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COMMITTEE

Program
Evaluation
Unit

Program Evaluation: The Department of
Health's Role in the Early Childhood System

May 8, 2019

Report #19-02



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May 8, 2019

Ms. Kathyleen Kunkel, Secretary
New Mexico Department of Health
1190 S. St. Francis Drive
Santa Fe, NM 87505

Dear Secretary Kunkel:

On behalf of the Legislative Finance Committee, I am pleased to transmit the program evaluation, *The Department of Health's Role in the Early Childhood System*. The evaluation analyzed the program scope and funding of six Department of Health maternal and child programs; assessed performance and impact of those six programs; and explored current and potential connections of those programs to other early childhood services.

The report will be presented to the Legislative Finance Committee and public on May 8, 2019. An exit conference was held on April 30, 2019, with Department of Health representatives to discuss the contents of this report. The Committee would like a plan to address recommendations in this report within 30 days of the release of the report.

I believe this report addresses issues the Committee asked us to review and hope your organization will benefit from our efforts. We appreciate the cooperation and assistance we received from your staff.

Sincerely,

A handwritten signature in blue ink that reads "David Abbey".

David Abbey, Director

Cc: Senator John Arthur Smith, Chair, Legislative Finance Committee
Representative Patricia Lundstrom, Vice-Chair, Legislative Finance Committee
Olivia Padilla-Jackson, Secretary, Department of Finance and Administration
John Bingaman, Chief of Staff, Office of the Governor
Mariana Padilla, Director, New Mexico Children's Cabinet

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The Department of Health should better integrate its programs into the larger early childhood system

New Mexico has made significant strides in improving access to and quality of learning experiences for children under the age of 5. However, young children’s cognitive and academic development does not occur in isolation – it is dependent on good health and proper physical development. This makes New Mexico’s low ranking in several critical maternal and child health measures particularly concerning.

This evaluation reviewed six Department of Health (DOH) programs aimed at improving health metrics for young children and their mothers. The objective of the evaluation was to analyze each program’s funding, scope, performance, and impact. The report also contains the results of a review of the role of these DOH programs in the greater New Mexico early childhood system.

The evaluation process spanned the 2019 legislative session, during which the Legislature authorized the formation of a new cabinet-level department for early childhood education and care. Though two of the six programs investigated for this evaluation will transfer from DOH to the new Early Childhood Education and Care Department sometime before FY21, the findings related to individual program service delivery, administration, and effectiveness are relevant no matter each program’s parent department.

A primary conclusion of the evaluation is that the state lacks a cohesive strategy for addressing poor early childhood health outcomes. For the most part, DOH’s early childhood programs operate in silos and do not share, or adequately use, their own data to manage for performance. This results in poor targeting of services to high-risk mothers and children, and a lack of clarity on the effectiveness of each program.

This evaluation recommends DOH administrators make succession plans for the successful transfer of programs to the Early Childhood Education and Care Department and also develop agreements for data sharing and collaboration across departments and programs. The evaluation also outlines opportunities to strengthen DOH’s role in the state’s early childhood system. For example, DOH’s Maternal and Child Health Epidemiology program, could be playing a much larger role in developing data-driven early childhood policy than they currently do.

Finally, the evaluation finds that resurrection of the state’s Children’s Cabinet presents an opportunity for better interagency collaboration on statewide early childhood programs. Specifically, DOH and other administrators should use the Cabinet to organize and implement a cohesive early childhood support *system*, where programs and services are coordinated across agencies to comprehensively serve the needs of mothers, children, and families.

KEY FINDINGS AND RECOMMENDATIONS

Since FY12 WIC underspent \$26.1 million of federal funds

New Mexico's participation levels for the Special Supplemental Nutrition Program for Women Infants and Children (WIC) fell 28 percent since 2010 and only about half of all eligible women and children currently receive WIC food benefits. Decreases in participation have been more pronounced in some regions than others, yet WIC administrators have not been able to rebalance regional staffing accordingly. As a result of unsuccessful recruitment of WIC participants, DOH does not use its full federal WIC allocation every year.

FIT enrollment increased 23 percent between FY15 and FY18

Conversely, enrollment in the state's Family, Infant, Toddler (FIT) program has grown, but the amount of children who receive FIT services varies significantly across New Mexico counties. Some of this growth is likely the result of the state's generous eligibility criteria for FIT where children only at-risk for delay are deemed eligible for services.

Nine FIT providers contract with CYFD to provide home visiting

Some FIT service providers are contracted to provide state-funded home visiting services, and many FIT children with environmental risk factors are likely eligible to receive home visiting services. However, neither FIT nor home visiting administrators have developed guidance to help providers determine which children are best served in home visiting programs versus through FIT—likely leading to duplication of services.

DOH does not track performance of these programs through the Accountability in Government Act process

Increased reporting and improved data sharing could provide needed maternal and child health program oversight and improved outcome surveillance. However, limited data system functionality and a lack of rigorous evaluation leave administrators and policymakers unsure of the impact of many DOH programs. For example, despite a costly upgrade to the WIC data and enterprise system, the system was unable to provide even basic data reports for this evaluation. The Families FIRST database is similarly not fully functional and staff cannot easily pull data to monitor the outputs of their own work.

Centralized points of referral should improve program targeting and help the state avoid duplicating services

In order to develop a cohesive system of home visiting and early childhood services, the federal government recommends states develop a centralized intake, screening, and referral system to provide coordinated universal screening and referrals for pregnant women and children. In theory, such a system should reduce duplication of services and better target the right types of services to mothers and children based on their particular needs. DOH is piloting Family Connects, an evidence-based, light-touch home visiting program, that could serve as New Mexico's centralized intake and referral system if it is proven effective and expanded.

DOH has a team of epidemiologists dedicated to maternal and child health who could provide data-driven policy support

With its dedicated Maternal and Child Health Epidemiology program, DOH could play a more active role in monitoring and refining early childhood programs across state agencies. The coordination and joint powers agreement authority granted to DOH and other early childhood agencies through the Children's Cabinet Act of 2005 provide excellent vehicles for this type of coordination.

Key Recommendations

Through the Children’s Cabinet, administrators from the Department of Health; the Early Childhood Education and Care Department; the Children, Youth and Families Department; and the Public Education Department should:

As required by the Children’s Cabinet Act (32A-22-3D NMSA 1978), inventory early childhood health-related programs to identify points of service duplication and clientele overlap.

Organize a comprehensive state home visiting and early childhood support system that includes: 1) a universal centralized screening and referral entity, 2) a light-touch home visiting service for most families, 3) food, income and other social supports for families that require them, 3) early intervention services for children with developmental delays, and 4) more intensive home visiting services for families with higher needs.

Oversee the completion of the pilot of Family Connects—a Medicaid-eligible, evidence-based program. If the pilot yields positive results, then the Early Childhood Education and Care Department should consider expanding Family Connects statewide so that it can serve as the state’s universal centralized screening and referral program. Early Childhood Education and Care Department administrators could then discontinue Families FIRST and transition active Families FIRST clients to Family Connects or another appropriate evidence-based service.

Develop strategies to ensure state-funded programs are actually making a difference in improving maternal and child health. To do this, administrators and program staff will need to use existing programmatic data better, share that data with other early childhood programs, regularly monitor program performance, and engage Department of Health epidemiologists to develop action plans to improve program performance where necessary.

Determine avenues to best co-locate or co-deliver existing early childhood and other social services targeted to mothers, families, and children.

Hold meetings of the Children’s Cabinet at least six times a year, as mandated by the Children’s Cabinet Act. These meeting should be held following Open Meetings Act standards to maximize opportunities for collaboration both within and outside of state government.

Maternal and child health are essential components of a strong early childhood system

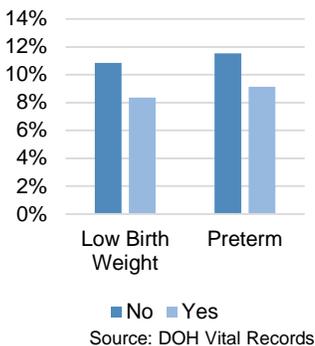
New Mexico ranks below the nation in several critical maternal and child health measures.

A 2016 joint interdepartmental review of early learning programs by the U.S. Departments of Health and Human Services and Education stated “young children’s cognitive and academic achievements do not develop in isolation; they depend on positive health and good physical development.”¹ While New Mexico is improving access to and quality of learning experiences for young children (those under the age of 5), the state still ranks below the national average in several critical maternal and child health measures, indicating a need for high-quality health services for mothers and their young children.

Figure 1. Health Outcomes from the 2018 Early Childhood Accountability Report

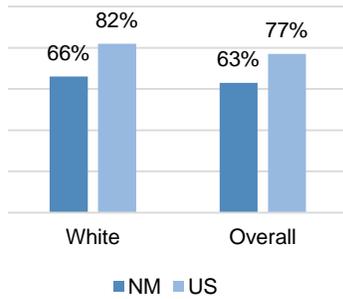
HEALTHY	Infant Mortality	Low Birth Weight	Immunization Rate	Early Access to Prenatal Care
	2016	2016	2016	2016
	6.2	9%	68.5%	63%
	Per 1,000 children	2,331 children		24,503 children
	U.S. – 5.9 (2016)	U.S. – 8.2% (2016)	U.S. – 71% (2016)	U.S. – 77% (2016)
	Worse	Worse	Worse	Worse
	2015 5.1	2015 8.7%	2015 70%	2015 66%
Source:	CDC	DOH	DOH	DOH

Chart 1. First Trimester Prenatal Care and Birth Outcomes, 2017



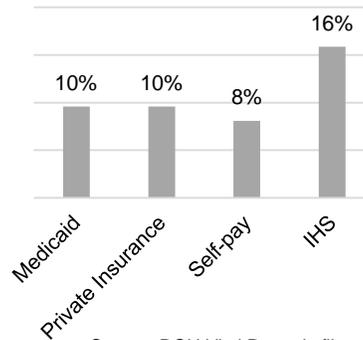
New Mexico has lower rates of prenatal care during the first trimester of pregnancy than most of the nation. State data show an association between low rates of first-trimester prenatal care and higher rates of low birth weight and preterm births. In 2016 in New Mexico, only 63 percent of pregnant women received first-trimester prenatal care, compared to 77 percent nationally. New Mexico is fourth lowest in the nation for the number of women accessing care during their first trimester of pregnancy and second lowest in the nation for the percent of women receiving adequate care throughout their pregnancy. There are ethnic differences regarding who receives first-trimester prenatal care, with Native American women 14 percent less likely to receive care than white or Hispanic women. Additionally, 22 percent of Native American women reported they did not start care as early as they wanted. This lack of early prenatal care may be partly responsible for worse birth outcomes for women using federally-provided Indian Health Services (IHS).

Chart 2. Percent of Women Receiving Prenatal Care During First Trimester, 2016



Source: National Vital Statistics System, DOH

Chart 3. Percent Low Birth Weight Births by Insurance Type, 2017



Source: DOH Vital Records files

Only 77%

of women with unintended pregnancies received prenatal care in their 1st trimester in 2016, compared to 89 percent of all women who were intentionally pregnant.

Source: PRAMS

Data from the New Mexico Department of Health (DOH) shows the top two reasons women do not access prenatal care during their first trimester are: 1) not knowing they are pregnant, and 2) an inability to get an appointment.¹ When women conceive intentionally, they are more likely to receive prenatal care in their first trimester and have healthy births.ⁱⁱ Women may not be able to secure an appointment due to a lack of insurance, or they may live in an area with a shortage of appropriate care providers. As discussed in the final chapter, New Mexico struggles with shortages of obstetric and gynecologist providers in certain regions of the state.

To improve access to care, New Mexico has presumptive Medicaid eligibility for pregnant women, meaning pregnant women can receive care before enrolling in Medicaid. Medicaid covers 73 percent of women in rural areas compared to 60 percent in urban areas. However, DOH data suggest living in an urban or rural area does not significantly affect whether a woman receives prenatal care during her first trimester.

New Mexico is experiencing a dangerous trend with increasing rates of babies exposed to drugs and alcohol before birth. Drug overdoses were the cause of approximately one-quarter of the state’s 97 pregnancy-associated deaths between 2010 and 2014. As of 2013, New Mexico had the fourth highest rate of infants born with Neonatal Abstinence Syndrome (NAS - the result of the sudden discontinuation of fetal exposure to substances that were used or abused by the mother during pregnancy) in the nation. The rate of NAS increased 424 percent in New Mexico between 2008 and 2017, from 3.3 per 1,000 live births to 14,

Table 1. Hospital Discharges Related to Neonatal Abstinence Syndrome,* 2009-2013

County of Residence of the Mother	NAS Rate per 1,000 live births				
	2009	2010	2011	2012	2013
Bernalillo	7.0	7.7	9.5	13.1	14.7
Chaves	1.9	4.1	3.2	2.1	5.3
Colfax	0.0	0.0	21.0	0.0	14.7
Dona Ana	0.9	1.5	3.4	2.9	4.6
Eddy	0.0	1.4	5.2	1.3	2.3
Grant	5.4	2.8	6.8	6.2	9.7
Lea	0.8	1.0	0.9	0.9	4.2
Lincoln	0.0	0.0	5.1	5.1	5.4
Los Alamos	0.0	0.0	0.0	16.9	6.3
McKinley	0.0	1.6	0.0	2.4	4.4
Mora	0.0	0.0	0.0	0.0	22.7
Rio Arriba	14.3	12.9	26.0	32.8	39.2
Sandoval	3.8	3.2	4.5	2.1	7.9
San Juan	0.0	1.0	1.6	2.1	2.1
San Miguel	3.2	5.8	9.5	0.0	6.3
Santa Fe	2.1	3.3	9.3	19.9	9.2
Sierra	0.0	0.0	34.5	0.0	8.7
Socorro	4.1	7.8	16.8	23.7	36.4
Taos	6.1	9.2	9.1	12.5	24.3
Torrance	0.0	6.1	5.8	0.0	6.8
Valencia	7.0	6.3	6.5	11.5	14.5
New Mexico	3.8	4.4	6.1	7.8	9.1

*Neonatal abstinence syndrome is an umbrella term that includes neonatal opiate withdrawal syndrome (NOWS) as well as newborns that experience withdrawal from any substances.

