce negative outcomes often associated with teen births through programs that support teen parents and children. New Mexico has substantially increased investments in programs to increase maternal education, improve parenting and reduce child maltreatment, and increase quality and access of early childhood education in New Mexico. All of these strategies work simultaneously to address poverty but could be better integrated and targeted to the state's most at-risk populations.

All children born to teens cost the state an estimated $84 million annually.

The original evaluation of TOP suggests the program produces a return-on- investment of roughly $1.29 for every $1 invested.

New Mexico's educational standards require school districts teach multiple strategies to prevent teen pregnancy and reduce risky behaviors, but not all schools report implementing these standards.

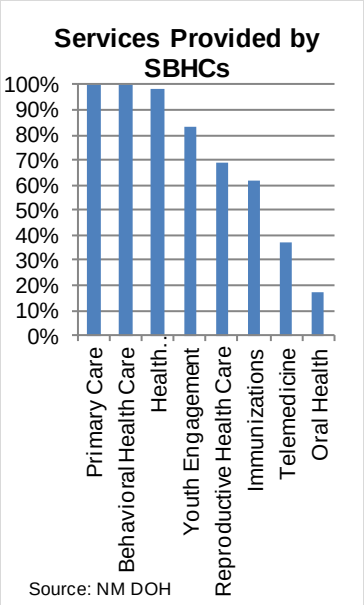
New Mexico could better leverage existing clinical interventions to reduce teen births. A variety of existing programs and revenue sources could be leveraged to increase access to the most effective clinical interventions for teens without substantial new costs to the state. Teens may currently access clinical reproductive health services through a variety of mechanisms in New Mexico, including school-based health centers and public health clinics. Additionally, several funding streams, including federal Title X and Medicaid, could be better leveraged to ensure that teens have access to the most effective clinical services.

School-based health centers (SBHC) are a mechanism through which teens may access confidential medical services. Multiple studies suggest school-based health centers can have a positive effect on the educational success of pregnant and parenting teens. DOH reports some school-based health centers provide reproductive health care in the form of testing or treatment but do not dispense contraception.

Opportunities to improve the financial efficiency of school-based health center may reduce their reliance on the state general fund and improve their sustainability. Billing data that could help determine the level of need for general fund support is not currently collected. The Department of Health allocates general fund support to school-based health centers. According to the New Mexico School-Based Health Alliance, SBHCs need supplemental funds to offset expenses incurred by providing services to students who are uninsured, underinsured, or whose insurance cannot be billed to ensure patient confidentiality. While the School-Based Health Alliance suggests SBHC should aim to quantify uncompensated care costs, DOH is currently only collecting this information for 10 SBHCs. The Department reports plans to begin collecting and reporting billing information for all SBHC providers beginning in FY16. School-based health centers are generally not billing private insurance, in part because school-based health providers want to protect patient privacy.

Medicaid expansion also provided the state with opportunities to expand access to effective clinical ways to reduce teen pregnancy through family planning services. The state's Medicaid plan covers family planning, including the most effective forms of contraception, and an estimated 57 percent of teens in New Mexico are enrolled in Medicaid. Long-acting reversible contraception (LARC) is the most effective form of reversible birth control for young adults. Colorado piloted a program that provided young women at risk for unintended pregnancies with LARCs, and these targeted efforts resulted in dramatic reductions in teen pregnancy.

Using a targeted approach, New Mexico could pursue a similar strategy to Colorado's to increase access to the most effective forms of contraception among high-risk teens**.** Given that Medicaid will cover LARCs, New Mexico could identify populations at high-risk for teen births, such as teens enrolled in the state's WIC and home visiting programs and teens who have already given birth, and facilitate collaboration, such as engaging community health workers, with these programs and medical providers to encourage access to the most effective forms of contraception. DOH may also be able to play a role in reducing knowledge gaps associated with



Colorado estimates the state saved over $6 for each $1 spent on the Family Planning Initiative that targeted high-risk teens.

LARC use. By targeting the populations most at risk for teen births, New Mexico could experience significant population-level reductions in teen pregnancy.

KEY RECOMMENDATIONS

The Legislature should:

Direct the Department of Health, in collaboration with the Human Services Department, Children, Youth, and Families Department, and Public Education Department to develop a comprehensive state plan as part of the department's comprehensive strategic plan to be presented to the Legislature and Department of Finance and Administration to reduce teen births with strategies that include:

- identifying communities demonstrating high numbers or rates of teen births as priority regions;
- establishing ambitious yet feasible targets for teen births reduction;
- identifying needs and gaps in services to prevent and support teen parents;
- prioritizing resource allocation for evidence-based program implementation in high-need communities;
- providing training and technical assistance regarding evidence-based health education strategies in collaboration with the PED; and
- developing a plan for coordinating and delivering services.

Even without a statutory change, however, the Department of Health may take action to include such a plan in its annual comprehensive plan.

Target state appropriations to continue to invest in programs and services to support teen parents and their children, including adult basic education, the GRADS program, home visiting, and early childhood programs.

The Department of Health should:

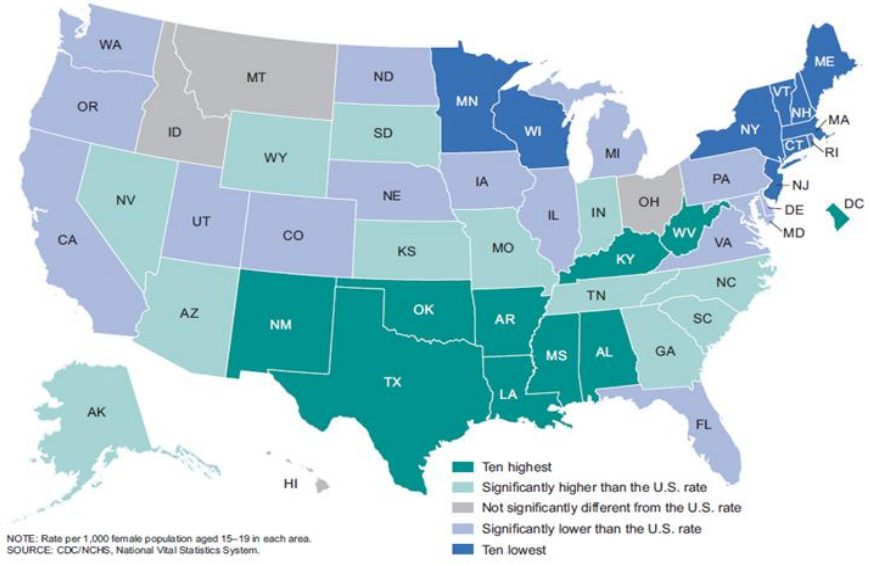
Establish a plan to collect and analyze school-based health center billing data for all provider sites by July 1, 2015. In the short term, the DOH should use this data to develop a new formula for distributing general fund allocations to school-based health centers to prioritize centers with the greatest needs. The DOH should also work with the legislature to develop recommendations to begin replacing general fund revenue with Medicaid funds and establish a plan for meeting reasonable payer mix levels as part of the budget cycle beginning September 1, 2016.

Collaborate with the Human Services Department to develop a plan to increase knowledge and provide technical assistance to safety net providers regarding the most effective forms of contraception, as recommended by the CDC.

Pursue public-private partnership opportunities to implement best-practices related to the most effective forms of contraception among teens at high-risk of becoming parents.

Nationally, teenage birth rates reached historic lows in 2013, though rates remain among the highest in the developed world. According to the Centers for Disease Control and Prevention (CDC), the U.S. recorded a birth rate of 26.5 births per 1,000 females 15 to 19 years of age, a rate higher than nearly all other industrialized countries. Despite these persistently high rates, teen pregnancy rates in the U.S have declined to the lowest levels the country has witnessed since the 1940s.

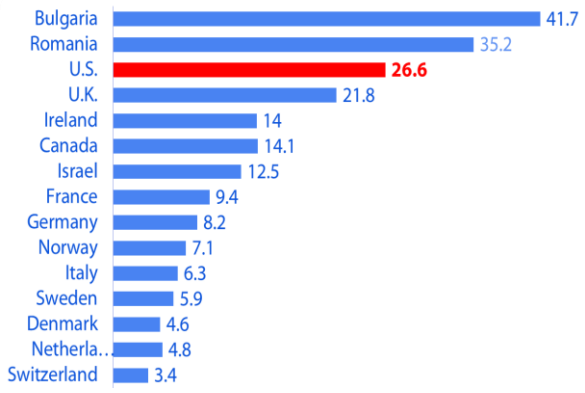
Figure 1. U.S. Teen Pregnancy Rates, 2013



Source: CDC

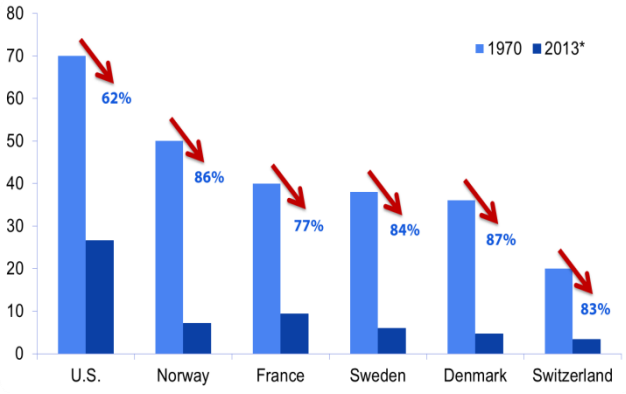
The U.S. continues to have a higher teen birth rate than many countries of similar economic status. Despite the recent decline in teen pregnancies, the U.S. teen birth rate is equal to that of some developing countries. Rates of teen pregnancy in other developed countries are far lower and are decreasing much faster than in the U.S.

Figure 2. Teen Birth Rate (Births per 1,000) in Developed Countries



Source: CDC

Figure 3. Percentage Decrease in Teen Pregnancies from 1970 – 2013 in Six Developed Countries



Source: CDC

Births to teens result in high costs to states. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, teen childbearing in the U.S. costs tax payers at least $9.4 billion in 2010. Most of the costs of teen childbearing are associated with negative consequences for the children of teen mothers, including costs for health

care (Medicaid and the Children's Health Insurance Program), increased risk of abuse, neglect, and foster care, incarceration, participation in the child welfare system, and lost tax revenue associated with decreased earnings and spending. Sixty-seven percent of teen mothers who move out of their own family's household live below the poverty level, and 63 percent of teen mothers receive some type of public benefits within the first year after their children are born (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2012). Less than 25 percent of teen mothers receive any child support payments. The National Conference of State Legislatures (NCSL) reports the children of teen mothers are twice as likely to be placed in foster care, compared to children born to older parents. Children born to teen mothers are more likely to start school behind their peers, score lower on standardized tests, and are twice as likely to repeat a grade as their peers not born to teen mothers.

High rates of teen pregnancy and associated sexual risk behaviors are of concern in the United States; nationwide, 47 percent of high school students have had sexual intercourse and 24 percent have had four or more partners by graduation, reports the CDC. In 2011, nearly 40 percent of sexually active high school students report not using a condom during their last sexual intercourse, increasing the risks of pregnancy and sexually-transmitted infections (STIs).

Research suggests that explanations for teen pregnancy fall into three general categories—motivation, knowledge, and access. These categories can be further described as cultural shifts toward acceptance of unwed childbearing; a lack of positive alternatives to motherhood among the less advantaged; a sense of fatalism or ambivalence about pregnancy; a lack of marriageable men; limited access to effective contraception; a lack of knowledge about contraception; and the difficulty of using contraception consistently and correctly (Sawhill et al, 2010). For teens in poverty, researchers recommend pregnancy prevention be designed to motivate individuals to avoid unintended pregnancies, improve their knowledge about contraception, remove barriers to contraceptive access, and provide feasible life alternatives.

The Brookings Institute reports low-income women are five times more likely than affluent women to have an unintended birth, but sexual activity does not vary by income level. Across income levels, women between the ages of 15 and 44 report similar levels of sexual activity. The Brookings Institute attributes the differences in unintended births to women of varying income levels to differences in contraception use and reports low-income women are less likely to use contraception consistently and correctly. According to the Brookings Institute, evidence suggests limited access to sex education and contraceptives in low-income communities widens the income-fertility gap. While the federal Affordable Care Act mandates the coverage of family planning services, the Brookings Institute reports a lack of knowledge about the efficacy of LARC methods and limited access to quality medical advice about contraception among low-income women.

Child Maltreatment. Children born to teen parents are more likely to experience poor social and educational outcomes, developmental delays, and poorer health than children born to parents above the age of 20. Children born to teen parents are more likely to experience child abuse and neglect, suggests research compiled by Florida State University, and children with early experiences of maltreatment are also significantly more likely to become parents as teens (Smith, 1996).

Previous LFC reports have highlighted the fact that many New Mexican children are living in poverty, exposing these children to risk factors that can impair brain development. Poverty negatively impacts child development and a child's readiness to learn. As a result, one quarter of New Mexico's children enter kindergarten without being able to read a single letter, far behind their peers. To address this issue, significant investments have been made in evidence-based early childhood programs. Research consistently shows that quality early intervention, through education and health care before age 5, impacts future success. New Mexico ranks among the highest in the nation for increases in early childhood funding.

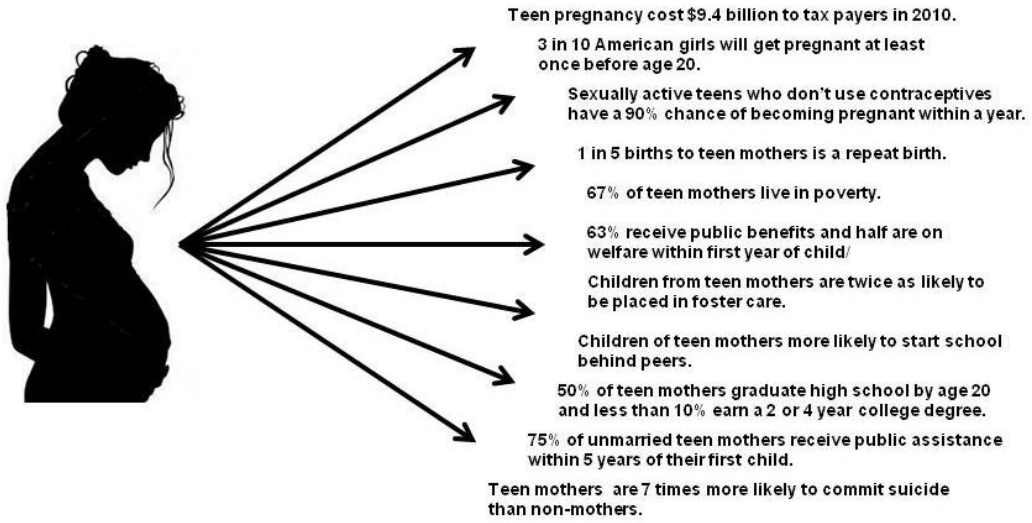
In addition, costs of child maltreatment in New Mexico are substantial, with $113 million spent annually through the Child Protective Services Division of the Children, Youth and Families Department. A previous LFC study found 36 percent of children who are the victim of a substantiated case of maltreatment will be abused or neglected again before they are 18-years-old. Previous LFC evaluations have concluded that reducing child maltreatment and

placement in foster care, even just by 10 percent, can save tens of millions of dollars. A recent documentary about child maltreatment in New Mexico highlights the need for early intervention to support families with risk factors to help prevent teen pregnancy (Schueler, 2014).

High School Graduation. Though the state's four-year graduation has increased since FY08, New Mexico's dropout rate continues to remain one of the highest in the nation. A 2014 LFC evaluation estimated significant costs to the state result when students fail to complete a high school credential or equivalent. Each ninth grade class loses roughly 7,700 students who fail to graduate in four years, and in FY13 nearly 7,200 students dropped out of the state's public school system. National research indicates adults without a high school credential are more likely to live in poverty, become incarcerated at some point in their lives, rely on public assistance, and cost tax payers $200 thousand over their lifetimes. In New Mexico, the annual median income for an adult without a high school credential is $17 thousand, compared to an adult with a high school diploma, who earns an annual median income of $25 thousand. Over 50 percent of adults incarcerated in New Mexico lack a high school credential. The 2014 LFC evaluation concluded increasing the number of students who graduate annually by 2,600 would result in an estimated $700 million in net benefits to tax payers, society, and these students over their lifetime. According to NCSL, teen pregnancy is a significant risk factor that makes students more likely to drop out.