Source: February 2017 Presentation by Dr. Heather Pratt-Chavez of UNM’s Family and Community Medicine Resident School. <https://tinyurl.com/ycmh3b7j>

¹ Data comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) is a survey conducted as a joint effort of the U.S. Centers for Disease Control and Prevention and 27 participating states.

compared to a 207 percent increase nationally. Roughly, this means that of the 23,700 babies born in New Mexico in 2017, 330 were born with NAS.

Infants born with NAS often require long-term health and social services. As a condition of receiving federal Child Abuse Prevention and Treatment Act (CAPTA) funds, states are required to have policies for the development of a plan of safe care for infants identified as affected by “substance abuse or withdrawal symptoms.” These plans are expected to protect the safety and wellbeing of infants by addressing their health and the substance use treatment needs of their parents. The U.S. Department of Health and Human Services notes referrals to early intervention services are a best practice in the development of safe plans of care.ⁱⁱⁱ In New Mexico, this means many infants born with NAS are referred to the Family, Infant, Toddler (FIT) program, due to their heightened risk for developmental delay. Including the federal share of Medicaid, FIT services cost an average of \$1,570 per child annually.

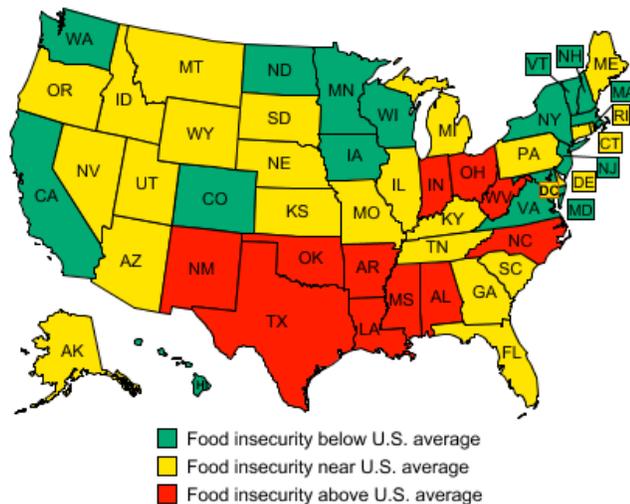
Further, the prevalence of adverse childhood experiences (ACEs) is strongly correlated with alcohol and drug use in exposed children^{iv} As ACEs increase, often so too does a family’s interaction with child welfare, juvenile justice, and human services programs, all of which have a cost to the state.

New Mexicans suffer from the highest level of household food insecurity in the nation. The U.S. Department of Agriculture (USDA) defines food security as access by all people at all times to enough food for an active, healthy life. USDA reports roughly 149 thousand households in New Mexico (17.9 percent) experienced food insecurity between 2015 and 2017. The U.S. Census Bureau reports a similar proportion (17.5 percent) of children in New Mexico living in food-insecure households.

New Mexico’s household food insecurity rate is the highest in the country and 5.6 percentage points more than the national average. Even more concerning, USDA reports New Mexico was the only state with a statistically significant increase (5.6 percent) in food insecurity from 2012-2014 to 2015-2017.^v

Figure 2.

Prevalence of food insecurity, average 2015-17



Source: USDA, Economic Research Service, using data from the December 2015, 2016, and 2017 Current Population Survey Food Security Supplements.

This growing level of food insecurity is almost certainly having a negative effect on the health of children. The American Psychological Association noted “household food insecurity has insidious effects on the health and development of young children, including increased hospitalizations, poor health, iron deficiency, developmental risk and behavior problems, primarily aggression, anxiety, depression, and attention deficit disorder.”^{vi} According to a 2008 research study, caregivers in food-insecure households were two-thirds more likely than caregivers in food secure households to report their children were at risk for developmental delays.^{vii}

DOH has six programs to address these and other maternal and child health outcomes.

Program	Description/Purpose	FY18 Enrollment	FY14-FY18 Enrollment Change	FY18 Expenditures	FY14-FY18 Expenditure Change	FY18 Percentage of Expenditures from General Fund
FIT	The Family, Infant, Toddler (FIT) program provides early intervention to children birth to age 3 who have or who are at-risk for developmental delay. The program operates in accordance with the federal Individuals with Disabilities Education Act (IDEA) Part C.	15,734	23%	\$45,681,776	21%	44%
WIC	The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) safeguards the health of low-income women, infants, and children up to age 5 who are at nutritional risk. WIC provides nutritious foods to supplement diets, nutrition education, and referrals to health care and other social services.	42,921	-22%	\$46,273,354	-9%	2%
Families FIRST	Families FIRST is a program funded by Medicaid to provide case management to Medicaid eligible pregnant women and children birth to 3 years old.	3,192	-24%	\$1,927,354	9%	23%
Maternal Health	The Maternal Health program's purpose is to assure quality maternal health care by delivering support to providers that give prenatal care for women who could not access it otherwise. Mainly a coordinating body, the program studies pregnancy care quality and works with stakeholders to strengthen pregnancy care resources. The program is also responsible for licensing midwives.	N/A		\$996,423	14%	39%
Child Health	The Child Health program works collaboratively with other child-serving state agencies and community-based programs to provide health leadership, program updates to community initiatives, Results Based Accountability and Collective Impact, keep partners informed about early childhood related issues and topics of interest, and work together to align and eliminate duplication of efforts.	N/A		\$148,848	-87%	43%
Maternal and Child Health Epidemiology	The Maternal and Child Health Epidemiology program gathers, interprets and presents data about mothers, infants and children. Staff work with public health leaders to use data in statewide health promotion, policy development and community collaboration.	N/A		\$682,538	5%	40%

New Mexico law requires an interagency working group, the Children’s Cabinet, to promote coordination among agencies with children’s programming.

The Children’s Cabinet was created in statute in 2005 for the express purpose to “study and make recommendations for the design of a coordinated system to maximize outcomes among children and youth under age twenty-one, particularly those in disadvantaged situations” (32A-22-1 NMSA 1978). Not an actual agency, the Children’s Cabinet is instead a coordinating group consisting of secretaries of 11 state agencies including DOH, and representatives from the Governor and Lieutenant Governor’s office.

The 2005 Children’s Cabinet Act specifically tasks participating agencies to study and make recommendations for the design of a coordinated system to maximize children’s outcomes related to health and family support. However, the Cabinet has been operationally defunct and has not produced a report to the Legislature since at least 2011. However, in 2019, the Governor hired a staff person in her office to reinstate and oversee the Children’s Cabinet moving ahead.

As discussed in the last chapter, the Children’s Cabinet allows for participating agencies to enter into joint powers agreements which may be good vehicles by which DOH could implement a number of recommendations listed in this report.



DOH spends \$96 million annually on its six programs to improve maternal and child health

Together these programs represent a significant portion of total expenditures on early childhood in New Mexico.

In addition to being a significant cost center for state spending on early childhood, each of DOH's six maternal and child health programs has a notable impact (or potential for impact) on the health of a number of New Mexico's young children. The LFC's 2018 Early Childhood Accountability Report noted New Mexico lagged behind the nation in key early childhood health metrics and many of the DOH's early childhood programs offer services meant to improve those metrics. Better understanding of why those health metrics lag behind the nation and how DOH is working to improve them through their early childhood programs are key aspects of this evaluation.

This chapter provides details on the structure of each program—its funding sources and expenditure trends, the population it provides services to, and the impact it is having on that population. Special focus is given to the three programs providing direct services to women and children (WIC, Families FIRST, and FIT).

WIC is a federally funded program to provide food and education to low-income mothers and children.

As stated in the background section, food insecurity is an acute and prevalent problem for at least 17.5 percent of families in New Mexico—and food insecurity is a major barrier to the normal development of children. In order to combat the negative effects of food insecurity on young children, the federal Special Supplemental Nutrition Program for Women Infants and Children (WIC) provides supplemental foods, nutrition education, breastfeeding promotion and support, and health and social service program referrals.

Each year, the U.S. Department of Agriculture (USDA) distributes federally appropriated grant funds for WIC to state agencies. State agencies then implement the WIC program, distributing some of the funds to women on electronic benefit cards (pictured at left.) These electronic benefits cards (or, EBT cards) are used like a debit cards to buy certain types of foods at grocery stores. To receive WIC benefits, women must apply and be determined eligible, usually through an hour-long appointment at a WIC office. USDA sets eligibility criteria for WIC to be uniform across all states. To be eligible, individuals must:



Figure 3.

WIC Income Guidelines – July 1, 2018 to June 30, 2019

Household Size	Yearly Income is no greater than	Monthly Income	Weekly Income
1	\$22,459	\$1,872	\$432
2	30,451	2,538	586
3	38,443	3,204	740
4	46,435	3,870	893
5	54,427	4,536	1,047
6	62,419	5,202	1,201
7	70,411	5,868	1,355
8	78,403	6,534	1,508
Each Add'l Family Member, add	+\$7,992	+\$666	+\$154

If you are pregnant, you should count yourself as two.

Source: Georgia Dept. of Public Health

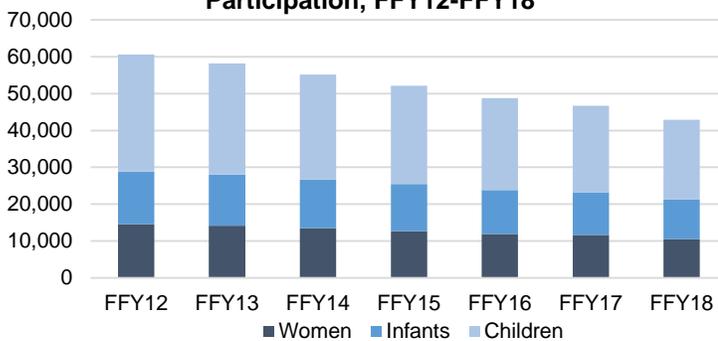
- Be a pregnant woman, a breastfeeding woman up to one year postpartum, a nonbreastfeeding woman up to six months postpartum, or a child birth to age 5.
- Live in a household with total gross income at or below 185 percent of the federal poverty income level (under \$46,436 annually for a family of four through June 30, 2019). WIC counts an unborn baby as a household member.
- Be at nutritional risk. WIC participants receive an initial health and diet screening at a WIC clinic to determine nutritional risk. WIC uses two main categories of nutritional risk 1) medically-based risks such as a history of poor pregnancy outcomes, underweight status, or iron deficiency anemia, and 2) diet-based risk factors such as poor eating habits which can lead to poor nutritional and health status.
- Apply in person.

After an initial determination of eligibility, WIC most often issues three months of food benefits onto the participant’s card. WIC staff also determine a schedule for the mother or child to return to the WIC clinic for additional health checks – usually at three or one month intervals.

Nationally, WIC improves birth outcomes, leads to better nutrition and health for children, and higher academic achievement for students.

According to a 2017 report from the Center for Budget and Policy Priorities, WIC has many benefits for both mother and child.^{viii} That report highlighted research from USDA which found prenatal WIC participation led to fewer premature births, lower incidence of low birth-weight infants, and fewer infant deaths. Furthermore, WIC improved the quality of participants’ diets, especially for infants and children. Additional research shows WIC families eat more whole grains, fruits and vegetables, and drink lower fat milk. There are also other less immediate impacts on child immunizations, health, and cognition. Immunization rates for participating WIC children are the same as rates for higher income peers, and between 11 percent and 15 percent higher than for individuals who are eligible but not participating in WIC services. In addition to nutrition and health-related factors, children whose mothers’ participated in WIC while pregnant scored higher on assessments of mental development at age 2 than similar children whose mothers did not participate and these differences were still present once these children entered school.

Chart 5. Average Monthly New Mexico WIC Participation, FFY12-FFY18



Source: LFC analysis of DOH data

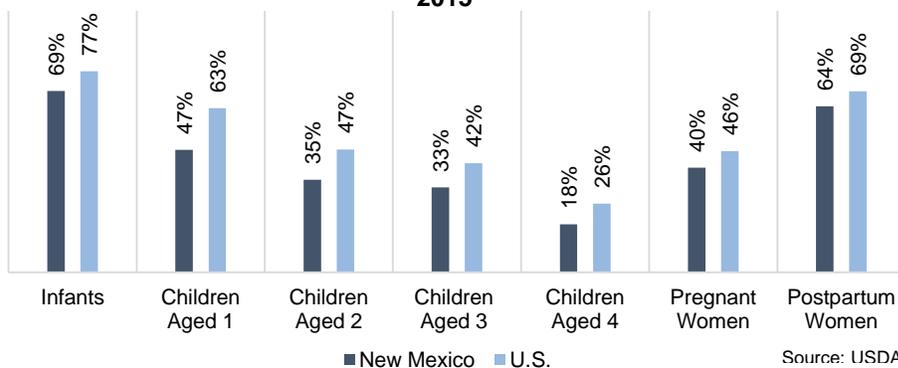
Both nationally and in New Mexico, WIC participation has dropped steadily after reaching a peak in 2010.