Early Childhood Education. Poverty contributes significantly to child development and negatively impacts a child's readiness to learn, leading many students to enter school significantly behind their peers. Seventy-five percent of young children in New Mexico have at least one risk factor known to impact health, education, or development, and 23 percent of children are at moderate or high risk for developmental delays or behavioral problems. New Mexico ranks near the bottom nationally for child well-being outcomes, and in response the Legislature has made significant, targeted investments in intervention programs. Previous Legislative Finance Committee (LFC) evaluations and national research confirm evidence-based interventions and early childhood education programs can improve child well-being, safety, and educational outcomes and close the achievement gap. In an effort to achieve these outcomes, the Legislature has taken action to invest in prekindergarten, childcare assistance, home visiting, and the state's extended school year program K-3 Plus, among others. Since FY12, early childhood appropriations have increased by almost $100 million, and the General Appropriation Act of 2015 increased appropriations for early childhood by another $15.8 million.

Figure 4. Outcomes Associated with Teen Pregnancy



Source: LFC

FEDERAL PROGRAMS TO REDUCE TEEN PREGNANCY

Federal Title V and PREP. The federal State Abstinence Education Grant Program (AEGP), also known as 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 FY14, New Mexico was allocated $408 thousand through the AEGP.

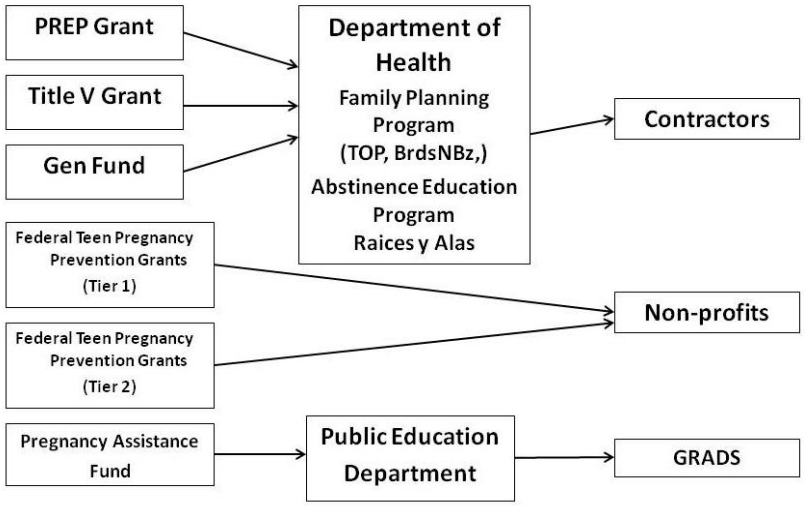
Through the State Personal Responsibility Education Program (PREP), the federal Family and Youth Services Bureau awards grants to state agencies to educate young people on both abstinence and contraception to prevent pregnancy and STIs, including HIV/AIDS. The program targets youth ages 10 to 19 who 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.

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.

Figure 5. Teen Pregnancy Prevention Education



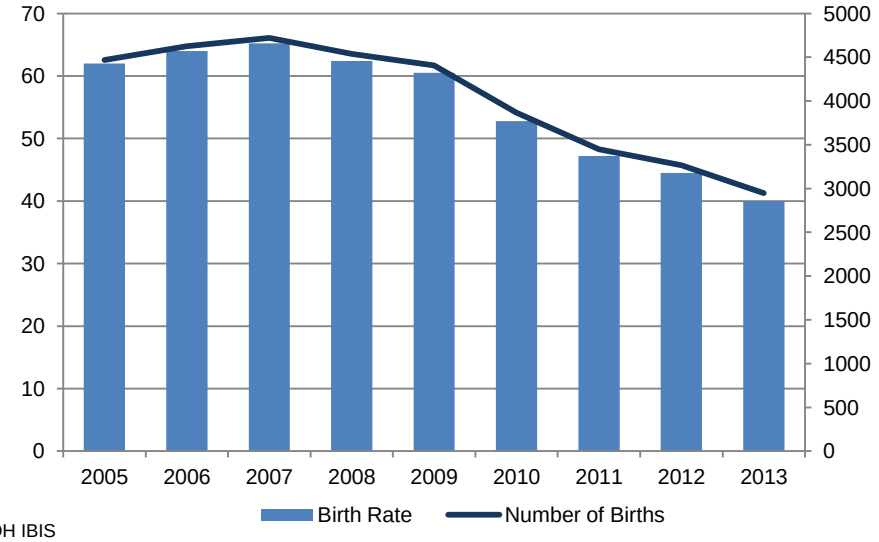
Source: LFC

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 non-profits. Title X provides funding to more than 4,400 clinics across the nation that serve nearly 5 million women, men, and adolescents. Almost 75 percent of counties in the U.S. have at least one Title X supported clinic. 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. In 2010, every $1 invested in publicly-funded family planning services saved $7.09 in Medicaid and other public expenditures that otherwise would have been needed (Guttmacher Institute). Over 90 Title X clinics operated in New Mexico, including 16 sites which operate on school campus. Title X funds are used to provide clinical services, unlike the federal funds mentioned above, which support programmatic interventions.

TEEN PREGNANCY CONTINUES TO BE ASSOCIATED WITH NEGATIVE OUTCOMES, PRODUCING SUBSTANTIAL COSTS TO THE STATE

The teen birth rate in New Mexico has declined by 35 percent over the last decade, though New Mexico has the second highest teen pregnancy rate nationally. Since 2005, the number of births to adolescents aged 10 to 19 in New Mexico has declined from 4,469 in 2005 to 2,980 in 2013, the most recent year for which data is available. At the same time, the rate of births to teens between the ages of 15 and 19 declined from 62 per 1,000 population in 2005 to 40 per 1,000 population in 2013, a 35 percent decline.

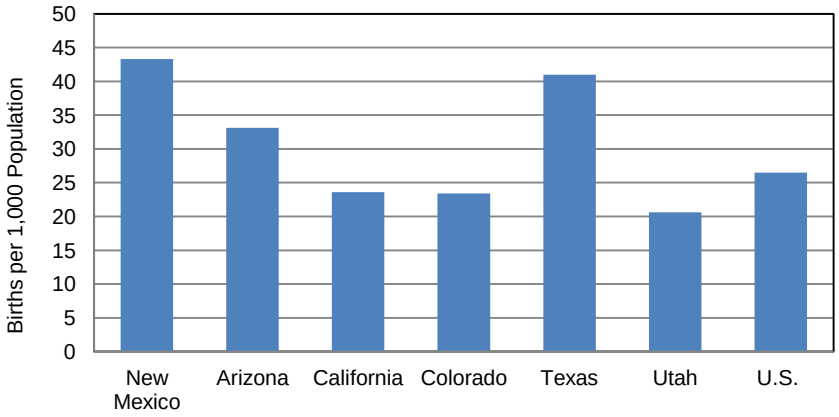
Chart 1. Number of Births to Adolescents Ages 15 to 19 and Teen Birth Rate, 2005-2013



Source: DOH IBIS

According to the Pew Charitable Trust, a variety of factors contribute to the national decline in teen pregnancy rates, including an increase in the use of long-acting reversible contraception (LARC) devices, the federal Teen Pregnancy Prevention Initiative, and a decline in teen sexual activity since the 1990s. Despite this decline, the Annie Casey Foundation reported New Mexico ranked 49th among states for births to teens ages 15 to 19, with 40 births per 1,000 in 2013, the most recent year for which data is available. The national average in this year was 29 births per 1,000 births. In 2012, the CDC reported New Mexico had the highest teen pregnancy rate nationally.

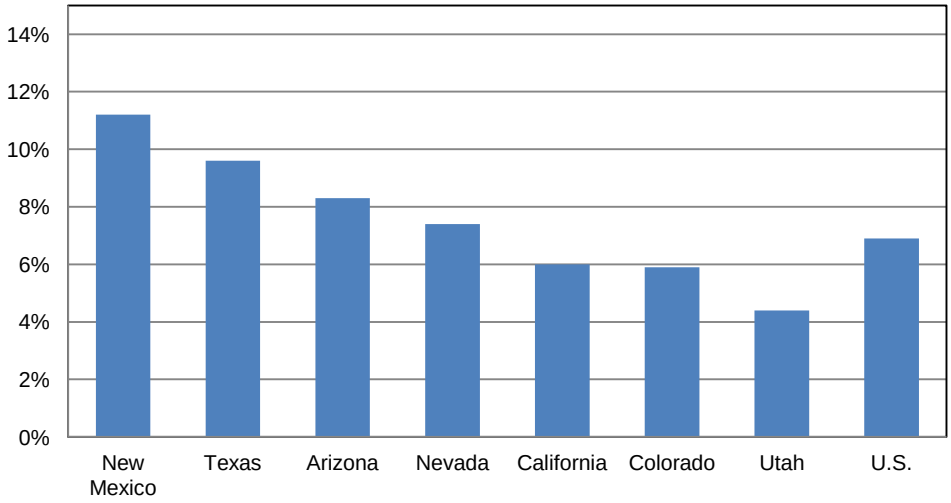
Chart 2. Teen Birth Rates Among 15 to 19-Year-Olds, 2013



Source: Centers for Disease Control

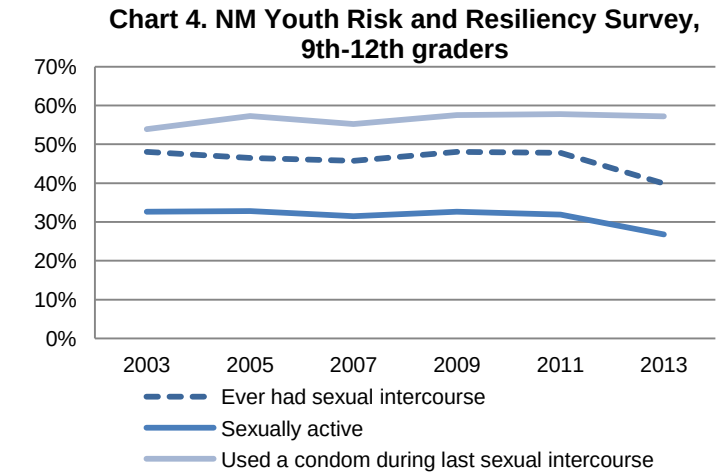
Births to teen mothers also account for a greater share of all births in New Mexico than do teen births in surrounding states. In 2013, births to teen parents accounted for 11 percent of all births in the state, compared to 7 percent of all births nationally.

Chart 3. Percent of Births to Teens, 2013



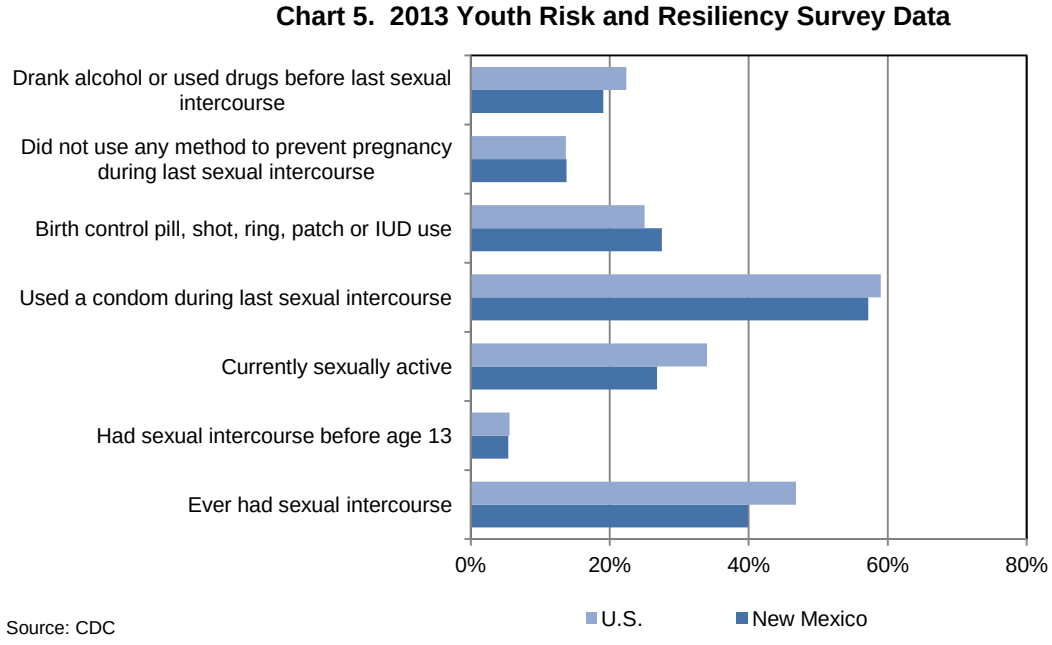
Source: LFC Analysis

Risky sexual behaviors among teens in New Mexico have declined slightly in recent years, reflecting national trends. The New Mexico Youth Risk and Resiliency Survey (YRRS) is a survey of public middle and high school students that includes questions about risky behaviors, including mental health, drug and alcohol use, nutrition, and sexual activity. From 2011 to 2013, the percent of teens who reported ever having sexual intercourse, as well as the percent of teens who reported being sexually active, declined, while the percent of teens who reported using condoms increased. This decline coincided with the decline in teen birth rate reported between 2010 and 2013.



Source: LFC Analysis

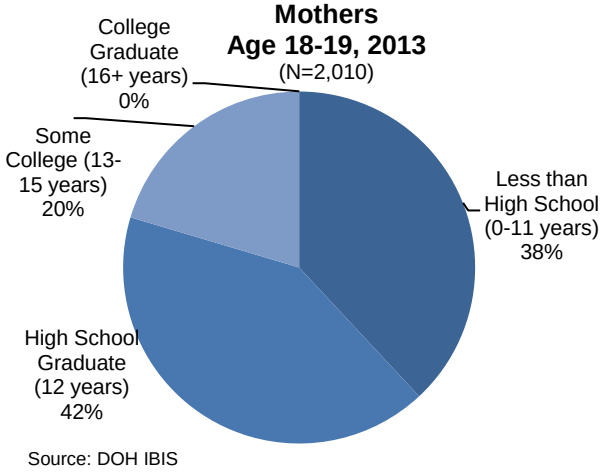
Additionally, CDC data suggest New Mexico teens generally are not more likely to report engaging in risky sexual behaviors than youth in other states. Results collected by the CDC in 2013 suggest New Mexico teens are less likely to report being sexually active than youth nationally.



Source: CDC

Teen pregnancy also contributes to the large number of students who fail to complete a high school credential. According to the CDC, pregnancy and childbirth have a significant impact on educational outcomes for children. Nationally, by age 22 only about 50 percent of teen mothers will receive a high school diploma and 30 percent will earn a high school credential equivalent, whereas 90 percent of women who do not give birth will receive a high school diploma, reports the CDC. Additionally, only about 10 percent of teen mothers complete a two- or four-year college program. Data in New Mexico suggest most teen mothers will give birth prior to entering post-secondary education, and national data suggest these women are unlikely to complete post-secondary education. Research indicates maternal education is one of the greatest predictors of a child's life outcomes. If the mother does not complete high school, the chances of a child being raised in poverty are dramatically increased, and the related risk factors associated with poverty increase (Strunk, 2008).

Chart 6. Educational Attainment of Teen Mothers Age 18-19, 2013
(N=2,010)



Source: DOH IBIS

High numbers and rates of teen births tend to be concentrated in a few counties and among certain high-risk populations, suggesting geographically targeted approaches to teen pregnancy reduction may produce significant statewide improvements. Births to teens account for a greater share of all births in New Mexico than do teen births in other states. Statewide in 2013, roughly 11 percent of all births were to mothers between the ages of 10 and 19, though rates varied by county and exceed 15 percent in Lea, Roosevelt, Eddy, Quay, Socorro, and Luna counties.

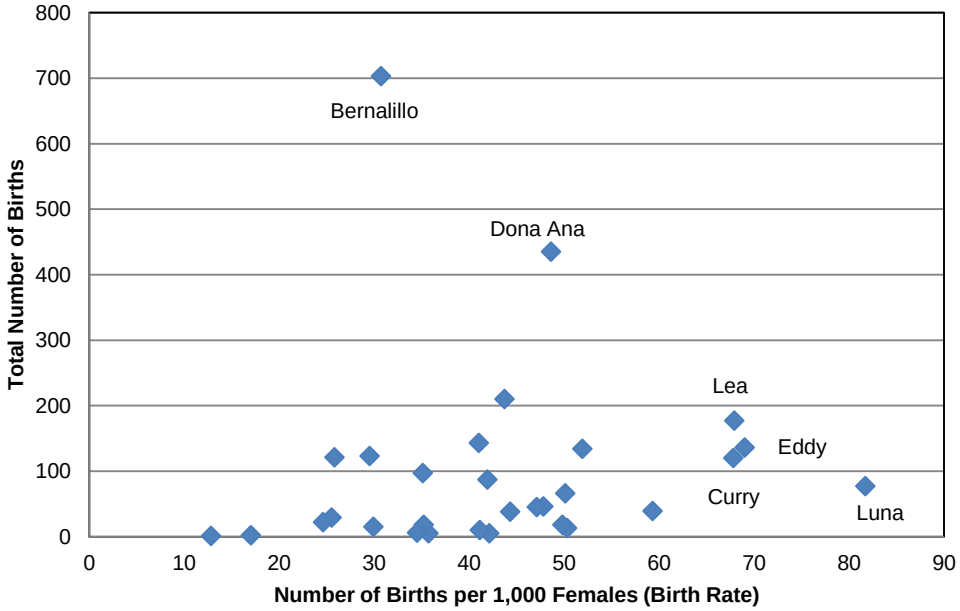
Table 1. Percentage of All Births to Adolescent Mothers Ages 10-19, 2013

Luna	20%
Socorro	18%
Quay	17%
Eddy	15%
Roosevelt	15%
Lea	15%
Dona Ana	14%
Chaves	14%
Union	14%
Colfax	13%
Curry	13%
Hidalgo	13%
Cibola	13%
McKinley	13%
Grant	12%
Rio Arriba	12%
Valencia	12%
Mora	11%
Statewide	**11%**
San Juan	11%
Otero	11%
Torrance	10%
Lincoln	10%
Santa Fe	9%
San Miguel	9%
Sandoval	9%
Sierra	9%
Bernalillo	9%
Taos	8%
Guadalupe	5%
Catron	5%
Los Alamos	3%
De Baca	0%
Harding	0%

Source: DOH IBIS

While Bernalillo and Dona Ana Counties account for the largest numbers of births to teen parents, Lea, Curry, Eddy, and Luna counties have the highest rates of teen births.

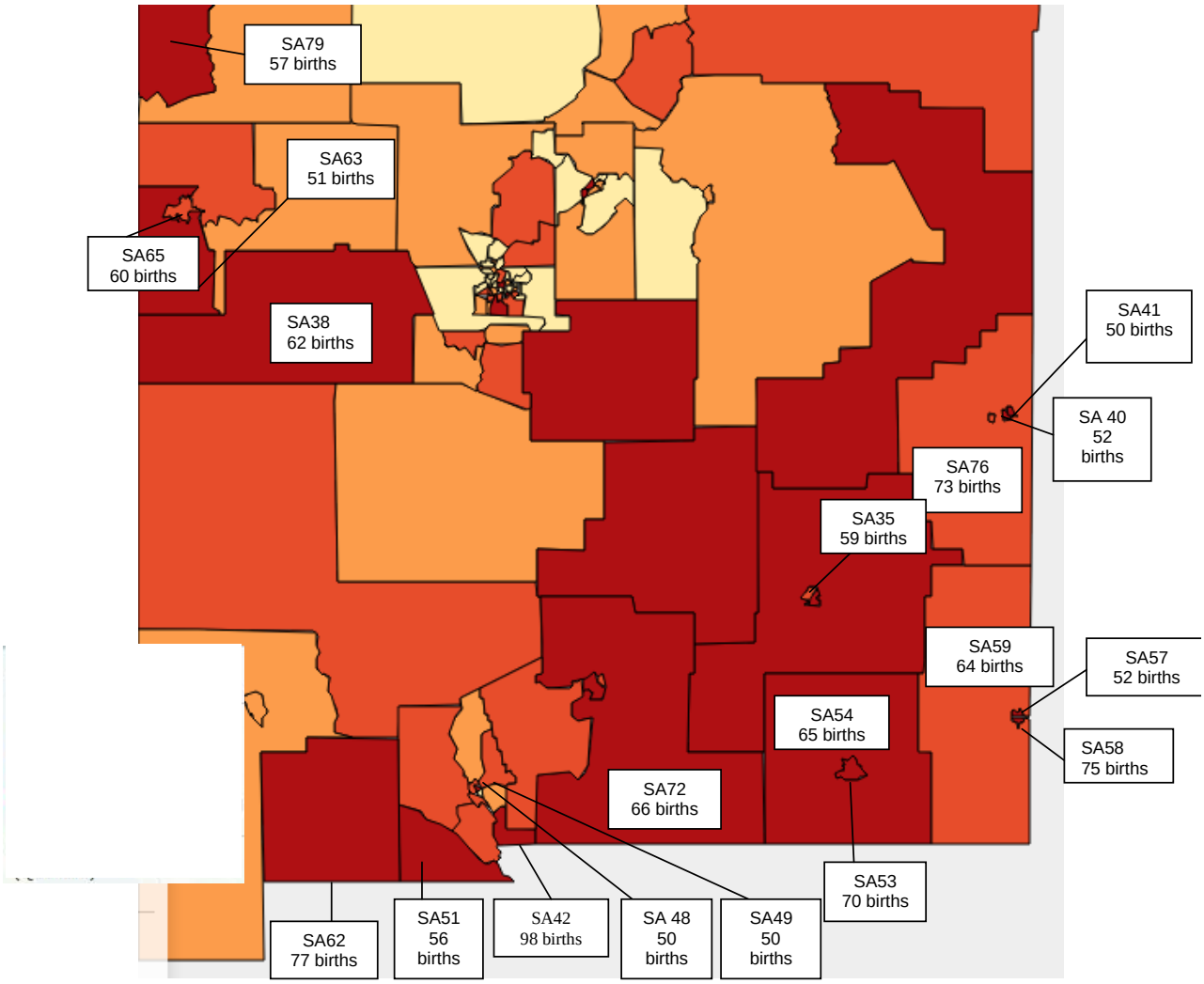
Chart 7. 2013 Teen Birth Rate and Total Number, by New Mexico County



Source: LFC Analysis

The U.S. Census defines small areas, which are geographic regions that contain roughly 30 thousand people. New Mexico contains 109 small areas. Teen births are also concentrated at the sub-county level; 22 of the 109 small areas in New Mexico reported 50 or more births to teens in 2011, the most recent year for which data is available. Together, the 22 small areas with 50 or more teen births in 2011 account for roughly 42 percent of all teen births. These data suggest teen births are concentrated in certain geographic locations, and targeting efforts to reduce teen births in these communities could produce dramatic reductions in teen births at the state level.

Figure 6. New Mexico Small Areas with More Than 50 Births, 2011



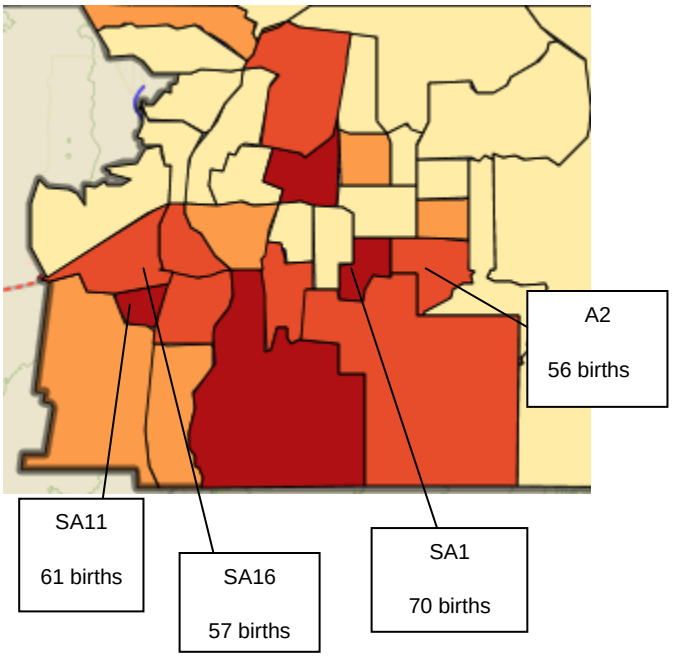
Source: LFC Analysis

Table 2. Small Areas with More Than 50 Teen Births, 2011

NM Small Areas	NM Small Areas ID	Number of Births in Small Area	Birth Rate Per 1,000 Girls Ages 15-19
Dona Ana County, Anthony Berino Chaparral	SA42	98	87.2
Luna County	SA62	77	79.7
Lea County, Hobbs South	SA58	75	131.6
Roosevelt County/Curry County, Other	SA76	73	56.5
Bernalillo County, Central Penn	SA1	70	71
Eddy County, Carlsbad	SA53	70	70.6
Otero County, Other	SA72	66	70.2
Eddy County, Other	SA54	65	73.3
Lea County, Other	SA59	64	53.8
Cibola County	SA38	62	64.4
Bernalillo County, Arenal Unser	SA11	61	66.2
McKinley County, SW	SA65	60	61.1
Chaves County, Roswell N.W.	SA35	59	50.2
San Juan County, Farmington West/Kirtland/La Plata	SA79	57	57
Bernalillo County, South Ninetyeight	SA16	57	48.6
Dona Ana County, Sunland Park	SA51	56	61.3
Bernalillo County, Central Tabo	SA2	56	56.9
Curry County, Clovis West	SA40	52	85.2
Lea County, Hobbs North	SA57	52	75.3
McKinley County, Gallup	SA63	51	51.6
Curry County, Clovis East	SA41	50	72.9
Dona Ana County, Sonoma Butterfield Moongate	SA49	50	51.8
Dona Ana County, Northwest Las Cruces	SA48	50	51.6
Total Statewide		**3,447**	**47.2**

Source: LFC Analysis

Figure 7. Bernalillo County Small Areas with More than 50 Teen Births, 2011



Source: LFC Analysis

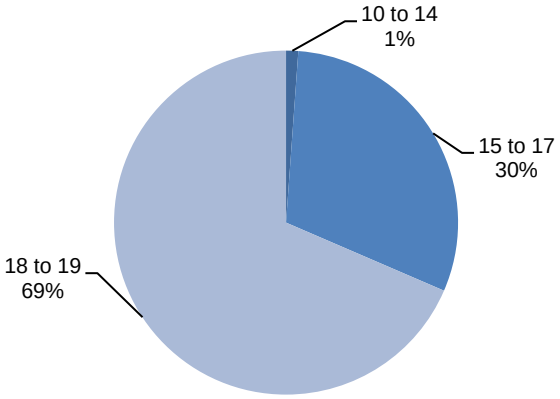
Eighteen and 19-year-old mothers account for 70 percent of all teen births in New Mexico. Teenage birth rates are calculated for women ages 15 to 19, but the rates among teens ages 18 to 19 are nearly four times that of their younger peers, and nearly three-quarters of teen births in New Mexico are to 18-to 19-year-olds. In 2013, 7 percent of all 18-and 19-year-old women in New Mexico gave birth.

Table 3. Percent of NM Adolescent Female Population Giving Birth, 2013

Age Range	Total Births	Total Female Population in Age Range	% of Female Population in Age Range Giving Birth
10 to 14	34	70,339	<1%
15 to 17	904	44,174	2%
18 to 19	2,042	29,447	7%

Source: DOH IBIS

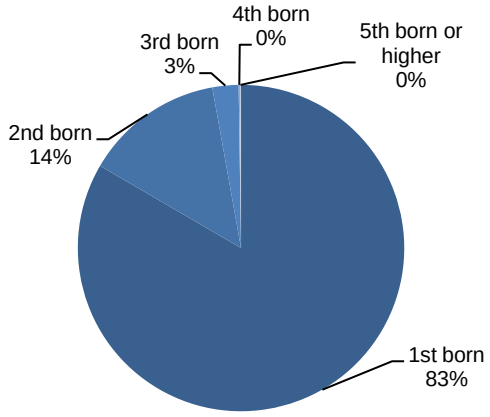
Chart 8. 2013 NM Adolescent Births by Age Range
(N=2,980)



Source: DOH IBIS

Roughly 17 percent of all teen births in New Mexico are to mothers who have already had a child. In 2013, 498 of all teen births, roughly 17 percent, to mothers between the ages of 10 and 19 were repeat births. This rate is similar to the national average, as the CDC reports 20 percent of all births to teen mothers are not the first birth.

Chart 9. NM Birth Order of Births to Teens, 2013



Source: DOH IBIS

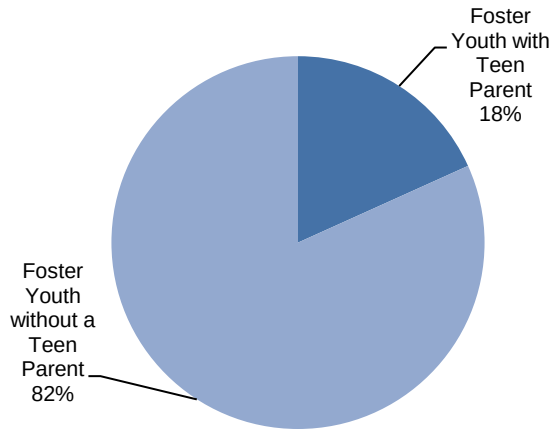
Table 4. Percent of NM Births that are Subsequent Births by Mother Age, 2013

Girls 15 to 17 Years Old	7%
Girls 18 to19 Years Old	21%

Source: DOH IBIS

Child maltreatment is linked to teen births, resulting in the need for Child Protective Services interventions. In FY14, 18 percent of all New Mexico youth in foster care had a teen parent, and 12 percent of youth aging-out of foster care became parents by age 19. Research suggests children born to teen mothers are at greater risk for child abuse and maltreatment, compared to children born to older mothers (Stier et al, 1993). As a result, children born to teen parents make up a greater proportion of the children in CYFD custody than among New Mexico's overall child population. In 2014, 684 of the 3,063 children in CYFD custody had one or more caretakers who were 19-years-old or younger at the time of the child's birth. Assuming this number reflects only a single year of child custody and roughly 3 thousand children are born to teen parents every year, teen pregnancy does appear to be a significant risk factor associated with child maltreatment in New Mexico.

Chart 10. New Mexico Foster Youth Born to a Teen Parent, 2014



Source: LFC analysis

At the same time, NCSL reports teen pregnancy rates among teens in foster care are much higher than among their peers. By age 19, pregnancy rates for girls in foster care are 2.5 times greater than among their peers not in the system. Nearly half of all girls in foster care become pregnant by age 19, and 75 percent become pregnant by age 21, compared to one-third of their peers. Young men in foster care report having impregnated someone at higher rates as well; by age 21, 50 percent of men in foster care say they have impregnated someone compared to 19 percent of young men not in foster care. Youth aging out of foster care as parents face significant challenges, including caring for children, completing education, and finding employment. In 2011, a cohort of 65 New Mexicans aged out of the foster care system. According to the National Data Archive on Child Abuse and Neglect, by age 19, 12 percent of these young adults reported having a child.

Given certain populations appear to be at greater risk for teen pregnancy and account for a disproportionate share of teen births in New Mexico, efforts to target interventions to these populations have the potential to produce dramatic population-level reductions in teen pregnancy.

Negative outcomes associated with teen births cost New Mexico an estimated $84 million in FY13. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, teen childbearing in the United State cost tax payers at least $9.4 billion in 2010 and cost New Mexico $103 million in 2010. Most of the costs of teen childbearing are associated with negative consequences for the children of teen parents, including costs for health care (Medicaid and CHIP), increased risk of abuse, neglect, and foster care, increased risk of incarceration, increased risk of participation in the child welfare system, and lost tax revenue associated with decreased earnings and spending. Sixty-seven percent of teen mothers who moved out of their own family's household live below the poverty level, and 63 percent of teen mothers receive some type of public benefit within the first year after their children are born.