In 2018 there were only 6.9 million WIC participants – a 25 percent decrease from peak enrollment of 9.2 million participants in 2010. In New Mexico, the decrease has been more pronounced—a 28 percent decrease from 65.1 thousand to 46.7 thousand over the same period. USDA attributes the drop in WIC participation to the improving economy and falling birthrates, especially for teen mothers (the total fertility rate in New Mexico dropped 10 percent since 2010, and the teen birthrate has fallen 37 percent).

Though almost two-thirds of all infants born in New Mexico are eligible, only a little more than half receive WIC benefits. WIC is underutilized nationally with between 26 percent and 77 percent of eligible women and children participating, depending on age. However, compared to the U.S. as a whole, a smaller percentage of eligible New Mexicans participate in WIC. In 2015, the latest year of national data available, New Mexico had the fifth-lowest coverage of eligible WIC participants of all states.

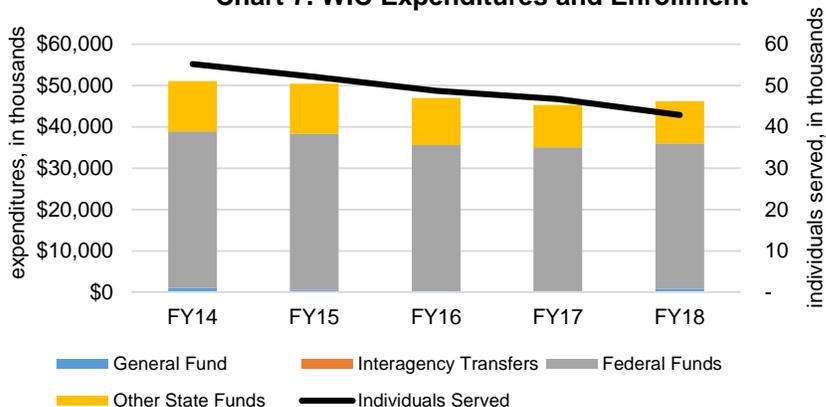
Participation in WIC tends to drop as children progress in age. In New Mexico, the largest changes in coverage occur between infants, with 69 percent of eligible infants receiving WIC benefits, and 1-year-olds, where only 47 percent of eligible 1-year-olds receive benefits. Another notable (14 percentage point) drop in coverage occurs between 3- and 4-year-olds. This is likely because the value of WIC benefits decreases as children age, particularly for formula-fed infants as they move to less costly diets.

Chart 6. Percent of Eligible Individuals Participating in WIC, 2015



Low WIC participation led to underutilization of federal funds and a greater administrative cost burden. The U.S. Department of Agriculture’s (USDA) Food and Nutrition Service administers WIC and provides formula-based grants to state agencies which, in turn, provide food benefits and services to participants. In federal fiscal year (FFY) 2018, New Mexico received \$34.1 million in federal WIC funding to serve approximately 47 thousand women, infants and children.

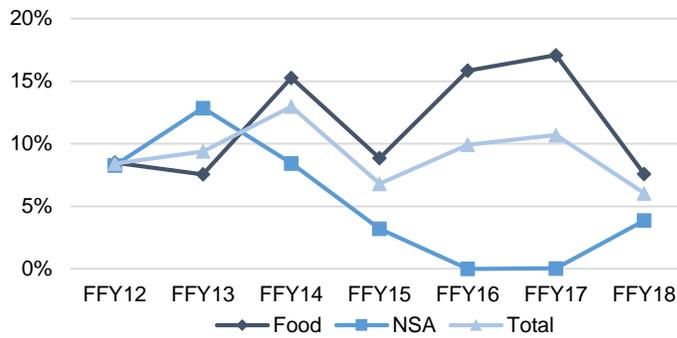
Chart 7. WIC Expenditures and Enrollment



The state's federal WIC grant consists of two components, one for participant food benefits and one for nutritional services and administration (NSA). The food grant is determined by a formula that factors the number of WIC participants, the overall population, state salary levels, the number of WIC-eligible persons in the state, and how much WIC funding a state received in the prior year. When the state does not spend all of its award in a fiscal year because of inadequate participation, the remainder stays with the federal government and does not benefit New Mexico.

Overall, WIC underspent its federal allocation by \$26.1 million since FFY12 and ranged between approximately 7 percent of the total grant in FFY15 to 13 percent in FFY14. Underspending for food benefits made up \$20.7 million, or 79 percent of the total amount, and ranged from about 8 percent in FFY13 and FFY18 to as high as 17 percent in FFY17. NSA underspending by New Mexico WIC was lower, totaling \$5.4 million since FFY12.

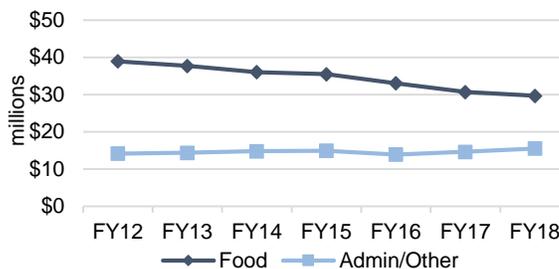
Chart 8. Percent of Federal WIC Grant Unused



Source: LFC analysis of DOH data

Administrative and other nonfood costs, including nutrition education and client services, make up an increasing proportion of WIC expenses as demand for the program decreases. Total WIC spending was \$45.2 million in FY18, 15 percent less than the \$53.1 million spent in FY12. This decrease is entirely due to less spending on food assistance. In FY12, WIC food expenses totaled \$38.9 million, or 73 percent of total program costs. However, in FY18, WIC spending on food totaled \$29.7 million, 24 percent below FY12 levels and 66 percent of total program costs. Meanwhile, administrative and other costs increased by 10 percent, from \$14.2 million to \$15.6 million over the same period.

Chart 9. WIC Expenditures, FY12-FY18



Source: LFC analysis of SHARE data

Regional variations in WIC utilization indicate a need for strategic planning to balance staff and resource allocation. While WIC enrollment and redemptions are down across the entire state, recent changes have been more pronounced in the Northeast and Southeast regions. The Northeast region experienced the largest decrease in WIC food redemptions (-37 percent) and the second-largest decrease in average monthly enrollment (-31 percent) between FFY12 and FFY18, while the Southeast region experienced the largest enrollment decline (-35 percent). Additionally, while the population of children under age 5 has also decreased statewide, likely contributing to WIC declines, the fall in WIC utilization has outpaced this trend, indicating other factors at play.

Contributing to the decrease in the Southeast’s WIC enrollment is its faster rate of family income growth, likely due to expanded economic activity in and surrounding oil and gas industry operations. Median family income in the Southeast region grew by 8 percent between 2012 and 2017, faster than all other public health regions and the state as a whole. Meanwhile, the Northwest region, which has experienced the smallest decreases in WIC activity in the state, had the slowest income growth.

Regional patterns in WIC participation effect the caseload carried by the program’s dietitians and nutritionists, who conduct nutrition screenings and work with clients to monitor nutritional outcomes. For example, lower participation in the Northeast contributed to smaller caseloads and a higher staff vacancy rate. On the other hand, the Southeast region maintains the largest caseload per dietitian/nutritionist despite having the second lowest vacancy rate. Shifting funded but vacant positions from areas with lower caseloads, such as the Northeast region, to relieve some of the burden in higher-caseload areas such as the Southeast region, could improve efficiencies and better respond to population trends.

Figure 4. Department of Health Public Health Regions

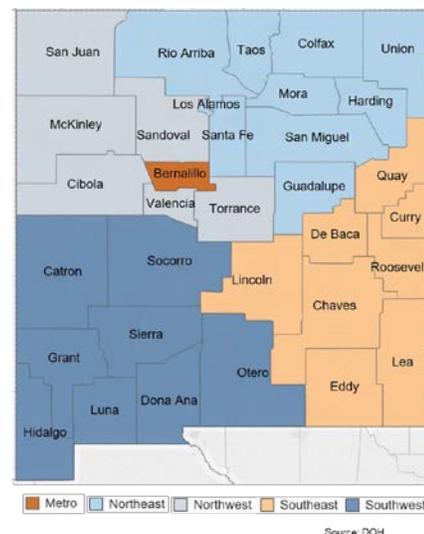
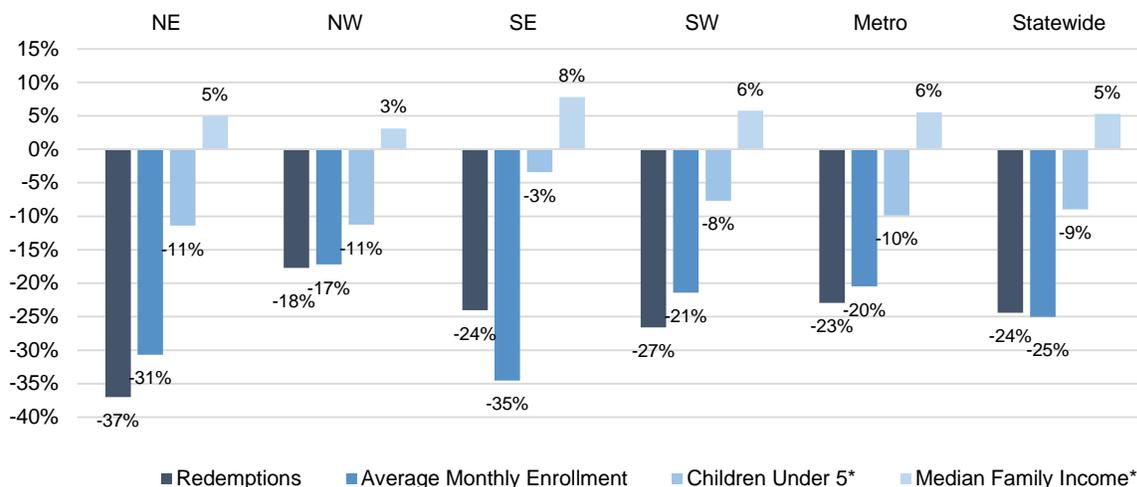


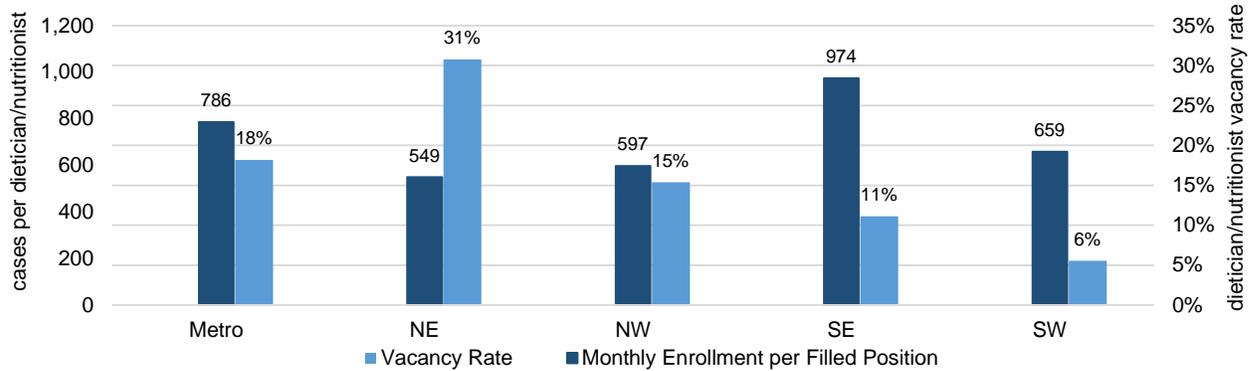
Chart 10. Percent Change in WIC Food Redemptions and Average Monthly Enrollment by Region, FFY12-FFY18



Notes: *Change in number of children aged 0-5 is for CY12-CY17
 ** Median family income represents change in weighted averages across counties from CY12-CY17

WIC staffing vacancies grew during FY18, especially in the Northeast, which had a vacancy rate of 39 percent as of July 1, 2018, and Northwest, where the vacancy rate was 21 percent, compared with 8 percent a year earlier. The Southeast region went from no vacancies among its 15 dietician/nutritionist positions on July 1, 2017, to six vacancies (29 percent) a year later. Meanwhile, the Metro and Southwest regions remained relatively constant.

Chart 11. WIC Enrollment per Dietician/Nutritionist by Region, February 2018



Source: LFC analysis of DOH and SPO data

Pay may be a factor in difficulty recruiting for WIC positions. Based on data from the State Personnel Office and the U.S. Bureau of Labor Statistics, full-time dieticians and nutritionists currently employed with the New Mexico WIC program earn approximately \$5,000 less per year, on average, than the median national salary. The average hourly rate for these positions in New Mexico, excluding supervisors, was \$22.42 per hour, compared with the median rate of \$24.81 per hour nationally, a difference of nearly 10 percent.

Moreover, some WIC staff indicated New Mexico universities are not training adequate numbers of dieticians/nutritionists to meet WIC program needs. However, both the University of New Mexico (UNM) and New Mexico State University (NMSU) offer a bachelor's degree in Nutrition and Dietetics and Central New Mexico Community College offers an associate's degree in nutrition with a transfer pathway to UNM's degree program. In academic year 2017, 31 students graduated from UNM's Bachelors of Science in Nutrition and Dietetics, and 17 students graduated from NMSU's Bachelor of Applied Arts and Sciences Family and Consumer Sciences Foods and Nutrition Concentration. It is unclear if the WIC program outreach to these new graduates has been insufficient or if the WIC program is simply not attractive to new graduates.

Table 2. Dietician and Nutritionist Degrees and Licenses Issued, Academic Year 2017

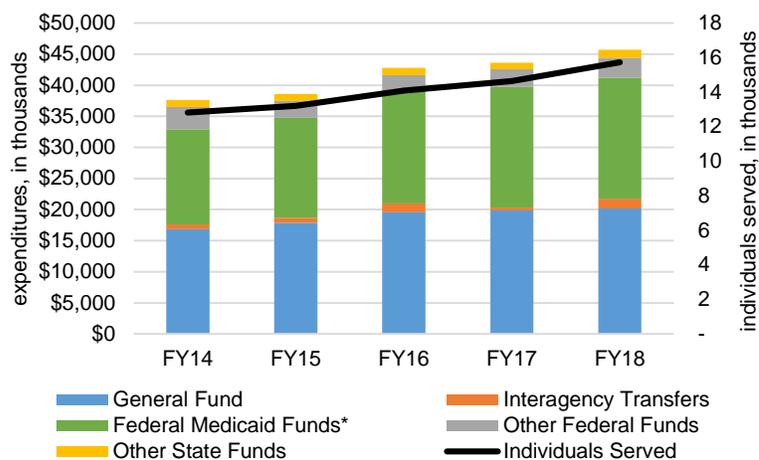
University or Licensing Body	Number of Degrees or Licenses
UNM: Bachelor of Science in Nutrition & Dietetics	31
CNM: Associate of Science in Nutrition. With Transfer pathway to UNM's program	11
NMSU: Bachelor of Science in Family and Consumer Sciences with a Dietetics Concentration	17
ENMU: Bachelor of Applied Arts and Sciences Family and Consumer Sciences Foods and Nutrition Concentration	Unknown
RLD-Ratified licensed dietitians in the ten months between September 13, 2016s through July 21, 2017	42

FIT works to ameliorate or prevent developmental delays for a vast number of young children in New Mexico.

DOH’s Family, Infant, Toddler program (FIT) uses federal Individuals with Disabilities Education Act (IDEA) Part C funds to intervene early in a child’s development to address actual or potential developmental delays and to improve later educational outcomes. The FIT program contracts with providers to deliver therapies and support services to young children (birth through age 2) who have, or are at risk for, developmental delays. Though not an entitlement program, all states currently participate in the Part C program. Under IDEA Part C, a participating state must assure that adequate early intervention services are available to all infants and toddlers that meet the state’s eligibility requirements.

FIT receives funding primarily from Medicaid, state general fund, and federal IDEA Part C. Medicaid funds pay for services provided to Medicaid-eligible children, while general fund revenues and private insurance pay for the remainder. Spending on FIT from all sources, including Medicaid funds matched by DOH, totaled \$45.7 million in FY18, of which about \$26 million was from DOH appropriations. DOH does not receive Medicaid funds directly for FIT, but rather reimburses the Human Services Department for the state share of FIT-related Medicaid expenditures from general fund appropriations.

Chart 12. FIT Expenditures and Enrollment



*Federal Medicaid funds reported by DOH; excludes additional federal Medicaid funds received but not matched by DOH
Source: DOH, SHARE

New Mexico uses generous criteria to determine infant and toddler eligibility for FIT services. Under IDEA Part C, states establish eligibility criteria to determine which children qualify for services. All states must include the following two categories in their eligibility criteria:

1. A child is experiencing a developmental delay, or
2. A child has a physical or mental condition that has a high probability of resulting in developmental delay.

New Mexico is one of only five states that serves at-risk children without identified developmental delays and is the only state that considers children experiencing only one environmental risk factor eligible.

Each state is given latitude to determine the level of delay a child must demonstrate to be eligible. New Mexico Administrative Code outlines that children who demonstrate a 25 percent developmental delay (after correcting for prematurity) in any single area, or a delay 1.5 standard deviations below the mean in any single area, are eligible (NMAC 7.30.8.10). These are relatively standard levels across most states, although about half of all states (24) have more stringent requirements for children with delays in only one area.

Under IDEA Part C, states also have the option of adding an eligibility category for children “at-risk” for developmental delays due to biological factors like low birth weight, prenatal drug exposure, or environmental factors such as a history of abuse or neglect. Currently, New Mexico is one of only five states that serve at-risk children without identified developmental delays and is the only state that considers children experiencing only one environmental risk factor eligible.

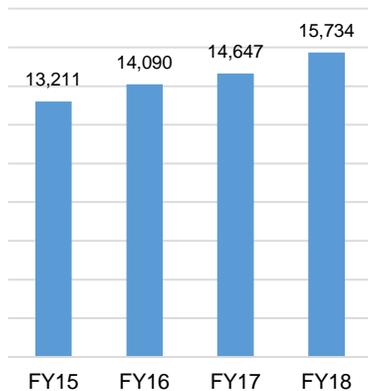
Over eight years, IDEA Part C programs nationwide grew at an average rate of 20 percent. However, the five states with eligibility criteria for children living with environmental risk factors grew faster at an average rate of 34 percent. Of these states, New Mexico experienced the second fastest growth in enrollment between 2008 and 2016 at 47 percent.

Table 3. Percent of Children Under Age 3 Served, and Growth in Enrollment in Environmental Risk States

State	Percent of Children Served, 2016*	Change since 2008
New Hampshire	5%	59%
New Mexico	7%	47%
Massachusetts	9%	40%
West Virginia	6%	32%
Illinois	3%	-8%

*This data denotes the percent of children served *at a point in time*. Since many children receive FIT services for only part of the year, more than 7 percent of all children receive services throughout the year. See Chart 13. below.
Source: U.S. Department of Education

Chart 13. Children Served by FIT Throughout the Entire Fiscal Year



Source: DOH

FIT enrollment increased 23 percent between FY15 and FY18, now encompassing approximately one in five New Mexican children under 3. On average, FIT enrollment grew 5 percent annually between FY15 and FY18. As of FY18, nearly 16 thousand children received services through FIT, up 7 percent from FY17 and 23 percent from FY15.

This growth may make FIT less sustainable over time and decrease its ability to serve children without delays, but at-risk for developing them. The number of children referred and determined eligible for FIT has grown to such a level that the department received \$2.6 million in additional state funding in the FY20 General Appropriation Act for FIT enrollment growth.

The percent of children served by FIT varies substantially by county. In FY18, FIT served almost 19 percent of children in Hidalgo County, while only serving 2.5 percent in Torrance County. This indicates that some contracted FIT providers may be over-diagnosing children while others may not provide adequate services. Depending upon the specific circumstances, the state could be over enrolling infants and toddlers or could be underestimating the current need for services.

Table 4. Percent of Children Served by County, FY18

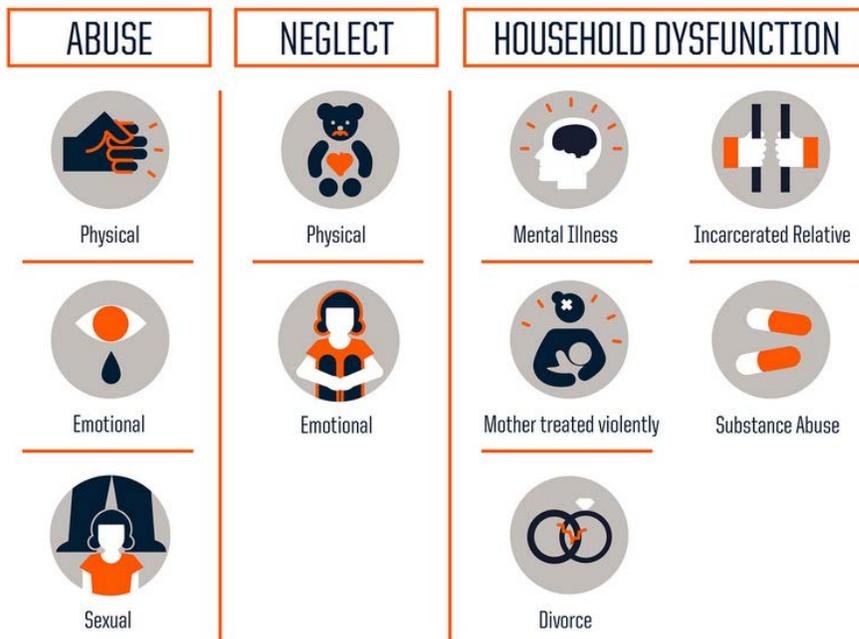
	County	Percent Served Birth through 1	Percent Served Birth through age 3
Lowest percent of children served	Torrance	1.3%	2.5%
	McKinley	1.8%	2.8%
	San Juan	2.0%	3.2%
	Catron	3.0%	4.1%
	Santa Fe	2.7%	5.0%
All other counties		4.3%	8.6%
Highest percent of children served	Curry	7.4%	14.2%
	Doña Ana	8.9%	14.9%
	Sierra	12.6%	16.7%
	Colfax	14.3%	18.1%
	Hidalgo	13.4%	18.9%
NM Total		4.9%	8.2%

Source: LFC analysis of FIT data

The needs of children enrolled in FIT due to environmental risks are uncertain as the tool used to determine environmental risk eligibility has not been validated. The FIT environmental risk assessment tool was developed in 2004 by the University of New Mexico’s Health Sciences Center. The tool’s development included statistical analysis of children served and the chance of children demonstrating a 25 percent delay as a result of risk factors in the child’s home and family life. FIT administrators did not know if the University or FIT piloted the tool to determine its predictive validity, interrater reliability, or construct validity. Without these measures, the extent to which the tool can reliably measure environmental risk is uncertain. Adverse childhood experience (ACE) assessment tools measure cumulative risk for

Figure 5. What are ACEs?

Adverse childhood experiences (ACEs) are all types of abuse, neglect and other traumatic experiences that occur to children. The U.S. Centers for Disease Control & Prevention categorizes ACEs in three categories:



Source: U.S. Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation, NPR

several future health and behavioral outcomes. Currently, there are three validated tools to screen for ACEs that could serve as an alternative to the current FIT environmental risk assessment. Moving ahead, FIT administrators may want to consider validating their own tool, or using an existing validated ACE tool to determine if a child is at-risk for developing a delay due to environmental risk factors, rather than continuing to use a homegrown tool of unknown validity.

Families FIRST is a homegrown case management program for pregnant and post-partum Medicaid-eligible women.

Families FIRST is a perinatal case management program administered by DOH's Public Health Division, designed to promote improved pregnancy outcomes and healthy infants and children. Families FIRST offers Medicaid-eligible pregnant women and children up to age 3 resources to access medical, social, and educational services. These include at least one voluntary home visit, establishment of a medical home, and other services and information delivered through a care coordinator, typically a nurse operating out of a DOH public health office. DOH developed Families FIRST in 1989 with the goals of improving birth outcomes, decreasing high-risk pregnancies, and identifying children with special health care needs for referral to Children's Medical Services and FIT.

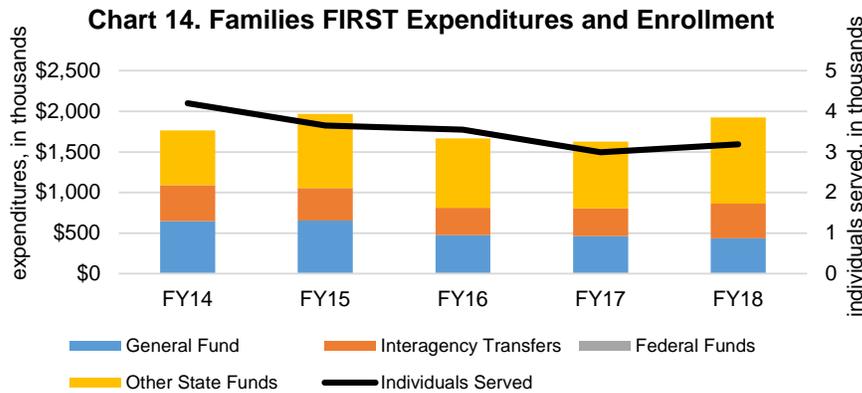
The Families FIRST program is revenue driven, billing Medicaid managed care organizations for targeted case management services. Families FIRST is the only Medicaid perinatal case management program in the state and is scheduled to move to the new Early Childhood Education and Care Department sometime in FY20.