Additionally, children born to teen mothers are more likely to start school behind their peers, score lower on standardized tests, and are twice as likely to repeat a grade than their peers not born to a teen mother, reports NCSL. Sixty-one percent of 18-and 19-year-old women who have a child while enrolled in college fail to complete a degree, a rate 65 percent higher than for students who do not have a child while in college. Teen pregnancy also significantly affects the educational attainment of the teen mother. According to NCSL, 30 percent of teenage girls who drop out of high school cite pregnancy or parenthood as a primary reason. This rate is even higher for Hispanic and African American teens, 36 and 38 percent, respectively. Nationwide, NCSL reports only 40 percent of teen mothers finish high school and less than two percent of teen mothers who have a child before age 18 finish college by age 30. Previous LFC evaluations have noted significant costs to taxpayers and individuals when students fail to complete high school.

In 2013, 2,980 babies in New Mexico were born to teen mothers, and the National Campaign to Prevent Teen and Unplanned Pregnancy estimates the average annual cost to taxpayers associated with a child born to a teen mother is $1,682. The National Campaign to Prevent Teen and Unplanned Pregnancy assumes this annual cost continues until the child is age 15 as a conservative estimate and excludes the cost of the child's birth. Assuming this cost estimate, the 2013 cohort of children will cost New Mexico roughly $5 million annually for 15 years. All children born to teen parents cost the state roughly $75 million annually, assuming the 2013 number of children born to teen parents remains constant.

Table 5. Estimated Costs Associated with Teen Births in New Mexico

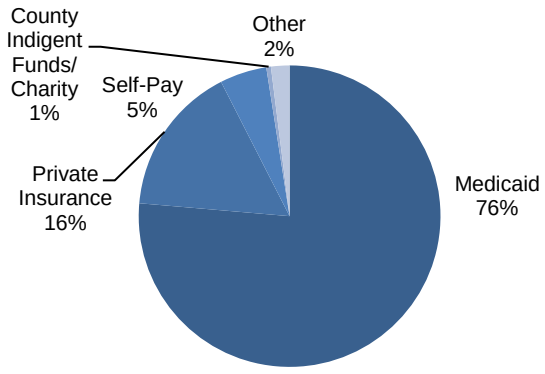
Number of NM Teen Births in 2013	2,980
Estimated Cost Per Year Of Child Born to Teen Parent	$1,682
Estimated Cost Per Year of 2013 Teen Births	$5 million
Estimated Cost Per Year Of All Children Between the Ages of 0 and 15 Born to Teen Parents in 2013	$75.2 million

Source: LFC Analysis

The National Campaign to Prevent Teen and Unplanned Pregnancy estimates that between 1991 and 2010, 93,760 children were born to teen mothers in New Mexico, costing tax payers an estimated $2.5 billion over that period.

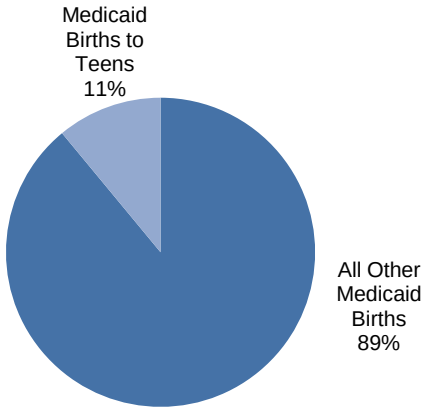
New Mexico incurs significant Medicaid costs from births to teen parents, as 76 percent of teen births were funded by Medicaid in 2013. In 2013, an estimated 76 percent of teen births in the state, or 2,155 births, were funded by Medicaid. Given a 2015 LFC evaluation which found roughly 80 percent of all births in New Mexico are paid for by Medicaid, this estimate may be conservative. Births to teen parents accounted for roughly 11 percent of all Medicaid births in 2013, comparable to the share of all births accounted for by teen parents.

Chart 11. Payer Source of Births to Teens, 2013
(N=2,822)



Source: DOH IBIS, Hospital Discharge Data

Chart 12. Percent of Medicaid Births to Teens, 2013
(N=19,150)



Source: LFC Analysis

A 2012 LFC evaluation titled *Improving Outcomes for Pregnant Women and Infants Through Medicaid* found health outcomes for full-term infants cost Medicaid roughly $2,100 during the first year of life, while pre-term babies cost Medicaid an estimated average of $20 thousand in medical care during the first year of life. In FY13, 13 percent of all teen births were preterm. Using this assumption, infants born to teen mothers in FY13 cost Medicaid an estimated $9.1 million during their first year of life.

New Mexico could reach the national average teen birth rate with roughly one thousand fewer teen births each year. In 2013, the average birth rate to teens between the ages of 15 and 19 was 26.5 per 1,000 births, reports the CDC. New Mexico's rate was 40.0 per 1,000 births. In 2013, 2,946 births were reported to teens between the ages of 15 and 19 in New Mexico. If this number were to decline by just 995 births, New Mexico would reach the national birth rate of 26.5 per 1,000 births. Reducing teen births by 995 from the 2013 level every year, New Mexico would save roughly $29.5 million annually.

NEW MEXICO IS IMPLEMENTING EVIDENCE-BASED TEEN PREGNANCY PREVENTION PROGRAMS, BUT EFFORTS ARE INCONSISTENT AND ARE NOT COORDINATED AMONG AGENCIES

Thirty-five teen pregnancy programs identified and evaluated by the U.S. Health and Human Services Department are designated as evidence-based programs. Since 2009, the U.S. Department of Health and Human Services (U.S. HHS) has sponsored an independent systematic review of teen pregnancy prevention literature to identify programs with evidence of effectiveness in reducing teen pregnancy, STIs, and associated risky behaviors. This review has been conducted by Mathematica Policy Research and Child Trends. As of 2013, the team has identified 35 programs meeting the review criteria for evidence of effectiveness. These criteria require programs to demonstrate evidence of favorable, statistically significant impacts on at least one sexual behavior or reproductive health outcome, including sexual activity, contraceptive use, STIs, pregnancy, or birth, and that the supporting research met established criteria for research design and execution.

Programs receiving an evidence-based designation are targeted to diverse population groups and reflect a range of approaches. The U.S. HHS notes that a broad range of program models delivered in diverse settings are evidence-based, with programs ranging from curriculum-based abstinence and sexuality education programs to individualized clinic-based services, in school, community, and clinical settings (Appendix B). This research suggests no single program, format, or curriculum for improving adolescent sexual health outcomes exists, and research suggests among similar types of program structures, significant variation in impact exists. This research also suggests options exist for identifying program structures that will meet the unique needs and interests of local communities. However, U.S. HHS cautions that program impacts may weaken if models are expanded without efficacy.

According to the U.S. HHS, in order to reduce teenage pregnancies, interventions should be designed to address multiple sexual and nonsexual antecedents that correlate with adolescent sexuality, and which may be related to the adolescents, their families, schools, communities and cultural factors. The U.S. HHS suggests the intervention should include non-sexual factors, such as skills training and personal development. Further, stakeholders including pregnant teens, parents, health sector, and schools should work together to devise programs that are practical, evidence-based, culturally-appropriate, and acceptable to the target population.

Research also suggests, the most effective programs in the United States combine medically accurate information on a variety of sexuality-related issues, including abstinence, contraception, safer sex, the risks of unprotected intercourse and how to avoid them, as well as the development of communication, negotiation, and refusal skills. Teens who have comprehensive sex education are half as likely to experience a pregnancy as those who attend abstinence-only programs. A 2007 review of sex education curricula found that the most effective comprehensive programs lowered risky sexual behavior by about one-third (Margolis & Roper, 2014).

New Mexico lacks a concrete, coordinated, and comprehensive state plan to reduce teen pregnancy. New Mexico has several established structures and programs for preventing teen pregnancy, including comprehensive health education standards developed and implemented by the Public Education Department (PED) and evidence-based prevention programs overseen by the DOH. Additionally, the work of individual non-profits suggests localized efforts to reduce teen pregnancy exist, but they are not coordinated or connected with other state efforts. Similarly, while DOH's efforts to implement evidence-based programs is promising, these efforts may be necessary, in part, because the state's public schools are not fully implementing the adopted health education standards.

Statute directs DOH to develop an annual comprehensive strategic plan for health. The department's FY14 to FY16 comprehensive plan includes preventing teen pregnancies and identifies continuing existing strategies as priorities. However, the plan does not identify strategies for coordinating efforts across agencies and does not establish targets for population-level reduction. Additionally, teen birth rate is not currently reported as an Accountability in Government (AGA) performance measure. Without a concrete and coordinated approach to reducing teen pregnancy, efforts in New Mexico may be duplicative and resources may not be targeted to the communities experiencing the highest rates and numbers of teen births. Examples of coordinated plans in other states suggest such approaches may allow states to make dramatic reductions in teen birth rates.

New Mexico's educational standards require school districts teach multiple strategies to prevent teen pregnancy and reduce risky behaviors, but not all schools report implementing these standards. In 2010, New Mexico statute was amended to require all students receive health education prior to graduation and allow school districts to decide whether health education will be offered in either middle or high school (Section 22-13-1.1 NMSA 1978). PED is responsible for developing and communicating the state's health education standards to districts. The state's health education standards were adopted in 1997 and last amended in 2009 (6- NMAC-29.6). In 2010, statute was also amended to required school districts and charter schools to submit a health education implementation plan in SY12 to demonstrate how the school district's health curriculum aligns with PED content and performance standards. Districts affirm that their curriculum meets standards, but PED does not conduct ongoing surveillance to ensure schools are teaching all of the standards; and PED likely does not have the current capacity to do so. While the adoption of specific health curriculum is determined by local school boards, the PED reports providing local school districts with suggestions about curriculum that meets the state's health standards. Statute also requires health education shall, "include age-appropriate sexual abuse and assault awareness and prevention training that meet department standards developed in consultation with the federal centers for disease control and prevention that are based on evidence-based methods that have been proven to be effective." (Section 22-13-1.1 NMSA 1978).

New Mexico's *Content Standards for Health Education* include abstinence and reproductive health beginning in grades three and four. Beginning in seventh and eighth grade, performance standards in health education include understanding "how healthy alternatives can replace unhealthy behaviors (i.e. abstinence, condom use, and other pregnancy prevention methods)." (6-NMAC-29.6).

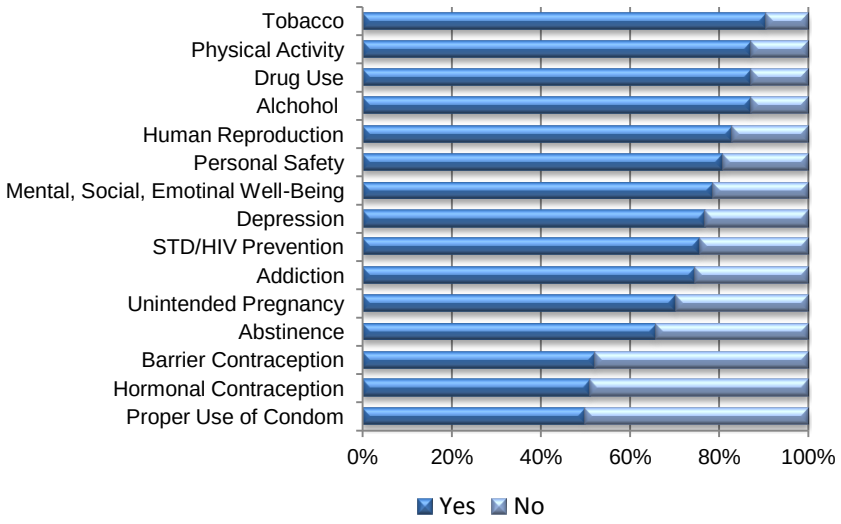
Thus, statute suggests evidence-based methods be used to teach some sexual health related topics but not pregnancy prevention specifically. New Mexico's health education standards for grades nine through 12, however, articulate that students should be able to describe how to delay onset and reduce risks of potential health problems in adulthood, including:

> "demonstrate knowledge of pregnancy prevention and prevention of sexually transmitted infections; understand human reproduction and how pregnancy can be prevented through the use of various methods of contraception, including barrier and hormonal methods; and understand the concept of sexually transmitted infections and recognize prevention strategies including abstinence, the proper use of condoms, and immunizations." (6-NMAC-29.6).

Educational materials and the grade levels at which they will be introduced are determined by local school districts. All instruction must be age-appropriate. Local school boards must "ensure the involvement of parents, staff, and students in the development of polices and the review of instructional materials" (6-NMAC-29.6). New Mexico's *Content Standards for Health Education* also require each school district or charter school implement a policy that will ensure parents have the ability to "opt-out" or request that their child be exempted from the parts of the health education curriculum that address sexuality performance standards.

Half of surveyed charter and district high schools report they do not teach topics of pregnancy and STI prevention included in the state's health education standards. LFC staff sent a survey to all middle and high schools, asking if the school taught topics listed in the state's health education standards. LFC survey and site visits indicate that many are not teaching concepts listed in the state's health standards for grades nine through 12.

Chart 13. Health Topics Taught by High Schools,
(N=94)



Source: LFC Survey

In addition, only a few principals who responded to the LFC survey reported implementing health curriculum identified as evidence-based by the U.S Office of Adolescent Health. These data suggest that school districts are not fully teaching the state's adopted health education standards, which may necessitate the teen pregnancy prevention programs offered outside of schools by the DOH and non-profits. As a result, the state may be paying for reproductive health education services through multiple funding sources in a potentially duplicative manner.

The PED is piloting efforts to help school districts implement health education best practices. The CDC provides school districts with the Health Education Curriculum Analysis Tool (HECAT) to provide schools guidance, appraisal tools, and resources to conduct effective health education curricula. As part of the Exemplary Sexual Health Education (ESHE), the CDC acknowledges that schools are a vital partner in providing health education that helps young people learn how to take responsibility for their health. Education programs, especially HIV/STI prevention programs, help delay first sexual intercourse, reduce the number of sex partners, decrease the number of times students have unprotected sex, and increase condom use. Results of the HECAT can help school districts and charter schools select or develop appropriate and effective health education curricula and improve the delivery of health education. The HECAT can be customized to meet local community needs and conform to the curriculum requirements of the state or school district. PED has received a grant from the CDC to examine health education curriculum in 13 school districts and provide training regarding the CDC's evidence-based approaches to HIV/STI prevention.

The New Mexico Department of Health is using teen pregnancy prevention funds to implement evidence-based approaches. The DOH Public Health Division (PHD) receives roughly $65 million in general fund support to provide a broad array of health services. The PHD's FY15 operating budget included a total of $182.7 million, a decline since the 2012 LFC evaluation, when the department's operating budget included $187.6 million. The PHD's mission includes the delivery of a variety of services, including the delivery of primary care, education, and outreach services. As a result, isolating funds allocated for teen pregnancy prevention is difficult, as services such as school-based health centers (SBHC) and public health offices, may provide reproductive health services for teens but are not exclusively devoted for this purpose.

Table 6. FY15 General Fund Allocations to Programs that May Support Teen Pregnancy Prevention
(in thousands)

DOH Program	Allocation
Family Planning Program	$1,345.7
School-Based Health Centers	$3,019.4
Adolescent Health	$88.0
Public Health Regional Offices	$15,948.0

Source: DOH

Additionally, the PHD received a total of $78.3 million in federal funds in FY15. Several of these federal funding sources are used to prevent teen pregnancy, among other health initiatives, but isolating the definitive amount spent on teen pregnancy prevention is difficult. The PREP grant and Abstinence Education grants (Title V) are intended exclusively for teen pregnancy prevention. In total, the PHD estimates $1.9 million was allocated for teen pregnancy prevention efforts via Title X clinics and community education programs in FY15. This total excludes funds allocated to school-based health clinics.