Perinatal case management programs may positively impact maternal and child health outcomes, leading to a return on investment ranging from \$2 to \$4 for every dollar spent. A study from 1999 found that a nurse case management program resulted in savings of at least \$16 million on infant health care. When examining telephone-based case management, researchers found those receiving this service had babies with increased birth weights and saved \$500 in health care costs per person, leading to a four-to-one cost-benefit.^{ix} Another case management program for women on Medicaid found a reduction in Neonatal Intensive Care Unit admissions for children whose mothers received case management services, with a two-to-one return on investment.^x Further analysis of the effect of case management for pregnant women on Medicaid using propensity score matching found strong effects of case management on birth weight^{xi} and preterm risk.^{xii}

Declining caseloads threaten the financial sustainability of Families FIRST. Families FIRST is funded entirely by reimbursements from Medicaid managed care organizations (MCOs) for targeted case management services. Expenditures ranged between \$1.5 million and \$1.9 million since FY12, primarily consisting of payroll costs for the program's care coordinators.

In FY18, Families FIRST reported opening 3,192 new cases, down 24 percent from a recent high of 4,203 in FY14. For the program to be self-sufficient, Families FIRST nurses would have needed to bill for 3,212 cases in FY18 (or, approximately 169 cases per year per nurse). Through FY18, Families FIRST received either \$500 or \$600 per case per year, depending on the MCO. Beginning FY19, the program bills at a rate of \$600 annually for all cases.

State general fund revenues from the Public Health program of DOH are used to support Families FIRST in years when MCO revenue is not sufficient to cover the operating costs of the program. Pregnant women make up about two-thirds of the clients a care coordinator sees, with the other third being infant clients. Infant clients can stay part of the program until their third birthday. A family who receives a single visit but does not remain active in Families FIRST will cost the same as a family who remains for the maximum duration. Due to difficulties accessing reports from the Families FIRST data system, DOH staff were unable to provide information on the average case duration, but the program’s policies and procedures manual notes that prenatal Families FIRST clients should receive three visits and pediatric clients should receive approximately four visits a year.



Source: DOH

As of November 2018, Families FIRST caseloads averaged 98 per care coordinator, near the low end of the recommended caseload range. Families FIRST policy requires full-time care coordinators to maintain an active caseload of between 75 and 200 cases and to submit 15 to 20 new billing claims monthly. November 2018 data shows caseloads averaged 98 per care coordinator but varied widely from as few as 12 to as many as 198. Eight of the 19 care coordinators (42 percent) carried a smaller caseload than the minimum of 75 cases that month. Overall, there were 52 fewer cases that month than the previous month, or an average of two fewer cases per care coordinator, with 10 of 19 care coordinators experiencing a drop in caseloads.

These numbers may be lower than average due to the change in MCOs, leading to fewer referred clients. According to DOH staff, the majority of MCO referrals came from two MCOs that are no longer serving Medicaid clients in New Mexico. Western Sky, the state’s newest MCO, had yet to sign a contract with DOH to refer clients to Families FIRST as of December 2018. DOH is currently not tracking the number of new cases per case manager due to Families FIRST program manager vacancies, and did not provide more complete caseload data to LFC staff, so it is not possible to develop a more complete caseload trend. If case managers are not able to bring in the needed number of cases, the program needs to increase recruitment efforts or employ fewer care coordinators.

Table 5. Families FIRST caseload data, November 2018

Case Manager	Location	Pediatric	Prenatal	Total	Difference from Prior Month
1	Albuquerque	30	93	123	-46
2	Clovis	94	104	198	-27
3	Las Cruces	20	49	69	-22
4	Clovis	76	105	181	-15
5	Belen	61	34	95	-14
6	Farmington	24	54	78	-12
7	Hobbs	14	30	44	-5
8	Anthony	48	83	131	-3
9	Alamogordo	70	44	114	-3
10	Anthony	55	88	143	-1
11	Hobbs	28	43	71	4
12	Roswell	14	76	90	8
13	Roswell	10	89	99	12
14	Ruidoso	33	30	63	12
15	Clovis	0	12	12	12
16	Las Cruces	25	42	67	13
17	Albuquerque	2	68	70	16
18	Las Cruces	30	44	74	16
19	Las Cruces	59	83	142	18
Total		693	1,171	1,864	-52
Average		36	62	98	-2

Source: Adapted from DOH files

Despite their small budgets, DOH’s three maternal and child health support programs have broad goals and responsibilities.

In FY18, the Maternal Health, Child Health and Maternal and Child health Epidemiology programs of the DOH had total combined expenditures of only \$1.8 million, yet the goals and purpose of the programs are sweeping.

The goals for the Maternal Health and Child Health programs include:

- 1) providing prenatal care to uninsured and insured women,
- 2) increasing the number of infants placed to sleep on their backs,
- 3) increasing the number of children who receive a developmental and behavioral screening,
- 4) preventing infant mortality, maternal morbidity, and maternal mortality,
- 5) improving perinatal regionalization, and
- 6) regulating and licensing certified nurse midwives and licensed midwives.

The Maternal and Child Health Epidemiology program tracks current health outcome data for mothers and children. Epidemiology is the study of patterns, causes, and effects of health in defined populations. DOH’s Maternal and Child Health Epidemiology program focuses on prenatal, maternal, infant, child, and adolescent health across the state. Often as a requirement of federal and other grant programs, trained epidemiologists examine outcome trends and benchmarks where New Mexico stands in the nation in regards to maternal and child health. Major annual activities of the Maternal and Child Health Epidemiology Department include conducting and analyzing data from the Pregnancy Risk Assessment Monitoring System (PRAMS) survey; monitoring maternal mortality, and preparing data for DOH’s annual report and application for the federal Maternal and Child Health Services Title V Block Grant.

The Maternal Health, Child Health, and Maternal and Child Health Epidemiology programs receive a portion of the federal Maternal and Child Health Services Block Grant. The U.S. Department of Health and Human Services administers the block grant, authorized under Title V of the federal Social Security Act. Title V aims to improve the health of low-income pregnant women, mothers, and children. It supports a number of DOH services including newborn bloodspot and hearing screenings, immunizations, services to high-risk pregnant women with no other source of health care coverage, and some functions of the department’s Maternal and Child Health Epidemiology program. States must match every \$4 of federal Title V funding they receive by at least \$3 of state or other non-federal dollars. In federal FY17, DOH spent \$3.5 million in Title V funds, matched with \$9.7 million in state funding.

Chart 15. Maternal Health and Child Health Expenditures (combined)

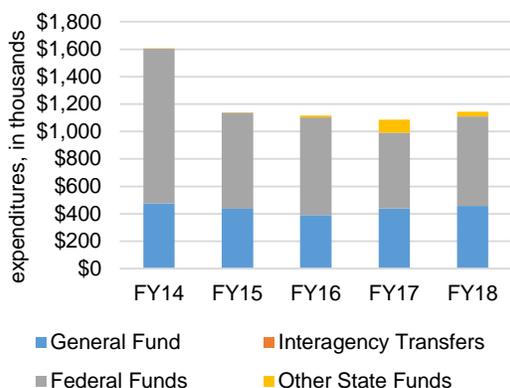
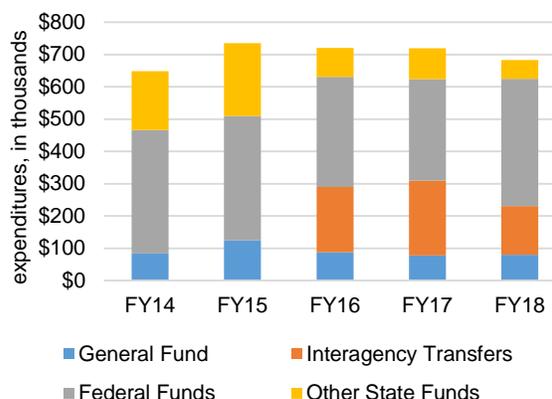


Chart 16. Maternal and Child Health Epidemiology Expenditures



Source: DOH

States are required to use at least 30 percent of their block grant allocations for their Children’s Medical Service (CMS) program (which is not covered in this evaluation), 30 percent for services for preventive and primary care services for children, and 40 percent for services for either of these groups or for other appropriate maternal and child health activities. States may not use more than 10 percent of their federal allocations for administrative costs. In New Mexico, DOH’s Family Health Bureau divides its non-mandatory CMS funding to a number of other programs including its Maternal Health, Child Health, and Maternal and Child Health Epidemiology programs.

The U.S. Maternal & Child Health Bureau uses Title V funds to improve specified health goals that link to national health objectives. DOH’s 2018 state application included specific goals for each group.

Table 6. New Mexico Title V Goals, 2018

Target Population	Goals
Mothers	Ensuring: <ul style="list-style-type: none"> • Care for high-risk infants and mothers • Access to annual preventative medical visits • Postpartum visits
Infants	Improve breastfeeding and safe sleep initiatives by: <ul style="list-style-type: none"> • Comparing baby friendly indicators in PRAMS for baby-friendly regions and designated hospitals • Integrating breastfeeding and safe sleep messaging with CYFD home visiting programs
Children	<ul style="list-style-type: none"> • Increase the percentage of children receiving a developmental screening • Decrease child abuse and maltreatment
Adolescents	<ul style="list-style-type: none"> • Collaborate to implement a statewide plan to prevent/reduce teen pregnancy • Expand marketing to deliver youth-friendly services
Children with Special Care Needs	<ul style="list-style-type: none"> • Improve the system of care • Increase the number of services available to improve transitions to adult care

Source: Adapted from DOH

Recommendations

Department of Health administrators should:

- Encourage FIT administrators to consider validating their own tool, or using an existing validated ACE tool to determine if a child is at-risk for developing a delay due to environmental risk factors.
- Before December 1, 2019, deliver a report to the Legislative Finance Committee detailing WIC staff efforts to increase coverage and enrollment, including the results of efforts to reach out to eligible families enrolled in Medicaid, but not WIC.
- Before December 1, 2019, deliver a report to the Legislative Finance Committee detailing a financial sustainability plan for Families FIRST.

Women Infant and Children program administrators should:

- Shift funded but vacant WIC positions from areas with lower caseloads to relieve some of the burden in higher caseload areas to improve efficiencies and better respond to population trends.

Some DOH early childhood programs lack sufficient data to monitor impact and improve performance

Limited data system functionality and a lack of rigorous evaluation make examination of program effects difficult and unreliable.

Despite a significant and costly upgrade to the WIC data and enterprise system, the system was unable to provide even basic data reports for this evaluation. In FY15, DOH's WIC program along with WIC programs from Oklahoma, Louisiana, and Texas entered into a regional solution to update their databases. According to a December 2018 presentation at the Department of Information Technology's (DoIT) Project Certification Committee, the database system construction is complete and the project is in closeout, with a final price tag of \$7.1 million of federal funds. However, while DOH reported completion of the system construction, the data reporting capabilities were not fully functional. As a result, DOH was only able to provide very few data reports for this evaluation beyond required federal reporting. This setback, while potentially unavoidable, makes current program surveillance impossible on a state level.

The limited outcome data New Mexico WIC does report shows positive, but not definitive results. According to the New Mexico WIC 2017 annual report, the rate of toddlers on WIC who are obese declined slightly from 11 percent in 2013 to 10.5 percent in 2015. However, since no data is available for the state population, it is difficult to determine if this decline in obesity rates is due to changes in WIC policy.

WIC staff also report increased rates of breastfeeding initiation for women enrolled in WIC, from 58 percent in 2007 to 81.5 percent in 2017. For the most recent comparable year across the state, this rate is lower than both the state rate of 91 percent and the rate for women on Medicaid at 87 percent. Lower breastfeeding rates for women in WIC is a long-standing national trend^{xiii} and may be due to women using infant formula having an added incentive to enroll in the program. When looking at statewide variation in breastfeeding initiation, the Southeast had the lowest rates at 73 percent while the Albuquerque metro area had the highest initiation rates at 89.5 percent. The Southern regions are the only WIC regions in the state that did not meet the surgeon general's healthy people 2020 goal of 81.9 percent of women initiating breastfeeding. Additional outcome measure analysis is currently unavailable due to the ongoing WIC data system construction.

Many states publish WIC performance measures and share WIC data with other state organizations. New Mexico does not. In 2011, the U.S. Centers for Disease Control and Prevention stopped generating reports focused on the Pregnancy Nutrition Surveillance System and the Pediatric Nutrition Surveillance System, leading to the loss of national data systems to analyze WIC performance. However, seven states worked together to continue collecting and reporting information focused on nutrition for pregnant women and children. In 2017, Michigan published a report summarizing state trends from 2010-2015, highlighting that while enrollment and the total birth population decreased, low birth weight and anemia increased.^{xiv} Tracking trends focused on birth and child outcomes for the WIC population helps the

Chart 17. New Mexico Toddler Obesity Rates for WIC Children

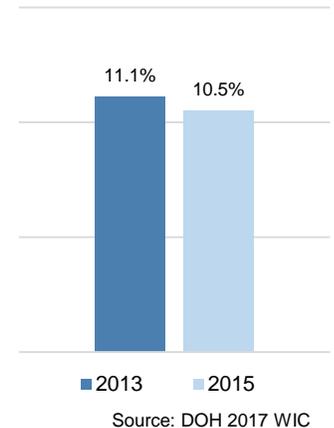
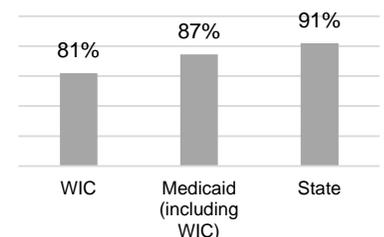


Chart 18. Women Initiating Breastfeeding, 2015



state determine whether the program is effective in meeting its goals and where program attention needs to be focused. Publishing these reports informs stakeholders of the current situation. However, DOH is not actively publishing reports of this kind and New Mexico WIC staff cannot currently track program data due to the limited functionality of their new data system. Therefore, it is unknown how effective New Mexico WIC is in meeting its goal of improving the health of women and children.

Families FIRST staff cannot easily pull data report to monitor the outputs of their own work.

The Families FIRST database is similarly not fully functional, leading to limited access to data reporting, restricting the state's ability to determine program impact. Families FIRST administrators migrated the program's data system to a new contracted data system manager in 2016 and since that time, staff have relied on the administrator, Acro Service Corporation, to pull reports on the program. Acro provides database hosting and service for a number of DOH programs and, in total, the Department has paid the company \$4.1 million for its services since the beginning of FY16.

Since FY16, DOH paid \$4.1 million to Acro Service Corp. for database services for several programs including Families FIRST.

Because of the data system administration, Families FIRST staff and administrators cannot easily pull data and reports to monitor the outputs of their work. This lack of accessible data makes it nearly impossible to gauge the efficiency and impact of Families FIRST. To remedy this situation, DOH administrators should work with Acro to find ways to make reporting on Families FIRST more accessible to both administrators and staff. Further, DOH should undertake this exercise before transferring the program to the new Early Childhood Education and Care department (by the end of FY20).

Survey data remains one of the few ways evaluators can monitor the outcomes of WIC and Families FIRST.

Currently, one of the only sources to examine the short-term effects of maternal and early childhood health is the Pregnancy Risk Assessment Monitoring System (PRAMS). Due to inaccessible program data for Families FIRST, for this evaluation LFC staff examined the effects of the program primarily using state survey data from PRAMS. PRAMS is a survey conducted in 27 states through a joint effort by the U.S. Centers for Disease Control and Prevention and participating states. The survey provides information on the relative differences between individuals participating in state or federal programs, such as WIC, Medicaid, and Families FIRST, and those not---potentially allowing for examination of outcomes. The survey collects information on a variety of topics such as infant sleep safety, breastfeeding initiation and duration, substance use, pregnancy intention, health insurance and access to prenatal care. As New Mexico has participated in the survey since 1999, PRAMS data is a useful tool to examine factors affecting maternal and child health over time. However, since PRAMS information is self-reported by women, and since some populations are oversampled, the data may not fully represent the state's current maternal and child health status.

New Mexico performs above the rest of the nation for FIT outcomes; however, New Mexico also provides services to children only at-risk for delay which likely sways performance data. FIT includes three early childhood outcome measures in their annual federal reporting: 1) positive social-emotional skills, 2) knowledge and skills, and 3) appropriate behavior to meet the child's needs. For each of these, FIT measures both the percent of children who significantly improve, as well as the percent of children functioning at age expectations.

Relative to other DOH early childhood programs, FIT staff provide a variety of information on their website including a program-wide annual report and report cards of provider performance. As a requirement of IDEA Part C, the program also reports on the number of infants and toddlers receiving FIT services and receiving individualized family service plans in a timely manner.

FIT does not track other outcome measures for children enrolled in the program, though. New Mexican children enrolled in FIT early intervention programs showed “significant improvement” at about the same rate as children across the country in federal FY16. However, that same year, the percent of New Mexican children functioning at age expectations in all three measures was vastly above the national rate, especially in the knowledge and skills category.

A variety of factors could cause New Mexico’s higher rate of children “functioning at age expectations.” For one, compared to other states, New Mexico has a relatively large number of children receiving FIT services who are only at-risk for delays. These “at-risk” children already function at age expectations, and the purpose of providing them FIT services is to prevent *potential* delays from developing. Therefore, New Mexico’s skew toward serving children at-risk for delay also skews its “functioning at age expectation” measure. This makes comparing New Mexico to other states in this particular output measure difficult.

Many children who are at-risk of delay due to environmental factors such as abuse or other ACEs likely have problems with social-emotional skills. Indeed, the smallest difference between New Mexico and the rest of the country is for the social-emotional skills category. According to a research brief from the National Center for Children in Poverty and a tutorial from the Center for Early Childhood Mental Health Consultation, children in homes with more environmental risk factors (parental substance abuse, family violence, parental mental health, poverty) have more social-emotional problems.^{xvixvi}

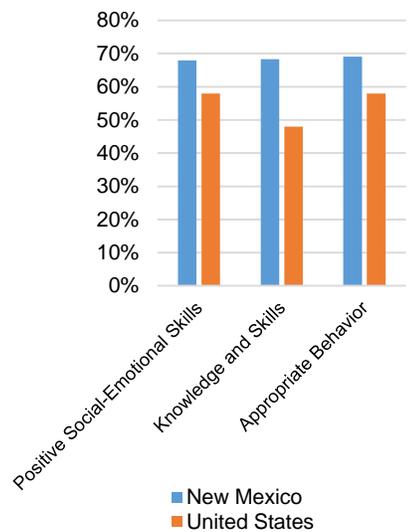
New Mexico’s rate of children functioning at age expectations has generally decreased since federal fiscal year (FFY)16, when a new training on measuring and reporting early childhood outcomes was implemented by FIT administrators. However, national data for FFY17 and FFY18 are currently not available, so it is unknown if New Mexico is still disproportionately high for these outcome measures

Table 7. Average Early Childhood Outcome Measures, FY16

	Making Significant Improvement	Functioning at Age Expectations
New Mexico	72%	68%
United States	71%	55%

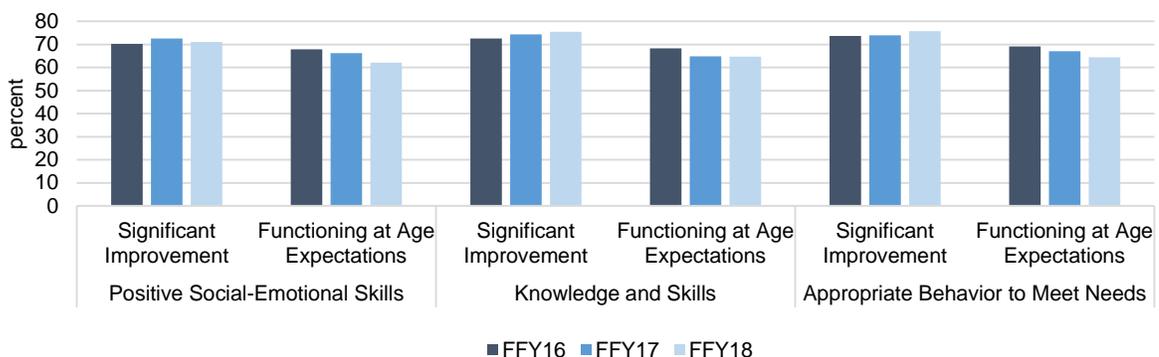
Source: OSEP, 2018 Early Childhood Technical Assistance Center report

Chart 19. FIT Children Functioning at Age Expectations by Category, FFY16



Source: OSEP, 2018 Early Childhood Technical Assistance Center report

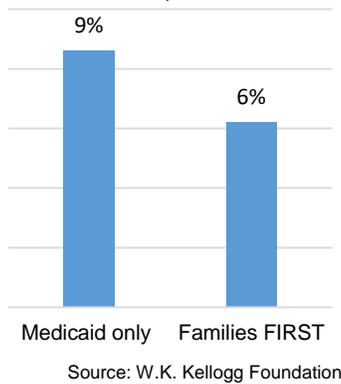
Chart 20. FIT Outcomes



Source: DOH FIT Early Child Outcome reports

According to the most recent data provided by DOH for FFY18, about half the children enrolled in FIT significantly improved functioning across the three categories. Another almost 20 percent improved functioning but at a slower rate, and did not function at the level expected for their age. About 25 percent to 30 percent of children did not show significant improvements, but the majority of those children were already functioning at the appropriate developmental level. If children are at-risk for a delay, but do not currently exhibit one, DOH staff should determine how to provide evidence the program is improving a child’s development trajectory and report this information in the annual provider report cards. DOH should work to develop a tool to track improvements for children at-risk of developing delays as this population may skew federal reporting tools. Without this information, it is difficult for agencies and policymakers to determine whether children at-risk for developing delays are better served in early intervention versus other programs for high-risk families, such as home visiting.

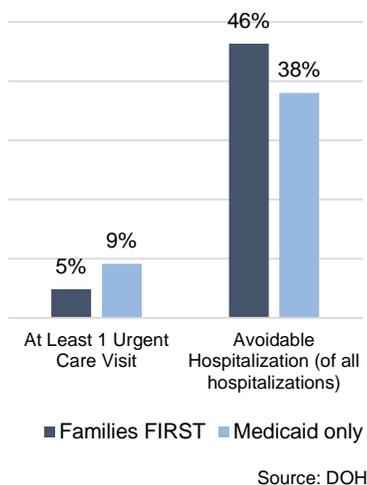
Chart 21. Percent of Low Birth Weight Infants, 1991



Families FIRST participants show some positive birth outcomes but, DOH has not conducted a rigorous evaluation of the program. Two evaluations investigated the impact of Families FIRST over the past 20 years. However, neither evaluation was rigorous—lacking randomization and with limited controls. The W.K. Kellogg Foundation evaluation of Families FIRST in 1997 found women enrolled in Families FIRST had similar birth outcomes as New Mexican women not enrolled in Medicaid, i.e., higher income women. Additionally, Families FIRST families had infants who incurred lower average hospital discharge costs. The Kellogg study did not include a matched control group so these findings could be the result of inherent differences between those participating in the program, rather than the program causing these positive effects.

DOH also analyzed the effects of Families FIRST in 2014, finding those enrolled in the case management program were less likely to have complications during delivery. Specifically, 46 percent of women enrolled in Families FIRST had a healthy and uncomplicated delivery compared to 35 percent of other Medicaid participants. However, additional measures showed less clear program benefits. While a significantly lower rate of children in Families FIRST had at least one visit to an urgent care center compared to all children on Medicaid (4.8 percent versus 9.1 percent), more Families FIRST children had a potentially avoidable hospitalization (46.3 percent of all hospitalizations versus 38 percent). Therefore, Families FIRST may impact family outcomes; however, the specific effects are not clear. Similar to the Kellogg study, the 2014 DOH study did not have a randomized comparison group but, rather, used a matched comparison group.

Chart 22. Medical Outcomes for Families FIRST versus Medicaid Only, 2014 Analysis



Since the Families FIRST database could not run specific reports of interest, outcome data for the program was instead examined using New Mexico PRAMS data. DOH epidemiologists conducted analyses for this evaluation using 2012-2017 PRAMS data to determine if there was an effect of Families FIRST on care, birth outcomes, and breastfeeding. According to DOH analysis, participation in Families FIRST was not found to affect outcomes for typical high-risk women. Furthermore, these results may be skewed due to selection bias. For example, many women participating in Families FIRST are referred from WIC. These women may have been more likely to seek services and therefore had relatively better outcomes than other low-income women regardless of their participation in Families FIRST. As a result, DOH should rigorously evaluate Families FIRST to understand how and if the program truly affects family outcomes.

Increased reporting and improved data sharing can provide needed program oversight and improved outcome surveillance.

As a requirement of the state’s Accountability in Government Act (AGA), DOH reports quarterly on a suite of performance measures to the Legislative Finance Committee. None of DOH’s current AGA measures include metrics on WIC, FIT, Families FIRST, the Maternal Health program, Child Health program, or the Maternal and Child Health Epidemiology program.

DOH does self-report the number of clients participating in food tasting in WIC clinics with kitchens on its dashboard of program performance on its website. While DOH’s dashboard of program performance measures is useful for other programs, this specific WIC measure focuses on process rather than outcomes. Without regular tracking of outcome-focused metrics, it is difficult to know whether DOH early childhood programs are meeting their goals. Further, without these metrics, it is near impossible for program directors to manage activities and staff for success. To improve performance tracking and management DOH should work with LFC and the Department of Finance and Administration to develop new AGA measures for these programs. As most of these programs have required federal reporting, DOH could, where appropriate, report these pieces to the Legislature along with national averages to allow benchmarking of New Mexico data.

The U.S. Department of Health and Human Services’ Health Resources and Services Administration published a best practice report highlighting how to manage data for performance improvement. This report had four main tenets including determining which data to collect, ensuring reliable collection of each measure, tracking data to assess performance, and publishing this information to inform policy and management decisions.^{xvii} For DOH’s three service programs, all have at least one area needing improvement. Both Families FIRST and WIC have multiple areas needing improvement, largely due to their aforementioned database issues. When program managers cannot access both performance and process information, they cannot make data-driven decisions.

Table 8. Best Practice Checklist for Collecting and Analyzing Data by DOH Program

Best practice for data collection and reporting	Families FIRST	WIC	FIT
Decide what data to collect	Yes	Yes	Yes
Standardize Collection of Each Measure	No	No	Some
Regularly Track Data	No	No	Yes
Publish information to Stakeholders	No	Some	Yes

Source: HRSA 2011 report, LFC Analysis of DOH information

While New Mexico is nearing completion of an early childhood data system, the system only includes limited health data. In their 2018 State of Early Childhood Data Systems report, The Early Childhood Data Collaborative noted New Mexico is one of 22 states with an early childhood data system to integrate information from various agencies. While not currently available, the state should have a functional early childhood

Recommendations

Through the Children’s Cabinet, administrators from the Department of Health; the Early Childhood Education and Care Department; the Children, Youth and Families Department; and the Public Education Department should:

- Develop strategies to ensure state-funded programs are actually making a difference in improving maternal and child health. To do this, administrators and program staff will need to use existing programmatic data better, share that data with other early childhood programs, regularly monitor program performance, and engage Department of Health epidemiologists to develop action plans to improve program performance where necessary.