Table 7. FY 15 Public Health Division Allocations for Teen Pregnancy Prevention Efforts
(in thousands)

Teen Pregnancy Prevention Activity	Title X	Title V & State Match	PREP	Total
Title X Clinical Services*	$744.9	$520.6	N/A	$1,265.5
Community Education Programs	N/A	$200	$356.6	$627.8

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

Source: DOH

The DOH issues contracts to local providers to implement one of the evidence-based models identified by the U.S. HHS. The DOH allocated roughly $600 thousand for the evidence-based program Teen Outreach Program (TOP) in both FY14 and FY15. The department has elected to use funds to implement TOP and a texting service, called BrdsNBz, through which teens may receive medically-accurate answers in response to questions sent to public health nurses. Additionally, DOH awards Abstinence Education Program funds to several counties in southern New Mexico to implement an evidence-based abstinence education model. In FY14 roughly $700 thousand in state general funds and federal funds were allocated for TOP programs and the BrdsNBz texting service. In FY15 roughly $625 thousand has been allocated. This sum is slightly less than that allocated in FY14, in part because contracts with several providers were terminated during FY15.

BrdsNBz

The BrdsNBz texting service allows teens and parents to access medically-accurate reproductive health information by texting 66746. A public health nurse will respond to question within 24 hours.

Table 8. Funds Allocated for Evidence-Based Teen Pregnancy Prevention, FY14 and FY15

	FY14	FY15
New Mexico State General Fund	$251,122	$198,008
Federal Title V Funds	$175,000	$128,883
Federal PREP Grant Funds	$280,200	$298,400
Total	**$706,322**	**$625,291**

Source: LFC Files

The DOH reports the Teen Outreach Program, an evidence-based approach validated by the U.S. Office of Adolescent Health, is being implemented in 11 counties in New Mexico. The NM DOH Family Planning Program (FPP) promotes population-based strategies to reduce teen pregnancy, including youth development programs, adult/teen communication programs, and comprehensive health education programs. FPP maintains educational contracts for implementation of the evidence-based program Teen Outreach Program (TOP) operated in 16 sites in 11 counties in FY15. Contracts are awarded through an request for proposal (RFP) process. DOH reports 744 youth enrolled in the program and 507, or 68 percent, completed the program in FY14. Of these students, 99.7 percent did not become parents during FY14. Notably, several counties with large numbers or high rates of teen births, including Curry, Lea, Eddy, and Bernalillo counties, have few or no TOP sites.

Teen Outreach Program (TOP)

Wyman's Teen Outreach Program, a national youth development program, is designed to prevent adolescent problem behaviors by helping adolescents ages 12 to 18 develop healthy behaviors, life skills, and a sense of purpose. The non-profit Wyman Center is the developer of TOP. The nine-month curriculum combines service learning, adult support and guidance, and curriculum-based group activities. TOP groups meet at least once a week throughout the school year to discuss topics, including communication skills, understanding and clarifying values, relationships, goal-setting, decision-making, and adolescent health and sexual development.

A 2001 large-scaled, random assignment study of the program found that participating teens were significantly less likely to have failed a course (52 percent lower risk), be suspended from school (60 percent lower risk), or get pregnant (53 percent lower risk), and reductions in school dropout rates (60 percent). TOP costs an estimated $620 per student, and the Brookings Institute estimates a $1.29 return on investment for every $1.00 spent. However, research suggests the TOP program is most effective, and produces the greatest return on investment, when the program is targeted to high-risk youth.

Source: Child Trends, the Brookings Institute, Allen and Philihiber, 2001, Kilburn, 2014

Table 9. FY15 TOP Sites

Contractor	TOP Site	Location
Apple Tree Educational Center	Boys and Girls Club of Sierra County Manzano Christian School	Sierra County
Ben Archer Health Center	Village of Columbus Community Center Hatch Valley High School Dona Ana Community Center	Luna County Dona Ana County
Las Clinicas Del Norte	Mesa Vista Middle School	Taos County
Luna County	Deming High School Deming Intermediate School Red Mountain Middle School	Luna County
Navajo Prep	Navajo Preparatory School	San Juan County
Santo Domingo Pueblo	Kewa Family Wellness Center	Sandoval County
Torrance County	Estancia Town Hall	Torrance County
UNM Department of Pediatrics	Laguna Acoma Jr/Sr High School	Cibola County
UNM School Based Health Center	Native American Community Academy	Bernalillo County
West Las Vegas	West Las Vegas Middle School	San Miguel County
Youth Development, Inc.	Youth Development, Inc.	Valencia County

Source: DOH

Community organizations funded by the DOH Family Planning Program (FPP) also implement Raices y Alas, a two-hour workshop for parents of adolescents, designed to increase parents' confidence to talk with their children about health and relationships. Each TOP provider must complete two Raices y Alas workshops in their communities. The DOH Family Planning Program has issued an RFP for FY16 for contractors to implement additional evidence-based teen pregnancy prevention programming, including Cuidate!, HARMONY, Families Talking Together, and Adult Identity Mentoring Project.

Non-profits and other entities are also implementing local efforts to reduce teen pregnancy in high-risk communities. Several non-profits in New Mexico have received federal funds to validate or implement evidence-based teen pregnancy prevention programs among high-risk populations, but these grants will expire next year**.** In FY11, New Mexico received three federal grants totaling roughly $3 million from the U.S. Office of Adolescent Health for teen pregnancy prevention**.** The Office of Adolescent Health coordinates adolescent health programs and initiatives and manages several grant programs including the Teen Pregnancy Prevention Program, the Pregnancy Assistance Fund, and the National Resource Center for HIV/AIDS Prevention Among Adolescents. The Pregnancy Assistance Fund, which awarded a $1.5 million grant to the Public Education Department, aims to serve expectant and parenting teens. The Teen Pregnancy Prevention Program requires grantees to adopt evidence-based models approved by the U.S. HHS to reduce teen pregnancy among at-risk teen populations.

Table 10. New Mexico Federal Grant Recipients, FY10-15
(in thousands)

Agency	City	Program	Grant Amount
Capacity Builders, Inc.	Farmington	Teen Outreach Program	$988.2
National Youth Leadership Project	Gallup	Web of Life, adaptation of Project Venture and Circle of Life	$555.7
New Mexico Public Education Department		High schools/ community service centers; domestic violence and sexual assault prevention	$1,500.0

Source: US Office of Adolescent Health

Capacity Builders, Inc. is implementing the Teen Outreach Program model in Central Consolidated Schools, serving roughly 700 students annually. In 2010, Capacity Builders, Inc. received a federal Teen Pregnancy Prevention Tier 1 (TPP) grant from the Office of Adolescent Health to implement the evidence-based TOP program in San Juan County and began implementing the program during the FY12 school year. The Farmington-based non-profit is currently implementing the program in Central Consolidated School District sixth and ninth grade health classes. The program works one day each week in existing health classes to implement the TOP curriculum and is implemented by Capacity Builders, Inc. staff, who also monitor program fidelity. The program focuses on teaching youth to make positive decisions regarding risky behaviors, wellness goals, and teen pregnancy. The Tier 1 grant received by Capacity Builders, Inc. focuses on program replication (not evaluation), and so separating the impact of the program from the general decline in teen pregnancy rates around the state is a challenge. Additionally, teen pregnancy data is not yet available for 2014 or 2015. However, the program reports initial positive impacts. Compared to students in FY11, high school students in Central Consolidated School District reported declines in risky behavior on the Youth Risk and Resiliency Survey, and the birth rate among Native American teens in San Juan County declined.

Table 11. Central Consolidated School District Youth Risk and Resiliency Survey Results

	2011	2013
Used a condom	57%	49%
Ever had sexual intercourse	44%	32%
Sexually active	28%	22%
Had sexual intercourse before age 13	8%	2%

Source: NM YRRS

The federal TPP grant to Capacity Builders, Inc. expires in 2015. Capacity Builders, Inc. estimates Central Consolidated School District could continue implementing the program according to the current model, using Capacity Builders staff facilitators for a cost of $394.35 per student, or $256 thousand annually. Capacity Builders, Inc. reports Central Consolidated School District could continue implementing TOP using school district staff trained by Capacity Builders, Inc., a licensed TOP training organization, for roughly $33 per student, or a total of $22 thousand annually.

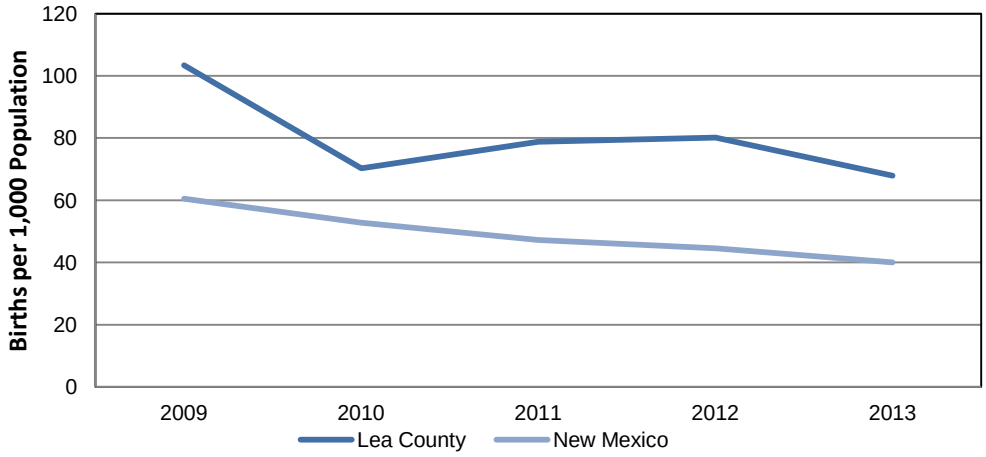
The original evaluation of the TOP program assumed costs between $500 and $700 per student, producing a return on investment of roughly of $1.29 for every $1 invested. The TOP program administered by DOH costs more per student, roughly $1,000, compared to the TOP programs administered by Capacity Builders, Inc., which costs roughly $400 per student. This difference may result from variations in economies of scale associated with universal participation in Capacity Builder's program, which serves all students in Central Consolidated health classes. In contrast, TOP programs administered by DOH are awarded to contractors who operate voluntary programs outside of the school day. DOH reports TOP programs sometimes struggle to maintain full program enrollment, and DOH allocates up to $200 per student as a participation incentive. Increasing the cost of the program implementation will reduce the cost-effectiveness and return on investment of the program, though the TOP may continue to produce positive outcomes. The DOH should consider ways to encourage new applicants or partnerships, such as school districts, which may be able to implement the program to among larger concentrations of students, reducing per-student costs.

National Indian Youth Leadership Program (NILYP) received a federal grant to determine the evidence-basis of Web of Life program in two McKinley County middle schools. In 2010, NILYP received a federal Teen Pregnancy Prevention (TPP) Tier 2 research and demonstration grant from the Office of Adolescent Health to evaluate an innovative teen pregnancy prevention programs in high-risk populations. The grant requires NILYP conduct a rigorous outcome evaluation. NILYP reports serving a total of 330 students during the grant period, which will end in 2015.

The Web of Life Program is a modification of the Project Venture and Circle of Life interventions developed by NILYP, and the program does not include explicit information about reproductive health. The final evaluation report, to be finalized in July 2015, will highlight a quasi-experimental design comparing survey data for intervention and comparison of three youth cohorts. Initial findings indicate increases in ethnic identity, positive identity, and empowerment. The federal TPP Tier 2 grant expires this year and NIYLP will be seeking additional TPP Tier 2 funding to focus the program on high school students in McKinley County, partnering with teen school based health clinics. As a result, NILYP may discontinue the Web of Life program in the current middle school sites.

My Power, Inc. aims to reduce teen pregnancy and risky sexual behavior in Lea County through a positive youth development program for girls. MyPower , Inc. was founded in 2009 to address the high teen pregnancy in Lea County by empowering pre-teen and teen girls, with over 2,800 fifth through eighth grade girls participating in after-school or summer camp programs. The program focuses on teen's making positive choices, setting goals, succeeding academically, and avoiding teen pregnancy and risky sexual behavior. Grants from the J.F. Maddox Foundation and other local organizations provide financial support to the MyPower program. MyPower relies on volunteers to implement the program. MyPower works closely with Hobbs Municipal Schools and assisted in changing the district's health education curriculum to an abstinence plus approach, which includes information about contraception in addition to stressing abstinence. Since 2009, Lea County's teen birth rate among youth ages 15 to 19 has declined by 34 percent, from 103.4 to 67.9 births per 1,000 population. Statewide, New Mexico's birth rate also declined 34 percent between 2009 and 2013. My Power, Inc. is not currently designated as evidence-based but is undergoing an evaluation of its logic model.

Chart 14. Teen Birth Rate Among Girls Ages 15 to19, 2009-2013



Source: DOH IBIS

The work of public schools, the DOH, and local non-profits demonstrate promising examples of efforts to prevent teen pregnancy. However, better coordination and collaboration could ensure communities exhibiting the greatest risks receive targeted interventions without duplicating efforts to maximize resource use.

Examples in other states suggest coordinated and targeted approaches to teen pregnancy prevention can accelerate reductions in teen births. The National Conference of State Legislatures (NCSL) recommends several options for states and localities to reduce teen pregnancy and the associated economic, social, and human costs. NCSL recommends policy-makers invest in evidence-based programs, including those identified by the federal Office of Adolescent Health, that reduce teen pregnancy and change sexual risk-taking behaviors by, for example, delaying the age of sexual intercourse, increasing condom and contraceptive use among sexually active teens, or reducing the number of sexually active partners. Additionally, NCSL recommends states target limited resources by focusing on geographic areas where teen birth rates are high or in areas that account for the majority of teen births in the state. Nevada demonstrates an example of such targeting as one of the state's health districts has used federal funding to replicate two evidence-based programs for high-risk teens in the seven zip codes with the highest rates of teen pregnancy in the county. Finally, NCSL recommends states enlist a broad range of stakeholders to address teen pregnancy on several fronts and improve access to information and services for teens.

Specifically, NCSL recommends states may wish to consider several policy options to help ensure teens make healthy, responsible decisions, including:

- Authorize child welfare agencies to provide foster youth with age-appropriate information about reproductive health;
- Support public health centers and school-based health care centers;
- Ensure programs focused on supporting young parents, such as home visiting, also focus on helping young women delay subsequent pregnancy.

California had one of the highest teen birth rates in the nation but has experienced one of the fastest declining teen pregnancy rates over the last decade as a result of comprehensive reduction efforts. According to NCSL, California reduced teen pregnancy rates through a comprehensive approach, including: sex education, community-based education programs for teens and their parents, public-private partnerships and investments, services and support for pregnant and parenting teens, and efforts to engage young men. California Public Health Officials particularly credit the state's Personal Responsibility Education Programs (PREP), which aims to reduce rates of teen births and STIs among high-need youth populations by replicating evidence-based program models in 19 California counties with teen pregnancy rates that consistently surpass the state's average.

The California Legislature also passed a bill in 2013, responding to a state study of teen pregnancy among foster youth. The law authorizes county child welfare agencies to provide foster youth with age-appropriate information about reproductive health, encourage them to help pregnant youth obtain the health services they need, and directs the state social services department to collect data on parents and pregnant youth in the system. California also administers the Family Planning, Access, and Care Treatment (PACT) Program, which provides comprehensive family planning services to men and women up to 200 percent of the federal poverty level (FPL) and lack other health coverage. New Mexico's family planning Medicaid waiver program is similar but provides services for men and women who earn up to 185 percent FPL and do not qualify for full Medicaid services.

North Carolina and Mississippi also serve as examples of coordinated efforts to reduce teen pregnancy. Mississippi, with the third highest teen birth rate in 2012, is pursuing a strategy similar to that of California. A law which requires mandatory sex education, either abstinence only or abstinence plus education, went into effect in 2012. Governor Phil Bryant has also appointed a task force on teen pregnancy prevention and has held town hall meetings to discuss the issue around the state. In 2014, Mississippi lawmakers passed Senate Bill 2563 to address the disproportionate incidence of unplanned pregnancy among older teens, who account for 70 percent of teen births statewide. The bill identified community colleges and universities as "critical venues" through which to prevent unplanned pregnancies among 18-and 19-year-olds and required the commissioner of higher education and executive director of the state community college board to develop a plan to address the issue and present the plan to the legislature in November 2014.

State-level leadership in North Carolina has focused on increasing the number of effective prevention programs available to North Carolina youth. The Adolescent Pregnancy Prevention Campaign of North Carolina leads a state task force established to guide the use of evidence-based programs and medically accurate reproductive health and safety education in North Carolina. This campaign established a goal to reduce teen pregnancy in North Carolina by 30 percent in 10 years. In 2009, North Carolina passed the Healthy Youth Act, which requires each local school district provide a reproductive health and safety education program, beginning in seventh grade, that includes evidence-based information.