Department of Health administrators should:

- Make reporting on Families FIRST more accessible to both administrators and staff before transferring the program to the new Early Childhood Education and Care Department (by the end of FY20).
- Develop a plan to more effectively utilize ECIDS and their other program-specific databases in order to monitor childhood health outcomes and program effectiveness across a wide variety of lenses.

Administrators at the Department of Health and Early Childhood Education and Care Department should:

- Work with the Legislative Finance Committee and the Department of Finance and Administration to develop Accountability in Government Act performance measures for WIC, Families FIRST, FIT, the Maternal Health, Child Health, and Maternal and Child Health and Epidemiology programs. These measures should be focused on program outcomes rather than process and should be clear, reliable, and valid.
- By November 30, 2019, work with the Public Education Department, the Children, Youth and Families Department, and Legislative Finance Committee staff to complete construction and test functionality of the ECIDS data system, including its data dashboard.

Family, Infant, Toddler program administrators should:

- Develop a standardized measure of developmental progress for children only at-risk for a developmental delay. This measure should be included in annual provider report cards.

Many opportunities exist for strategic partnerships among early childhood programs

Programs with similar goals and target populations demand an integrated strategy to avoid duplication of services.

The overarching goals for all six of DOH’s early childhood-focused programs are quite similar to one another, as well as to other early childhood programs in the Public Education Department and Children, Youth and Families Department, in that they each share desired outcomes of healthy, safe, normally developing young children. This overlap makes it difficult to know what program or combination of programs to target to specific families and creates problems with coordination and duplication. At worst, programs from different agencies might even be competing for clients. It also makes program evaluation difficult as many families already receive services from more than one program.

Multiple programs targeted at single individuals may lead to duplication in services and unclear outcomes

Imagine a single, low-income mother of a baby born pre-term at 34 weeks. The baby was born at the Baby-Friendly University of New Mexico Hospital, and after a short stay in the NICU, the baby was eventually brought to health, and the mother received breastfeeding support while waiting in the hospital. Hospital staff also referred and enrolled the mother into Nurse-Family Partnership, a state-funded home visiting program. A Partnership nurse visits during the mother’s second week at home with the baby. The mother is eligible for and receives Supplemental Nutrition Assistance Program (SNAP) and WIC benefits, and the nutrition and breastfeeding education that comes with her WIC food and formula benefits. She is covered by Medicaid and visits with a Families FIRST nurse in a public health office after her WIC appointment. Since the baby was premature, it qualifies as at-risk for developmental delays and therefore receives FIT services. As the baby lives with a low-income, single mother, the FIT provider enlists a social worker to visit with her as a part of the baby’s FIT services.

Here, the mother is enrolled in seven, state-administered programs across four different agencies:

University of New Mexico	Children, Youth and Families Department	Human Services Department	Department of Health
Hospital	Home Visiting	SNAP Medicaid	WIC Families FIRST FIT

She would need to visit three different locations (the hospital, the public health office, and the income support division office) and she would have had at least two different individuals in her home (for FIT and home visiting services). All this activity probably would have occurred before the baby was one month old.

In the above example, how are program administrators to know the extent and quality of services that the mother is receiving through the programs of other agencies and departments? How can they judge if their program is really making a positive impact on that mother and her baby, or if it is instead just duplicating services that she’s already receiving?

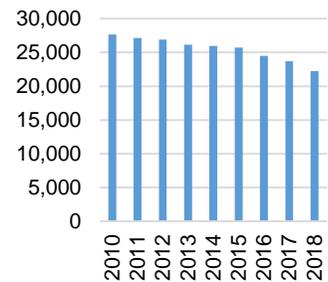
Even though the imagined mother above is receiving a number of services, she may still face other issues that are not in the domain of any of the programs with which she interfaces. As discussed in the background section, New Mexico has one of the lowest rates of women receiving prenatal care early in their pregnancy and one of the highest rates of babies born to mothers using alcohol and drugs. None of the programs listed above reached the mother early enough in her pregnancy to ensure she received adequate early prenatal care or to get her any necessary substance abuse treatment.

In sum, there are both duplication and gaps in New Mexico’s state-administered, health-related programs. However, there are multiple opportunities where programs, no matter the agency they are housed in, might cooperate better – share data, improve methods of service delivery, and act more strategically in targeting the right services to the right families – to the benefit of the health of mothers and their children.

New Mexico’s declining birthrate will require programs targeting young children to recalibrate their service levels accordingly.

The number of births in New Mexico is declining. New Mexico’s birth rate fell 20 percent between FY10 and FY18, from nearly 28 thousand to under 23 thousand. This decrease in births likely contributed to the challenges WIC and Families FIRST experienced in reaching pregnant women, infants, and very young children who may benefit from them. This trend also has implications for the other early childhood programs administered by DOH and the newly established Early Childhood Education and Care Department.

Chart 23. New Mexico Births



Source: DOH

Best practices in program collaboration from New Mexico and other states should be replicated and expanded to enhance outcomes.

Of all programs evaluated here, WIC and Families FIRST demonstrated the strongest collaborative relationship. In the Las Cruces public health office, WIC and Families FIRST staff reported all women that newly enroll in WIC are given a “warm-handoff” by WIC staff to Families FIRST, i.e., a walk down the hall to meet with a Families FIRST nurse who then enrolls them in that program. However, other referrals in WIC could likely be better tracked and enhanced. As an operating policy of the program, WIC refers its clients to several different services such as SNAP and childcare assistance. WIC staff reported they track referrals in their data system and they revisit those referrals with mothers in subsequent appointments. However, LFC was unable to determine the number or success of these referrals as DOH did not provide the WIC referral data for this evaluation (again, due to problems with the WIC data system).

As covered later in this chapter, WIC in New Mexico is a relatively small referral source to state-funded home visiting, but it is much stronger in other states. Generally, New Mexico provides funding for more home visiting than providers can find family clients to serve. A stronger WIC to home visiting referral pipeline could help build up the clientele list for home visiting providers.

Just as the co-location of WIC and Families FIRST leads to easy and successful referrals between programs, more strategically placed WIC satellite clinics could make applying for and receiving WIC benefits less burdensome. New Mexico WIC runs 28 satellite clinics serving approximately 3,700 participants a month. Most of these clinics take place in county-owned buildings in small communities, and at two Air Force bases. The Center on Budget and Policy Priorities notes co-location of WIC with other services as a best practice in streamlining WIC participation and specifically mentions a case in North Carolina where, in a few counties, WIC is co-located with their local income support division offices. As women on WIC are eligible for both SNAP and Medicaid, co-location of these services is

likely to improve coverage of all three services as well as make enrolling for these services less burdensome for women.

Piedmont Health Services, North Carolina: Reaching Participants in the Local Medicaid/SNAP Office

Piedmont Health Services serves two counties and partners with both of their local Medicaid/SNAP offices to reach more potential WIC participants. WIC staff are on site in one of the local Medicaid/SNAP offices weekly to talk with clients about WIC, provide informal nutrition assessments, and help set up WIC appointments. In addition, WIC staff regularly engage with the local Medicaid/SNAP staff – meeting at least quarterly – to be sure they understand how WIC works and the benefits it can offer their clients. Local Medicaid/SNAP staff can use a referral form to capture contact information for potential participants, upon which the WIC clinic follows up. In the coming months, WIC is planning to open a permanent satellite location at one of the local Medicaid/SNAP offices, allowing them to fully complete the WIC eligibility determination process and issue benefits on site.

Source: Center on Budget and Policy Priorities

WIC also has the opportunity to explore innovative partnerships for service delivery that might increase participation and coverage. A 2004 publication from USDA highlighted 20 innovative practices in WIC, including a case study where a local public health office integrated WIC service delivery into their Medicaid targeted case management program (their equivalent of Families FIRST).^{xviii} In the late 1990s and early 2000s in Grand Traverse County, Michigan, WIC services were provided in conjunction with a Medicaid-funded program of intensive support case management services for pregnant women and new mothers. The case management program involved monthly meetings with a nurse, dietitian, or social worker. Some of those meetings occurred through home visits, allowing in-home WIC benefit delivery, nutrition education, and occasional recertification. In this instance, WIC was an incentive to draw clients into the case management program, and WIC, in turn, benefited from the Medicaid funding, which provided reimbursement for the case management services.

The National WIC Association reported this sort of integration of WIC into home visiting services is rare, but not prohibited. Oregon’s WIC program notes some of its staff are eligible to perform WIC home visits. At the request of its state Legislature, WIC staff in Vermont recently held a summit to discuss innovative strategies to better recruit and retain WIC participants. One of the key recommendations of that summit was allowing staff to conduct WIC nutrition education activities via other programs, such as early childhood education and home visiting.^{xix} As New Mexico’s WIC program is both struggling to grow their clientele and improve their referral rates to some services, WIC staff should consider how to best implement these new and innovative types of WIC service delivery.

A New Mexico HSD-DOH memorandum of agreement allows for data sharing between the two departments for federal Maternal and Child Health programming. DOH should extend these types of data sharing agreements to other agencies. The DOH Family Health Bureau and HSD have a continuing memorandum of agreement that provides a framework for collaboration between the two to “provide and promote access to high-quality health care and services for pregnant women, infants, children and adolescents eligible for benefits under [Maternal and Child Health Block Grant] Title V and Medicaid.” The memorandum is a federal requirement of the Title V grant program, but importantly, it requires HSD to share otherwise confidential

Medicaid participant data with DOH. As a result, it should be easy for DOH to reach out to Medicaid participants that may qualify for other DOH-run programs. For example, WIC staff are just beginning to call expecting mothers and mothers of young children on Medicaid that qualify, but have not enrolled in WIC. Similar agreements between DOH, HSD and the new ECECD could enhance the ability for reciprocal referrals between programs at all three departments.

Other states share WIC information outside their designated department but New Mexico does not. Federal rule allows for the sharing of some WIC information, specifically as it relates to improving coordination of services between different state social service agencies.^{xx} Currently, WIC administrators receive information from Medicaid regarding enrollment status of eligible women, however additional sharing of information with programs such as home visiting and childcare services may help increase referrals and caseload, potentially leading to improved outcomes for children and families.

Other states have memorandums of understanding between WIC and outside entities. The Illinois WIC program routinely shares data with a University of Illinois researcher who examines interventions targeted at recruiting and retaining WIC participants.^{xxi} By sharing data, researchers were able to better identify and address barriers to WIC participation among eligible children. In Arizona, WIC collaborates with Head Start to boost referrals between the two agencies.^{xxii} As enrollment in Head Start and WIC is dropping in New Mexico, creating memoranda of agreement or understanding across different service programs may help to not only determine how to serve children and families better but also create a more comprehensive picture of where additional resources are needed. New Mexico WIC should work to determine how to share relevant information across agencies to improve service delivery and accountability such as creating agreements with the new Early Childhood Education and Care Department, potentially using the existing agreement with HSD as a template.

Illinois WIC routinely shares data with a University of Illinois researcher who examines interventions targeted at recruiting and retaining participants.

In March 2019, New Mexico started to participate in an initiative to develop and implement state-level policy solutions that address substance misuse and mental health disorders of women. The initiative is funded under a \$2 million cooperative agreement with the U.S. Health Resources and Services Administration’s Maternal and Child Health Bureau and is called PRISM (promoting innovation in state maternal and child health policymaking.) The Association of Maternal & Child Health Programs (AMCHP) broadly outlined the PRISM opportunity in their October newsletter:^{xxiii} “Four, one-year cohorts of six to eight state teams — with diverse compositions representing state and local public health, behavioral health and health care finance — will participate in PRISM. States can choose a legislative, regulatory, or administrative policy activity as the focus of their project. During the application process, states can receive assistance crafting a project proposal that best meets their state's unique needs.”

DOH and HSD could be collaborating better to prevent maternal drug abuse, leveraging both Title V and federal Substance Abuse Prevention and Treatment Block Grant funding.

Beyond the PRISM grant, AMCHP generally advocates for collaboration between state Title V programs and state substance abuse agencies that manage the federal Substance Abuse Prevention and Treatment Block Grant. For example, Massachusetts’ Title V collaborates with the state’s Bureau of Substance Abuse Services and Perinatal Neonatal Quality Improvement Network on the development of web-based resources for pregnant women with substance use concerns and obstetricians serving women with opioid use disorders. As the New Mexico Human Services Department (HSD) received \$9.8 million in Substance Abuse Prevention and Treatment Block Grant funding for FFY2018,^{xxiv} DOH should consider how to best leverage that grant to support its Maternal Health programming.

Past examples of insufficient collaboration among early childhood programs reveal opportunities for improvement.

Despite these examples of good collaboration, LFC evaluators found ample opportunities for increased collaboration and cooperation among its own early childhood programs, and with early childhood programs in other state agencies.