New Mexico has also made significant investments to reduce negative outcomes often associated with teen births through programs that support teen parents and children. Previous LFC evaluations have highlighted the benefits of two-generation approaches to addressing issues of poverty. Two-generation approaches to reduce cycles of poverty focus on addressing the needs of both vulnerable parents and children together by equipping parents to better support their children's learning. Currently, low-income parents may receive assistance from a variety of sources, including adult basic education and workforce development programs while their children receive services from early childhood education programs, such as child care or prekindergarten. Several models exist nationally for providing interventions and programs to parents and child simultaneously. New Mexico has made considerable investments in programs to increase maternal education, improve parenting and reduce child maltreatment, and increase quality and access of early childhood education in New Mexico. All of these strategies work simultaneously to address poverty but could be better integrated and targeted to the state's most at-risk populations.

Figure 8. Programs that Support a Two-Generation Approach in New Mexico

Source: LFC Files

The Graduation, Reality, and Dual-Role Skills Program (GRADS) aims to reduce subsequent pregnancies among teen parents and improve family outcomes. GRADS is a school-based program for teen parents in multiple high school settings, including traditional, charter, and alternative schools to facilitate parenting teen graduation, promote healthy families, and reduce risk-taking behaviors by reducing repeat pregnancies, retaining students through graduation, and promoting parenting skills.

The GRADS program reports working in 31 traditional public schools, charter schools, and alternative schools in New Mexico; 25 GRADS sites also operate childcare centers for program participants. In 2014, the program served roughly 500 young adults and reports promising outcomes. Additionally, DOH reports the Office of Adolescent Health, which oversees school-based health centers, also partners with GRADS programs in many of the school sites. According to the GRADS program, 77 percent of GRADS students graduated from high school, compared to 50 percent nationally, 3.4 percent of program participants experienced a repeat birth, compared to 18 percent of all teen parents nationally. Notably, several communities with large numbers or high rates of teen births do not operate GRADS programs. In particular, only one GRADS program operates in Albuquerque. In contrast Las Cruces, which reported the second largest number of teen births in 2013, operates GRADS programs in three high schools.

Table 12. School Districts with GRADS Programs

School District	School
Alamogordo Public Schools	Alamogordo High School Academy del Sol
Albuquerque Public Schools	Cesar Chavez Charter High School La Academia de Esperanza
Belen Consolidated Schools	Belen High School
Bernalillo Public Schools	Bernalillo High School
Carlsbad Municipal Schools	Carlsbad High School
Central Consolidated Schools	Career Prep Central High School
Deming Public Schools	Deming High School
Gallup McKinley Schools	Thoreau High School Crownpoint High School
Hatch Valley Public Schools	Hatch Valley High
Hidalgo Medical Services	Lordsburg High School Opportunity High School, Silver City
Hobbs Municipal Schools	Hobbs High School
Las Cruces Public Schools	Onate High School San Andres High School Las Cruces High School
Los Lunas Public Schools	Valencia High School
Lovington Public Schools	Lovington High School
Maxwell Municipal Schools	Maxwell High School
Portales Municipal Schools	Portales High School
Rio Rancho Public Schools	Independence High School
Roswell Independent Schools	University High School
Ruidoso Municipal Schools	Ruidoso High School
Socorro Consolidated Schools	Socorro High School
Santa Fe Public Schools	Santa Fe High School Capital High School
Taos Municipal Schools	Taos High School

Source: GRADS

GRADS has received legislative appropriations from either the general fund or TANF since FY96. Since FY12, the Legislature has appropriated $200 thousand from the general fund for the GRADS program annually. Additionally, the GRADS program received a $1.5 million grant from the U.S. Office of Adolescent Health in 2010 and in 2013 that will extend until 2017. PED reports grant funds have primarily been used to fund case managers for GRADS programs and facilitate community partnerships.

Table 13. General Fund Appropriations to the GRADS Program, FY11-FY15
(in thousands)

FY11	FY12	FY13	FY14	FY15	FY16
$288.7	$200	$200	$200	$199.5	$200

Source: LFC Files

The GRADS program reports school districts which participate in the GRADS program must identify a school employee willing to run the GRADS program and assume the personnel costs associated with this employee. The GRADS teacher leads course-bearing classes devoted to GRADS participants, which covers various health and parenting topics. GRADS instructors typically teach other courses, often health or family and consumer sciences. In the past, the GRADS program provided schools with $90 thousand during the first three years of operation, after which point school districts were expected to assume costs associated with the program. However, this stipend has been discontinued with reductions in general fund appropriations. Currently, participating schools receive curriculum supplies valued at $3,500 and technical support from the GRADS program. The federal GRADS grant has been used to supplement GRADS program services, including case management services and early childhood education training for GRADS staff.

Previous LFC reports have highlighted the need to better target home-visiting to families most at risk, as less than 8 percent of all teen parents currently receive home visiting services. In FY14, 230 teenage clients received home visiting services, while home visiting services reached a total of 1,880 clients in FY14. The 230 teen clients represent 12 percent of all home visiting clients, but only 8 percent of the 2,980 births to teens in just 2013. Because clients may participate in home visiting services for up to three years, these data suggest the vast majority of teen parents in New Mexico are not receiving home visiting services. The 2015 LFC special review of early childhood programs similarly found that home visiting programs are not always targeted at the families demonstrating the greatest risk, yet research suggests the greatest returns on investment for home visiting programs occur when programs serve populations demonstrating high risk.

Table 14. Teen Parents Who Received Home Visiting in 2014

Teen Clients Served	**Percent of All Home Visiting Clients** (N=1,880)	**Estimated Percent of All Teen Births to Women Ages 15 to 19 in 2013** (N=2,980)
230	12%	8%

Source: LFC Analysis

A previous LFC report highlighted the need to better target adult basic education programs because maternal education is one of the greatest predictors of child well-being. Research consistently suggests parental education is important in predicting children's achievement (Davis-Kean, 2005). Among low-income minority families, mothers with higher levels of educational attainment had higher expectations for their children's academic achievement, and these expectations were related to their children's actual achievement in math and reading (Halle et al, 1997). Similarly, maternal education has a consistent direct influence on children's cognitive and behavioral outcomes, yet the National Campaign to Prevent Teen and Unplanned Pregnancy reports only 38 percent of teen mothers ever earn a high school diploma. This research suggests targeting teen parents with low educational attainment for high school credential achievement may produce significant benefits not only to adults but also to their children. A 2014 LFC evaluation of adult basic education in the state found New Mexico does not target adults who lack a high school credential as the primary target population for services. Given the demographics of students pursuing a high school credential equivalent, many are likely the same populations for which early childhood interventions, such as home visiting and early childhood services, are intended and the state could further target the parents of children receiving other services who lack high school credentials.

Investments in early childhood education may alleviate or mitigate some of the outcomes associated with children of teen parents. Previous LFC evaluations and national research confirm evidence-based interventions and early childhood education programs can improve child well-being, safety, and educational outcomes and close the achievement gap, all of which are associated with children born to adolescent parents. In an effort to achieve these outcomes, the Legislature has taken action to invest in prekindergarten, childcare assistance, home visiting, and the state's extended school year program K-3 Plus, among others. Since FY12, early childhood appropriations have increased by almost $100 million, and the Legislature appropriated an additional $15.8 million in FY16.

Recommendations:

The Legislature should:

Direct the Department of Health, in collaboration with the Human Services Department, Children, Youth, and Families Department, and Public Education Department to develop a comprehensive state plan as part of the department's comprehensive strategic plan to be presented to the Legislature and Department of Finance and Administration to reduce teen births with strategies that include:

- identifying communities demonstrating high numbers or rates of teen births as priority regions;
- establishing ambitious yet feasible targets for teen births reduction;
- identifying needs and gaps in services to prevent and support teen parents[1];
- prioritizing resource allocation for evidence-based program implementation in high-need communities;
- providing training and technical assistance regarding evidence-based health education strategies in collaboration with the PED; and
- developing a plan for coordinating and delivering services.

Even without a statutory change, however, the Department of Health may take action to include such a plan in its annual comprehensive plan.

Target state appropriations to continue to invest in programs and services to support teen parents and their children, including adult basic education, the GRADS program, home visiting, and early childhood programs.

The Department of Health should:

Work with the Legislative Finance Committee and Department of Finance and Administration to identify performance measures related to teen pregnancy, including statewide teen birth rate.

The Public Education Department should:

Require school districts and charter schools with high numbers or rates of drop-outs to submit a plan to increase the number of students completing high school as part of the annual budget process, as recommended in a previous LFC report, and address teen pregnancy if the factor is identified as a significant cause associated with drop-outs in the school district.

Children, Youth, and Families Department should:

Collaborate with the Department of Health and Public Education Department to identify and refer high-risk teen parents, such as WIC recipients or GRADS participants, for referral to New Mexico's home visiting programs.

[1] Legislative Finance Committee Report: *Early Childhood Services Accountability Report Card, Gap Analysis, and Spending Plan.* January 2015, Report #15-01
Legislative Finance Committee Report: *Cost Effective Options for Increasing High School Graduations and Improving Adult Basic Education*. September 2014, Report# 14-09.

NEW MEXICO COULD BETTER LEVERAGE EXISTING CLINICAL INTERVENTIONS TO REDUCE TEEN BIRTHS

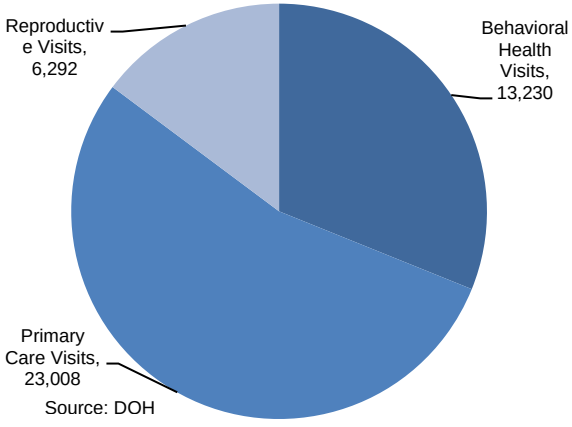
A variety of existing programs and revenue sources could be leveraged to increase access to the most effective clinical interventions for teens without substantial new costs to the state. Teens may currently access clinical reproductive health services through a variety of mechanisms in New Mexico, including school-based health centers and public health clinics. Additionally, several funding streams, including federal Title X and Medicaid, could be better leveraged to ensure that teens have access to the most effective clinical services.

School-based health centers (SBHC) are a mechanism through which teens may access confidential medical services. The Office of Adolescent Health, located within the Public Health Division of DOH, oversees 53 sponsored SBHCs located in 26 counties in New Mexico. While SBHCs may be located in any school, most are located in high schools (Appendix C).To be sponsored by DOH and be certified to bill Medicaid, SBHCs must meet DOH quality standards. Additionally, the Office of Adolescent Health coordinates an electronic patient management system, which collects patient data. The Office of Adolescent Health works to implement quality-improvement initiatives, including an electronic student health questionnaire as a screening tool to identify risk among patients.

Multiple studies suggest school-based health centers can have a positive effect on the educational success of pregnant and parenting teens. Research suggests absenteeism and dropout rates among pregnant and parenting adolescents were reduced when teens received care at school-based health centers, and several studies suggest school-based clinics have a positive impact on a pregnant teen's decision to use contraceptives and prevent repeat pregnancies (Strunk, 2008). While research suggests SBHCs may have a positive impact on teen parents, the primary focus of SBHCs is to provide a broad range of healthcare services beyond reproductive health care to youth. Analysis commissioned by the New Mexico Alliance for School-Based Health in 2013 found school-based health care in New Mexico yields a return of $6.07 for every dollar expended as a result of savings from reduced asthma hospitalizations, early treatment of STIs, reduced incidences of flu, mental health services savings, and other monetized health outcomes and indirect outcomes.

DOH reports SBHC provided 42,530 visits in FY14, 54 percent of which were primary care visits, 31 percent of which were behavioral health visits, and 15 percent of which were reproductive health visits (Appendix D). School-based health centers are not always located in the areas demonstrating the greatest needs. In several cases, counties with high teen pregnancy rates lack school-based health centers.

Chart 15. FY14 School-Based Health Center Visits



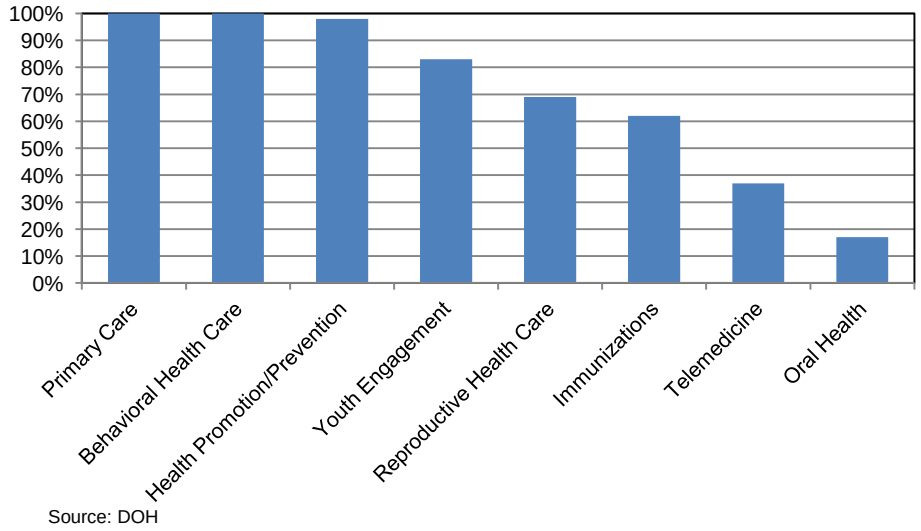
Source: DOH

Chart 16. New Mexico School-Based Health Clinics, FY2015

Source: New Mexico Alliance for School-Based Health Care

DOH reports some school-based health centers provide reproductive health care in the form of testing or treatment but do not dispense contraception. According to the Alliance for New Mexico School-Based Health, 69 school-based health centers operate in New Mexico, though only 53 are contracted by DOH. According to DOH, to be able to bill for Medicaid reimbursement, SBHCs must be overseen by the department, which maintains performance standards. In 2014, all SBHCs overseen by DOH provided primary and behavioral health care, while 69 percent provided reproductive health care and 17 percent provided oral health care. Several school-based health centers not overseen by DOH provided more limited services. DOH reports that some school districts prohibit school-based health centers from providing reproductive health services, while others provide reproductive health screenings and STI prevention but do not dispense contraception. In this case, resources also may not align with community needs as SBHCs in several counties with high rates or numbers of teen pregnancies are providing limited or no reproductive health services.

Chart 17. Services Provided by DOH School-Based Health Centers
(N=53)



Source: DOH

Additionally, nine of the state's SBHCs receive Title X funds in order to provide family planning and related preventative health services. DOH reports these funds are used to provide supplies and testing in SBHCs but typically do not cover the costs of reproductive health-related procedures or office visits.

Opportunities to improve the financial efficiency of school-based health centers may reduce their reliance on the state general fund and improve their sustainability. The New Mexico School-Based Health Alliance suggests certain characteristics and activities should exist to ensure a SBHC is viable and sustainable**.** In 2012, the New Mexico School-Based Health Alliance published *A Blueprint for Sustainability of School-Based Health Centers*, which provides recommendations for establishing model SBHCs. The blueprint suggests a service population of at least 1,000 patients, and at least 50 percent of the targeted service population must use the SBHC. SBHCs may improve their productivity through operational changes, integration with the school population, and outreach to the population outside of the school. As a benchmark for sustainable productivity, the New Mexico School-Based Health Alliance suggests 12 to 15 medical visits and 6 to 8 behavioral health visits daily, totaling between 2,280 and 2,850 visits annually, to reduce dependency on supplemental public funds.

Additionally, the target population of a SBHC must include a high number of Medicaid enrolled and eligible population of users, suggesting a payer mix of at least 60 percent of the target population enrolled in Medicaid. If the SBHC is overseen by a federally qualified health center (FQHC) or Indian Health Services, the SBHC may be able to generate more revenue because they receive enhanced Medicaid rates intended to cover costs. As a result, these providers might not require the same level of general fund support for uncompensated care as providers with low levels of productivity or providers that do not receive enhanced Medicaid rates.

Billing data that could help determine the level of need for general fund support is not currently collected. DOH allocates general fund support to school-based health centers. According to the New Mexico School-Based Health Alliance, SBHCs need supplemental funds to offset expenses incurred by providing services to students who are uninsured, underinsured, or whose insurance cannot be billed to ensure patient confidentiality. A general fund appropriation to Public Health Division of the DOH helps offset these expenses. While the School-Based Health Alliance suggests SBHC should aim to quantify uncompensated care costs, DOH is currently only collecting this information for 10 SBHCs. DOH reports plans to begin collecting and reporting billing information for all SBHC providers beginning in FY16. Since FY12, DOH has allocated roughly $3.5 million annually to SBHCs, including general fund and Medicaid matching funds. In FY15 the DOH operating budget allocated $3.3 million from the general fund and $1.4 million in internal agency transfers, which includes a Medicaid match received from the Human Services Department (HSD).

Table 15. Appropriations to School-Based Health Centers, FY11-15
(in thousands)

	FY11	FY12	FY13	FY14	FY15
General Fund	$2,960.3	$2,743.1	$2,753.1	$2,853.1	$3,338.4
Other State Funds (Medicaid Match)	$1,407.0	$1,388.0	$1,388.0	$1,144.4	$1,348.0

Source: LFC Files

DOH reports allocations to SBHCs are made according to a formula, which considers the number of days SBHC operate weekly. DOH reports programs open one day each week receive roughly $50 thousand annually, programs open two days each week receive roughly $70 thousand annually, and providers open three or more days each week receive roughly $90 thousand annually. DOH reports the department does not adjust allocations if a provider is an FQHC, which is able to collect enhanced Medicaid reimbursement rates. The agency also does not consider a provider's level of uncompensated care or size on uninsured population because this information is not available for all providers, though the DOH plans to collect billing data in the future. If such data were collected, DOH could adjust general fund allocations to meet uncompensated care levels, and the Legislature may be able to use this information to determine SBHC funding levels in the future.

School-based health centers are generally not billing private insurance, in part because school-based health providers want to protect patient privacy. As a general rule, New Mexico law requires a minor who seeks medical treatment to obtain the consent of a parent or guardian. As a result, SBHCs generally obtain parental consent at the beginning of the school year so that students may receive services. However, New Mexico statute explicitly allows minors over the age of 14 to consent for behavioral health services, and statute allows any individual, regardless of age, to consent for reproductive health services, including prescription contraceptives and counseling, testing and treatment for STIs and HIV. Services billed to Medicaid remain confidential because an explanation of benefits is not sent to patients. SBHCs and the DOH report that if providers were to bill private insurance companies, explanations of benefits sent to parents or guardians might violate a patient's privacy. As a result, SBHCs do not typically bill private insurance companies. One provider reported, however, that the SBHC is investigating ways to begin billing private insurance. DOH also reports about 15 SBHCs cannot bill private insurance because they do not have the administrative capacity needed to pursue the complexity of billing and often do not meet minimum requirements established by private insurance companies. The New Mexico School-Based Health Alliance suggests SBHC establish a separate billing system for confidential services for each student, and bill private insurance when

the patient is not seeking a confidential service. DOH may also be able to provide technical assistance to SBHC providers who do not have existing private-insurance billing infrastructure.

The state's public health offices also provide teens with reproductive health services, and a 2012 LFC evaluation found they face similar billing challenges. The Public Health Division oversees five regional and 54 local public health offices in New Mexico, which also play a significant role in preventing teen pregnancy through family planning services. Like SBHCs , public health offices serve as safety net providers and provide confidential health services, including chronic disease detection and prevention, WIC programs, prenatal care, and vaccinations. Additionally, public health offices maintain contracts with HSD and Medicaid managed care organizations. In 2012, the LFC conducted an evaluation of public health offices, which identified opportunities for improving outcome-focused efforts, contract management, and improved local partnerships. The evaluation also found public health offices are not persistent or consistent in determining a client's Medicaid eligibility or collecting third-party payments. Challenges identified by evaluators at the time are similar to the billing challenges faced by SBHCs.

Medicaid expansion also provided the state with opportunities to expand access to effective clinical ways to reduce teen pregnancy. In 2014, New Mexico began expanding Medicaid as permitted by the federal Affordable Care Act, allowing adults with incomes up to 138 percent of the federal poverty level (FPL) to enroll in Medicaid. Children between the ages of 6 and 19 in families with incomes of up to 235 FPL are also eligible to receive Medicaid services. As of February 2015, 691 thousand New Mexicans were enrolled in Medicaid.

The state's Medicaid plan covers family planning, including the most effective forms of contraception, and an estimated 57 percent of teens are currently enrolled in Medicaid. Federal law explicitly requires state Medicaid programs to cover family planning services and supplies for Medicaid beneficiaries of child-bearing age. New Mexico also operates a Medicaid family planning waiver for uninsured men and women who are ineligible for full Medicaid benefits. Women who are approved under this family planning waiver are eligible to receive pregnancy prevention services, including contraceptives, exams, screenings, and treatment associated with reproductive health. According to a HSD Medicaid Expansion update released in 2014, roughly 52 thousand adults were enrolled in this program as of January 2014. HSD announced plans in 2013 to transition adults enrolled in the family planning program with incomes at or below 138 percent FPL and would discontinue coverage for adults earning more than 138 percent FPL. However, HSD reported to LFC during the development of this evaluation that the agency decided not to discontinue the family planning program, and HSD's FY16 Medicaid enrollment projection included family planning program participants. Additionally, HSD reports 104,645 teens between the ages of 13 and 19 are enrolled in Medicaid in New Mexico. The LFC estimates this is roughly 57 percent of the state's teen population. Many teens in New Mexico are thus able to access reproductive health services through this program, and others may be eligible for Medicaid but not enrolled.

Long-acting reversible contraception (LARC) devices are the most effective form of reversible birth control for young adults. To be effective in preventing pregnancy, contraception must be used correctly and reliably. LARCs, which are either implanted or injected, do not rely on the woman or man remembering to use them correctly or consistently. Several medical associations, including the American College of Obstetricians and Gynecologists and the CDC, recommend the use of LARCs as a first line of defense for teens. The CDC also reports LARCs are not more risky for teenagers, and less than 1 percent of users become pregnant. However, the CDC reports many young adults are unaware of these contraceptive methods. Historically, LARCs may be viewed as cost-prohibitive, with costs for the device ranging between $400 and $1,000, and costs for insertion and removal ranging between $35 and $200.

Under the federal Affordable Care Act, insurance companies must provide family planning services. New Mexico's Medicaid plan provides reimbursement for LARC devices and insertion and removal, though some medical providers report Medicaid reimbursement rates do not fully cover the costs of LARC devices and insertion and removal. According to the DOH, individual SBHCs and other providers negotiate reimbursement with Manage Care Organizations (MCOs), and no single Medicaid fee schedule exists for SBHCs. Each MCO established a reimbursement schedule for services. SBHCs operated by FQHCs follow the negotiated contract between the entity and each MCO. HSD provided a Healthcare Common Procedure Coding System (HCPCS) fee schedule, which is used to establish minimum rates.

Table 16. Medicaid HCPCS Fee Schedule for LARC-Related Services

Intrauterine copper contraceptive	$739.00
Levonorgesterel-releasing intrauterine (Mirena)	$772.65
Etenogestrel contraceptive implant system	$653.75
IUD other than above (Progestacert)	$627.38
IUD insertion	$39.69
IUD removal	$99.40

Source: HSD

Unintended pregnancies commonly occur after an interpregnancy interval, the length of time between pregnancies, of less than 12 months, with 20 percent of deliveries to women who have just had a child occurring with a year of prior delivery (Simmons et al, 2013). Previous LFC studies have highlighted the importance of birth spacing on child wellbeing. Nationally, the CDC reports roughly 20 percent of teen births are repeat births and many repeat births could be prevented through postpartum use of LARCs. LARCs are also safe and effective when started immediately post-partum and may reduce the risks of unplanned pregnancy and improve the health of newborns and mothers by facilitating healthy spacing between pregnancies. According to research, however, women who choose LARC methods for postpartum contraception often face barriers to initiation, including inadequate or incorrect counseling, financial hurdles, and difficulty getting to postpartum clinic visits for placement of the LARC device (Simmons et al, 2013).

Despite their efficacy, many young adults do not use LARCs. According to 2013 data released by the CDC, only 7 percent of U.S. teens who access reproductive health care in Title X clinics use LARCs. Among teens that access reproductive health services in Title X clinics in New Mexico, the rate is also 7 percent. A recent article in *The Economist* suggests the main obstacle to LARC use is knowledge, not cost, as a survey conducted by the non-partisan National Campaign to Prevent Teen and Unplanned Pregnancy found that roughly 70 percent of Americans aged 18 to 45 knew "little or nothing" about LARCs. Similarly, *The Economist* reported medical providers are unaware of guidelines that recommend LARCs as "first-line" methods for teenagers.

Colorado piloted a program that provided young women at risk for unintended pregnancies with LARCs, and these targeted efforts resulted in dramatic reductions in teen pregnancy. Beginning in 2009, 28 Title X-funded agencies in Colorado received $23 million in private funding to support the Colorado Family Planning Initiative. The program aimed to provide LARCs to low-income young women and included funds for training, outreach, and technical assistance. Between 2009 and 2014, teen birth rates in Colorado declined by 40 percent, and the Colorado State Department's analysis suggests the program accounted for 75 percent of the overall decrease in the state's teen birth rates. In 2008, Colorado had the 29th lowest teen birth rate in the nation, which sharply decline to the19th lowest in 2012. Analysis also suggests a savings of nearly $2.3 million over two years per every one thousand Medicaid-eligible women as a result of reduced unintended pregnancies. Because teenage births in Colorado were six times more likely among low-income women, Colorado experienced significant reductions in the number of young women claiming benefits for unplanned births. Colorado estimates the state saved over $6 for each $1 spent on the program, excluding the benefits to the state from women who finished high school instead of dropping out.

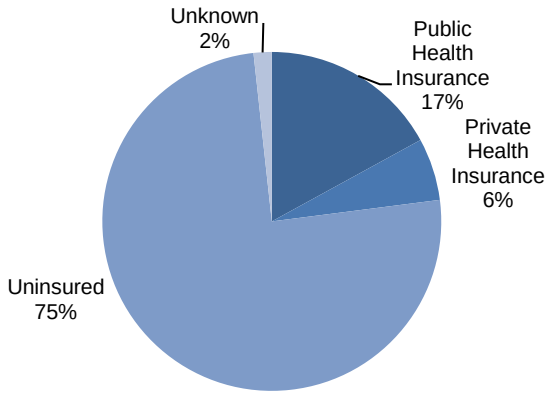
Using a targeted approach, New Mexico could pursue a similar strategy to Colorado to increase access of the most effective forms of contraception among high-risk teens. Given that Medicaid will cover LARCs, New Mexico could identify populations at high-risk for teen births, such as teens enrolled in the state's WIC and home visiting programs and teens who have already given birth, and facilitate collaboration, such as engaging community health workers, with these programs and medical providers to encourage access to the most effective forms of contraception. DOH may also be able to play a role in reducing knowledge gaps associated with LARC use. By targeting the populations most at risk for teen births, New Mexico could experience significant population-level reductions in teen pregnancy.

Title X serves as a safety-net mechanism to provide low-income and uninsured New Mexicans with reproductive health care. The DOH Family Planning Program (FPP) is the sole federal Title X grantee in New Mexico, supporting over 90 Title X-funded health centers across the state. Title X-supported family planning centers provided services that include pregnancy testing, contraceptive services, pelvic exams, screening for cervical and breast cancer, screening for high blood pressure, screening for STIs and HIV/AIDS, infertility services, health education, and referrals for other health and social services. Title X funds are distributed to safety-net healthcare providers in New Mexico, including public health offices and some SBHCs.

The National Family Planning and Reproductive Health Association (NFPRA) reported that 31,578 residents in New Mexico were served by Title X in 2013. Of those served by Title X-supported family centers in FY 13, 7,000 or 22 percent, were teens. According to the NFPRHA, in FY12 contraceptive service provided at these centers helped New Mexico women avoid 7,000 unintended births through contraception, counseling, and other services. NFPRHA reports that without Title X services, the unintended pregnancies in New Mexico would be 46 percent higher and the services provided at Title X-supported centers saved New Mexico an estimated $47.6 million in public funds in FY10. These centers provided an important role in serving the uninsured who often cannot afford to pay out-of-pocket costs at private health care providers.

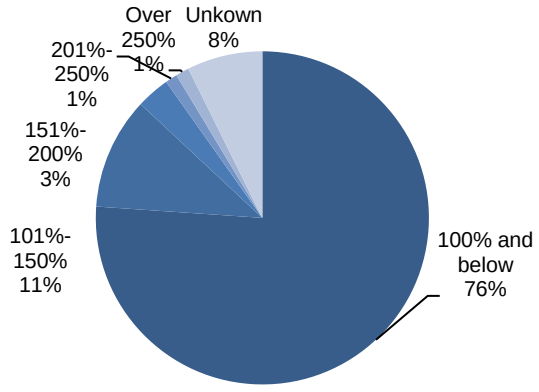
Title X clinics are primarily serving low-income and uninsured New Mexicans. Of the 31,578 New Mexico residents in FY13 who accessed Title X-supported family planning centers 75 percent were uninsured. Seventy-six percent of Title X patients had incomes at or below 100 percent of the federal poverty level (FPL), meaning they earned $11,490 a year or less. Ninety-one percent of Title X patients had incomes at or below 250 percent FPL, or less than $26,725 a year.

Chart 18. Number of Title X Family Planning Users by Principal Health Insurance Coverage Status, FY13
(N=31,568)



Source: DOH

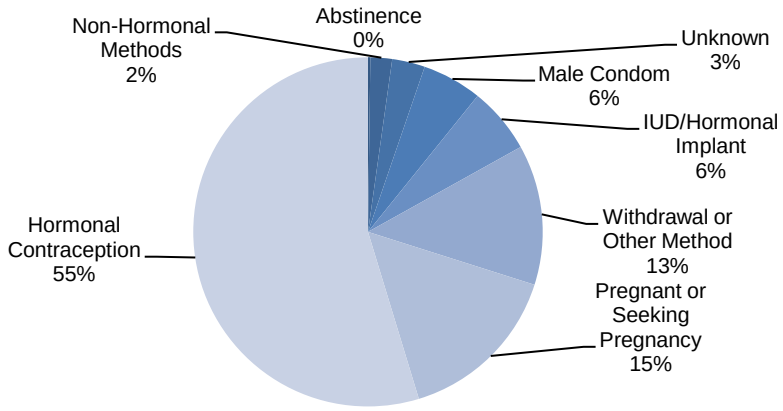
Chart 19. Title X Family Planning Users by Income Level



Source: DOH

DOH data suggests teens accessing reproductive health care in Title X clinics are primarily relying on forms of contraception that are not the most effective forms recommended by the CDC.

Chart 20. Primary Method of Family Planning Used by Title X Clients, Females Ages 10-19
(N= 5,544)



Source:DOH

Recommendations:

The Department of Health should:

Establish a plan to collect and analyze school-based health center billing data for all provider sites by July 1, 2015. In the short term, the DOH should use this data to develop a new formula for distributing general fund allocations to school-based health centers to prioritize centers with the greatest needs. The DOH should also work with the Legislature to develop recommendations to begin replacing general fund revenue with Medicaid funds and establish a plan for meeting reasonable payer mix levels as part of the budget cycle beginning September 1, 2016.

Collaborate with the Human Services Department to develop a plan to increase knowledge and provide technical assistance to safety net providers regarding the most-effective forms of contraception, as recommended by the CDC

Pursue public-private partnership opportunities to implement best-practices related to the most effective forms of contraception among teens at high-risk of becoming parents.

SUSANA MARTINEZ, GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

RETTA WARD, CABINET SECRETARY

11 May, 2015

Mr. David Abbey
Director, Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

RE: Response to LFC's 2015 Report on Effective Practices for Teen Pregnancy Reduction

Dear Mr. Abbey:

The Department of Health has reviewed this report and would like to respond as follows:

- We believe that the LFC report is a well-researched, informed, timely and dispassionate analysis of key challenges and opportunities pertaining to teen pregnancy reduction in New Mexico. We agree with its key conclusions and recommendations.
- LFC's estimated $84 million in annual fiduciary impacts to the state is credible, given that higher rates of teen pregnancy are a key root cause not only of reduced health status, but of higher poverty, lower graduation, higher incarceration and higher child abuse rates. Achieving a significant reduction in teen pregnancy would leverage improvements across a broad range of quality of life indicators in a cost-effective manner.
- We agree with LFC that significant reductions in teen pregnancy achieved elsewhere that exceed general reductions over recent years present an opportunity for New Mexico. Reducing teen pregnancy using evidence-based practices is a current winnable battle. DOH is prepared to take the lead on this in partnership with legislators, other executive agencies, and interested third parties.
- LFC recommends the creation of a comprehensive and coordinated statewide teen pregnancy strategy. DOH agrees with this recommendation, has prioritized "reduce teen births" in the state health improvement plan, in its current strategic plan and in strategy execution action items for FY16. As implementation and quarterly performance targets take shape, the department will work with and share information with LFC staff.
- LFC recommends replacing state general funds with Medicaid funds and relying on Medicaid to fund family planning services. DOH is already receiving Medicaid reimbursement for family planning services when applicable, but also provides safety net health services to non-Medicaid eligible teens. DOH is monetizing services by adding capability and capacity to PHD's billing unit and replacing outdated case management and billing software applications with more capable systems.
- DOH is also exploring grant and non-traditional sources of funding to raise the scope and scale of an ambitious teen pregnancy reduction program, and has begun meeting with grantor organizations. We believe that this addresses LFC's recommendation to *"pursue public-private partnerships to implement best-practices related to the most effective forms of contraception among teens at high-risk of becoming parents."* Similar programs elsewhere have saved over $6 for each dollar spent on the program, excluding the gains to women who finished high school instead of dropping out to care for a child.
- Targeted interventions in areas of greatest risk, including geographic regions, other teen populations and teens who have already become parents would be expeditious and cost-effective, as LFC has suggested. The

birthrate among Hispanic teens is almost three times higher than it is among non-Hispanic White teens, meaning that Hispanic teens should also be an area of focus.

- Interoperability gaps do exist across multiple departments and programs servicing teens—as well as across state government. DOH agrees with LFC that developing greater alignment and integration is a key opportunity for improvement. The department has begun to address this, including high level direct outreach to school district superintendents and board members; joint management of a state innovation model grant with HSD; partnering with CYFD on case management of medically needy children, and teen pregnancy initiatives with PED. Narrowly defined acceptable scopes of work for grant funded programs limit interoperability. DOH is exploring how best to overcome these limits.
- We agree with LFC's recommendation that DOH "*Establish a plan to collect and analyze school-based health center billing data for all provider sites,"* but a July 2015 target is unrealistic, based on a range of data availability, billing and systems issues. A feasible target date would be 2017.
- LFC's recommendation that DOH "*collaborate with the Human Services Department…to increase knowledge and provide technical assistance to safety net providers regarding the most-effective forms of contraception, as recommended by the CDC"* will be a component of the department's implementation plan around broadening access not only to the most effective forms of contraception, but to provider access and fixing reimbursement gaps.
- 77 percent of American women between the ages of 18 and 45 indicate that they know little or nothing about hormonal implants for birth control; 68 percent say the same about IUDs. In approximately half of publicly-funded clinics nationwide that provide contraceptives, staff incorrectly believe that IUDs and hormonal implants are not suitable for teenagers. Effective training and communication, including telehealth, very clearly need to be part of a comprehensive teen pregnancy reduction plan.
- Finally, views vary widely on policy related to pregnancy and reproduction. With this in mind, DOH will implement teen pregnancy reduction in a community specific manner.

LFC observes that if teen births were to decline by 995 annually, New Mexico would reach the national average birth rate of 26.5 per 1,000 (15-19 year olds), and the state would save roughly $29.5 million annually. While this would be a realistic target, our border state of Colorado was able to reduce teen birth rates by 26 percent and abortions by 34 percent in two years, significantly exceeding the national average using non-traditional sources of program funding. The majority of developed countries have achieved lower teen birth rates than the U.S. We suggest, and believe that LFC would agree, that New Mexico can and should aim higher than raising performance to national averages.

Mr. Abbey, on behalf of the department, we want to thank you, Mr. Sallee, Ms. Mercer-Smith, Mr. Lussiez and the LFC for graciously partnering with DOH on this project, and for a process review that seeks breakthrough level improvements. DOH agrees that this is possible and realistic. We look forward in working with the legislature in raising our performance on this cross-cutting and critical area of need.

With appreciation,

Retta Ward
Cabinet Secretary
Department of Health

Mark Williams
Director, Public Health Division
Department of Health

Cc: Lynn Gallagher, Brad McGrath, James Ross, Terry Bryant, Cathy Rocke, Janis Gonzales, M.D., Brent Earnest, Tres Schnell, Susan Lovett

APPENDIX A: EVALUATION INFORMATION

Evaluation Objectives.

- Identify and analyze the characteristics of births to teens in New Mexico.
- Evaluate teen pregnancy prevention programs in New Mexico.
- Identify evidence-based strategies to reduce risky adolescent behaviors.

Scope and Methodology.

- Reviewed applicable laws and regulations
- Reviewed prior LFC reports
- Reviewed external program evaluations, reports, and other literature
- Analyzed New Mexico IBIS data
- Interviewed key Department of Health, Public Education Department, school-based health center, and non-profit personnel
- Surveyed middle and high school principals
- Met with LFC staff, including analysts and LFC staff leadership

Evaluation Team.

Rachel Mercer-Smith, Lead Program Evaluator
Yann Lussiez, Program Evaluator

Authority for Evaluation. LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conferences. The contents of this report were discussed with the Department of Health on May 4, 2015.

Report Distribution. This report is intended for the information of the Office of the Governor; Department of Health; Office of the State Auditor; and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

Charles Sallee
Deputy Director for Program Evaluation

APPENDIX B: PROGRAMS DESIGNATED BY THE U.S. HHS AS EVIDENCE-BASED

	Sexual Activity	Contraceptive Use	STIs	Pregnancy or Birth
Health Improvement Program for Teens (HIP Teens)	+	na	na	na
Project IMAGE	na	na	+	na
Support to Reunite, Involve, and Value Each Other (STRIVE)	+	na	na	na
Families Talking Together (FIT)	+	na	na	na
Aban Aya Youth Project	+	na	na	na
Adult Identity Mentoring Project (AIM)	+	na	na	na
All4You!	+	+	na	na
Assisting in Rehabilitating Kids (ARK)	+	+	na	na
Be Proud! Be Responsible!	+	+	na	na
Be Proud! Be Responsible! Be Protective!	+	o	na	na
Becoming a Responsible Teen (BART)	+	+	na	na
Children's Aid Society (CAS)- Carrera Program	+	na	na	+
Cuidate!	+	+	na	na
Draw the Line/Respect the Line	+	na	na	na
FOCUS	+	o	na	na
Heritage Keepers Abstinence Education	+	na	na	na
Horizons	na	+	+	na
It's Your Game: Keep it Real	+	na	na	na
Making a Difference!	+	o	na	na
Making Proud Choices!	o	+	na	na
Project TALC	o	na	na	+
Promoting Health Among Teens! Abstinence Only Intervention	+	o	na	na
Promoting Health Among Teens! Comprehensive Abstinence and Safer Sex Intervention	+	o	na	na
Reducing the Risk	o	+	na	o
Rikers Health Advocacy Program (RHAP)	o	+	na	na
Raising Healthy Children	+	o	+	+
Respeto/Proteger	na	+	na	na
Safer Choices	o	+	na	na
Safer Sex	+	o	na	na
Sexual Health and Adolescent Risk Prevention (SHARP)	na	+	na	na
SiHLE	+	+	+	+
Sisters Saving Sisters	+	+	+	na
Teen Health Project	+	na	na	na
Teen Outreach Program (TOP)	o	na	na	+
What Could You Do?	+	o	+	na

+= statistically significant program impact
o= no statistically significant program impact
na= not available
Source: US HHS

APPENDIX C: SBHC ALLOCATIONS FY14 and FY15

SBHC Sponsor	Service Delivery Site(s)	Amount of Contract (FY12)	Amount of Contract (FY13)	Amount of Contract (FY14 & FY15)
Belen Public Schools*	*Belen High School*	$80,000.00		
Community Foundation of Southern NM	Chaparral High School Gadsden High School Las Cruces High School Onate High School	$260,000.00	$250,000.00	$309,000.00
Dance Expose Productions (youth engagement group)	School on Wheels SBHC	$60,000.00	$57,250.00	$57,250.00
De Baca Family Practice Clinic	Ft. Sumner High School	$55,000.00	$52,500.00	$52,500.00
Dulce Independent Schools*	*Dulce High School*	$80,000.00	$70,000.00	
El Centro Family Health	Carlos Vigil Middle School Espanola Valley High School Maxwell High School Roy High School Taos High School Taos Middle School West Las Vegas High School	$430,000.00	$412,500.00	$577,500.00
Eastern New Mexico University	Goddard High School Mesa Middle School Roswell High School	$165,000.00	$157,250.00	$193,320.00
Hidalgo Medical Services	Cobre High School Lordsburg High School Silver High School	$190,000.00	$190,000.00	$180,000.00
JASSH-Casa de Salud (A community health organization)	RFK Charter High School	$90,000.00	$70,000.00	$70,000.00
La Clinica del Pueblo de Rio Arriba	Escalante High School	$55,000.00	$55,000.00	$55,000.00
Las Clinicas del Norte	Mesa Vista High School Pojoaque High School	$155,000.00	$155,000.00	$195,000.00
Navajo Preparatory School*	Navajo Preparatory School	$50,000.00	$30,000.00	
Nor-Lea Hospital	Lovington High School	$75,000.00	$75,000.00	$75,000.00
Presbyterian Medical Services	Capital High School Santa Fe High School Carlsbad High School Cuba High School Gallup Teen Center Lake Arthur High School Quemado Health Center *Socorro High School*	$366,750.00	$399,500.00	$439,250.00

Northwest Regional Educational Cooperative	Bernalillo High School Mora High School Raton High School Santa Rosa High School	$285,000.00	$265,000.00	$300,000.00
Central Regional Educational Cooperative (Albuquerque Area)	*Belen High School* *Jemez Valley High School* Mountainair High School	$110,000.00	$175,000.00	$175,000.00
Regional Educational Cooperative VI	San Jon High School	$55,000.00	$52,500.00	$52,500.00
Regional Educational Cooperative IX	Ruidoso High School	$80,000.00	$77,250.00	$106,250.00
San Felipe	San Felipe SBHC	$50,000.00	$47,500.00	$47,500.00
Socorro Independent Schools	*Socorro High School*	*$50,000.00*		
Union County Health and Wellness Network	Des Moines High School	$58,000.00	$55,500.00	$55,000.00
University of New Mexico - Prevention Research Center	ACL High School ACL Middle School To'hajillee SBHC	$130,000.00	$115,000.00	$115,000.00
University of New Mexico - Envision (Pediatrics)	Albuquerque High School East San Jose Elementary Highland High School Roosevelt Middle School Van Buren Middle School Washington Middle School	$300,500.00	$280,000.00	$460,000.00
University of New Mexico - Psychiatry	Mescalero Apache School	$70,000.00	$55,000.00	$55,000.00
TOTAL OPERATING BUDGET		$3,300,250.00	$3,096,750.00	$3,570,070.00

Source: DOH

SBHC Utilization

Data notes:
Range = July 1, 2011 to June 30, 2014
Dental Visits excluded

Behavior Health (BH)
Primary Care (PC)
Reproductive Visit (Repro)

	FY2011-2012			FY2012-2013			FY2013-2014		
	BH Visit	PC Visit	Repro Visit	BH Visit	PC Visit	Repro Visit	BH Visit	PC Visit	Repro Visit
Albuquerque High School	352	351	227	263	322	209	324	539	368
Belen High School	0	0	0	151	120	28	201	300	48
Bernalillo High School	7	28	12	15	89	26	17	216	11
Capital High School	896	122	864	214	115	794	554	123	715
Carlos Vigil Middle School	124	503	370	98	539	109	303	746	149
Carlsbad High School	52	320	34	61	536	62	27	648	48
Chapparal High School	161	316	70	253	358	66	35	265	90
Cobre High School	166	570	312	68	538	398	174	580	322
Cuba Schools Wellness	68	41	9	221	502	67	54	458	93
Des Moines High School	127	247	0	69	242	2	160	201	0
Dulce High School	156	413	115	0	0	0	0	0	0
East San Jose Elementary	179	181	0	8	216	2	28	317	1
Escalante High School	55	199	47	86	441	54	159	502	11
Espanola Valley High School	102	761	894	90	523	733	250	783	856
Ft. Sumner High School	233	92	0	166	200	2	190	290	12
Gadsden High School	616	270	133	421	393	143	425	456	85
Gadsden Middle School	281	437	6	0	0	0	0	0	0
Gallup High School	182	70	35	198	52	30	167	50	5
Goddard High School	47	124	4	68	169	9	102	198	32
Grant Middle School	327	472	26	573	584	11	1	0	0
Highland High School	483	541	287	157	487	218	321	319	223
Jemez Valley Public Schools	88	49	11	80	74	7	0	0	0
Laguna-Acoma High School	1080	846	91	708	318	0	360	276	10
Laguna Middle School	443	774	32	318	233	2	286	113	11
Lake Arthur Middle School	45	252	3	42	262	3	69	243	9
Las Cruces High School	223	252	107	271	309	63	203	291	73
Lordsburg High School	214	195	24	121	300	15	114	566	51
Lovington High School	792	2108	73	940	2551	74	845	2589	67
Maxwell Wellness	108	92	31	138	185	0	164	125	2
Mesa Middle School	88	416	21	219	485	10	195	505	23
Mesa Vista High School	487	738	91	279	347	30	479	326	13
Mescalero Apache School	54	191	12	191	66	6	190	68	2
Mora Independent School	72	663	20	175	973	27	52	950	33
Mountainair Mid/High School	115	175	9	106	197	30	81	234	29
NACA	69	40	23	0	101	11	0	0	0
Navajo Prep	92	433	65	0	1	0	0	0	0
Onate High School	395	290	145	517	351	120	523	504	123
Pojoaque Valley High School	498	1098	315	124	788	216	545	1009	201
Quemado School	70	396	8	122	264	15	148	302	17

SBHC Utilization Con't

	FY2011-2012			FY2012-2013			FY2013-2014		
	BH Visit	PC Visit	Repro Visit	BH Visit	PC Visit	Repro Visit	BH Visit	PC Visit	Repro Visit
Raton High School	15	86	1	22	258	2	26	181	3
RFK Charter School	309	60	73	267	66	116	147	84	95
Roosevelt Middle School	13	97	0	59	195	10	120	184	3
Roswell High School	61	290	14	181	286	10	617	335	36
Roy High School	0	17	7	23	48	0	43	97	17
Ruidoso High School	829	199	90	1079	562	44	1144	520	42
San Felipe Pueblo ES	110	1366	2	58	1528	9	28	1511	3
San Jon Schools	141	53	0	232	153	0	155	145	1
Silver High School	618	423	514	446	845	592	568	1248	528
Socorro High School	0	0	0	13	43	26	42	123	86
Santa Fe High School	848	190	1502	746	170	1400	723	210	1387
Santa Rosa High School	39	240	1	35	308	4	53	372	1
Taos High School	122	136	135	108	260	142	167	368	136
Taos Middle School	67	93	21	189	671	3	322	282	7
To'Hajiilee Teen Center	268	361	40	108	71	0	51	358	27
Van Buren Middle School	261	285	26	100	390	17	451	612	47
Washington Middle School	206	359	8	106	517	14	53	607	28
School on Wheels	591	244	178	572	131	104	557	77	17
Wilson Middle School	99	236	30	296	512	23	0	1	0
West Las Vegas SBHC	138	311	158	231	792	116	217	601	95
State Totals	14282	20112	7326	12402	22037	6224	13230	23008	6292