During the 2019 session, the Legislature approved and Governor signed a bill to create a new Early Childhood Education and Care Department (ECECD), which will house home visiting (including Families FIRST), FIT, prekindergarten, and childcare. The intent of combining these programs under one agency is to, in part, improve communication and help remove duplication of services between the programs newly housed there. However, without close attention to each program’s current service structure, goals, and needs, the new agency may not lead to any substantive outcome changes for the state or families in need. While it makes sense that programs operating under singular leadership should operate more cohesively, programs that relate to the health of young children and their mothers that the Legislature did not transfer to ECECD (WIC and Title V) need not stay siloed. Data-sharing agreements, co-location, and clearly stated plans for collaboration should make it so that programs offer their services in a strategic and coordinated way.

Administrators from DOH and state-contracted home visiting programs should focus on increasing the referral rate to home visiting programs for families in FIT and WIC. Only 4 percent of children are referred to home visiting from WIC and 5.1 percent by FIT—leaving a large number of families without potentially needed services. In FY18, 174 families out of 4,315 were referred to home visiting by WIC staff, and 218 families were referred by FIT providers. WIC provides services exclusively to high-risk pregnant women and young children, the same population targeted for home visiting services. The 25 percent of children receiving FIT services with environmental risk as an eligibility factor are also likely the target population for home visiting. As a result, both programs should have higher uptake into home visiting. However, FIT staff only successfully refer 4.4 percent of potentially eligible children to home visiting, and WIC staff only successfully referred 1.7 percent of potentially eligible women in WIC.

Divisions, bureaus and programs of the Early Childhood Education and Care Department:

- Child care licensing and services
- Early childhood education
- Early intervention services
- Home visitation bureau
- Family, Infant, Toddler program

Chart 24. Home Visiting Families Referred from WIC and FIT

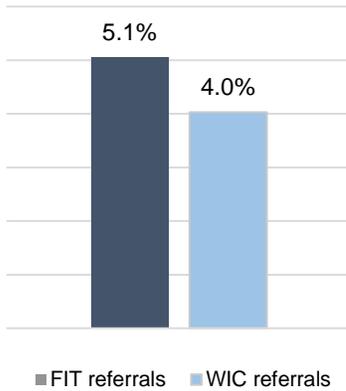
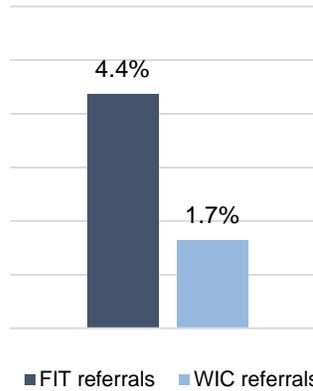


Chart 25. WIC and FIT Families Referred to Home Visiting



Source: LFC analysis of DOH and CYFD data

In other states, WIC is a stronger source of referrals to evidence-based home visiting programs, mainly as a result of formal arrangements between WIC offices and local home visiting programs. A 2016 report from the Mother and Infant Home Visiting Program Evaluation-Strong Start examining 67 local home visiting programs across 17 states reported WIC was a referral source for 73 percent of these home visiting programs.^{xxv} Further, 32 percent of these home visiting programs had formal arrangements (for example, a memorandum of understanding) with their local WIC clinics to facilitate these referrals. In a 2017 Minnesota study,^{xxvi} WIC was cited as the most common referral source for parents who successfully enrolled and stayed in home visiting services—as WIC and home visiting are often housed within the same public health agency in that state. Similarly, the largest WIC provider in New York State reported in a 2018 moderated discussion that monthly referrals to a local Nurse-Family Partnership home visiting program tripled after just one WIC peer counselor was enlisted to begin referrals to the program.^{xxvii} All these examples indicate that establishing similar WIC-to-home visiting relationships in New Mexico would likely increase home visiting participation.

As Families FIRST, FIT, and home visiting will soon be housed together within the Early Childhood Education and Care Department (ECECD), WIC and ECECD administrators should work together to develop a plan to refer clients between the two departments and DOH should report in their quarterly report cards referrals to and from WIC by FIT, home visiting and Families FIRST.

With its dedicated Maternal and Child Health Epidemiology program, DOH could play a more active role in defining and refining early childhood programs across state agencies.

The U.S. Centers for Disease Control and Prevention notes that state health departments have an important role to play in all domains of the policy process including problem identification, policy analysis to identify possible interventions, and strategy for prioritizing interventions.^{xxviii} This role is

DOH has a team of six epidemiologists, and several support contractors and staff dedicated to maternal and child health.

underpinned by the Department’s unique epidemiological capacity to provide guidance and support for evidence-based, outcomes-focused policymaking.

In a 2013 lecture at the Harvard T.H. Chan School of Public Health, Dr. Moyses Szklo, a Distinguished Service Professor of Epidemiology and Medicine at the Johns Hopkins University, argued for an expanded field of “translational epidemiology” wherein knowledge from epidemiologic studies is further integrated into planning and policy-making. That DOH has a team of six epidemiologists, and several support contractors and staff dedicated to maternal and child health issues makes it a natural fit to not only support annual required federal data collection and reporting but to additionally play a more integrated role in monitoring and guiding early childhood interventions across all state agencies.

DOH’s Title V-funded program activities lack focus, and the Department should clarify how it will employ its Maternal and Child Health Epidemiology program to provide more comprehensive policy guidance. Primarily funded with Title V funds, DOH’s Maternal Health and Child Health programs do have small initiatives that are addressing early prenatal care and growing cases of NAS, NOWS, and Sudden Unexpected Infant Death Syndrome. However, targeting these programs could often be improved as could their connections to other efforts in the state.

Title V funds are used to create federal and state partnerships that support:

- Access to quality health care for mothers and children, especially for people with low incomes and/or limited availability of care.
- Health promotion efforts that seek to reduce infant mortality and the incidence of preventable diseases, and to increase the number of children appropriately immunized against disease.
- Access to comprehensive prenatal and postnatal care for women, especially low-income and/or at-risk pregnant women.
- An increase in health assessments and follow-up diagnostic and treatment services, especially for low-income children.

For one, the Maternal Health program should better target birthing workforce retention fund awards to areas of the state with the highest birthing workforce needs. Since 2008, DOH has managed the birthing workforce retention fund. The fund is meant to offset premiums for medical malpractice insurance to incentivize the retention of the provider and services in New Mexico. In FY17 (the latest year of data provided), DOH awarded \$10 thousand awards to six providers; one certified nurse midwife in Grant County, one doctor in Doña Ana County and four certified nurse midwives in Bernalillo County. Malpractice insurance premiums for those providers ranged between \$15 thousand and \$22 thousand.

One of the criteria DOH uses to choose providers for the fund awards is the relative availability of birthing services for Medicaid and indigent patients in the community. In the last two years, the New Mexico Human Services Department assessed access to care by determining if there were enough obstetricians/gynecologists (OB-GYNs) and midwives in each county to provide services to the population in these counties. The health care report found in 10 counties there were no women’s health specialists in 2017—Catron, De Baca, Guadalupe, Harding, Mora, Quay, Roosevelt, Sierra, Torrance, and Union. In those counties with providers, seven were below the benchmark for OB-GYNs, six for certified nurse midwives, and four for licensed midwives. Otero county lost the most OB-GYNs since 2013, losing five providers. However, in FY17, the majority of eligible provider applicants for the birthing workforce retention fund were located in Bernalillo county – an area with relatively ample birthing services. DOH did not provide county locations for awardees for past years or any information on the fund for FY18 or FY19.

The Maternal Health program works to improve access to and quality of prenatal and birthing facilities in the state; however, the Department’s plan for growing access and quality remain undefined. DOH’s Maternal Health program administers a high-risk prenatal care initiative to provide prenatal care to medically indigent women. DOH is currently contracting with

providers to deliver this care in Albuquerque, Hobbs, Deming, Santa Fe, Espanola, and Las Cruces. The University of New Mexico receives approximately 40 percent or \$266 thousand of the contract total. According to the Department's Title V reporting, this contracting serves more than 1,200 women annually. The Department reports spending \$356.5 thousand of federal Title V dollars and \$359.9 thousand of state dollars for this purpose in federal FY17 (approximately \$600 per woman served.)

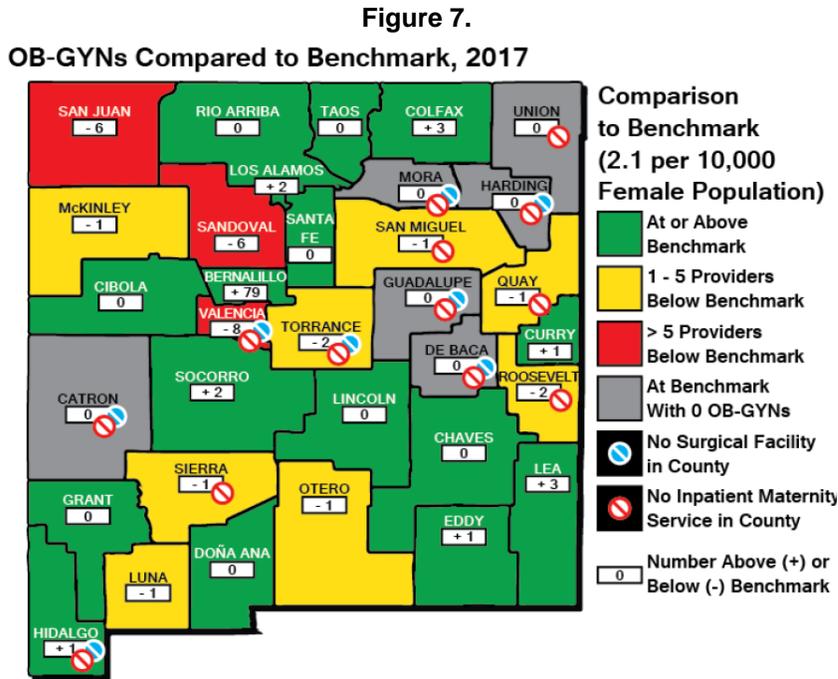


Figure 2.5. OB-GYN workforce relative to the national benchmark of 2.1 OB-GYNs per 10,000 female population is shown in the white boxes. Each county's color indicates whether it is at or above benchmark (green), below benchmark by five or fewer providers (yellow), or below benchmark by more than five providers (red). Gray counties have no providers and benchmark values of zero. Red "no" symbols denote counties without inpatient labor and delivery facilities; blue "no" symbols denote counties without surgical facilities.

Source: NM HSD's Health Care Workforce Committee

In addition to ensuring women and infants in the state receive care; the care must be provided by facilities that can meet the needs of those they serve. To determine whether the state is providing risk-appropriate care, DOH's Maternal Health staff are participating in a national effort examining perinatal regionalization in the state. The U.S. Centers for Disease Control and Prevention along with the American Academy of Pediatrics and the American College of Obstetrics and Gynecologists created standardized designations to report on levels of care at facilities nationwide. New Mexico and 11 other states are using these definitions to categorize local hospitals where individuals receive perinatal care. These categorizations are important as a 2010 meta-analysis showed very low birth weight and preterm infants born in level III or higher facilities had a lower chance of mortality.^{xxix} If the state can determine which hospitals provide what level care, they can better funnel resources and patients to improve facilities.

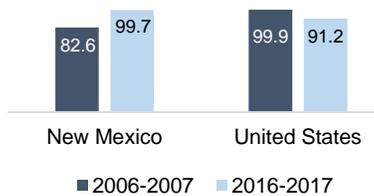
Maternal Health program staff collected information from every facility where New Mexico residents give birth and staff are now meeting with these hospitals to determine if the assessment correctly characterized the resources at each hospital. Michigan completed this process and used the assessments to

guide improvements in its regional perinatal system of care. Preliminary analysis shows New Mexico has only two level III maternal care centers and level III neonatal centers, all located within the Albuquerque metro area. DOH has not indicated how it will use this analysis to improve perinatal care access and quality throughout the state.

DOH has a mixed record of collaborating with Children, Youth and Families Department to reduce rates of Sudden Unexpected Infant Death.

Between 24 to 35 babies in New Mexico die every year from Sudden Unexpected Infant Death (SUID). DOH reports SUID is the leading cause of infant death after the first month of life in New Mexico and the third leading cause of infant death overall. While national SUID rates declined between 2007 and 2017, New Mexico’s rate of SUID increased over that same period.^{xxx} In 2016, the American Academy of Pediatrics released recommendations to reduce sleep-related infant deaths – a major portion of all SUIDs. This guidance includes placing infants to sleep on their backs in a bare crib, and not letting infants share a bed with their parents.

Chart 26. SUID Rates per 100,000 Live Births



Source: CDC WONDER Underlying Causes of Death

To promote this guidance, DOH’s staff reported during 2016 and 2017 they made several attempts to engage home visiting staff from the Children, Youth and Families Department (CYFD) to plan and design a common “safe sleep” plan to be used across both agencies. However, in their 2018 federal Title V report, DOH stated that CYFD home visiting staff refused to meet to discuss the concept in 2017. The two programs did meet once in early 2018 at the request of their respective cabinet secretaries, but no collaborative programming on safe sleep was ever formulated.

Despite the breakdown of collaboration with CYFD home visiting staff, in that same Title V report, DOH stated their staff was able to collaborate with CYFD’s Child Protective Services staff. In 2017, DOH’s Office of Injury Prevention developed an education model to train approximately 600 Child Protective Services staff in safe sleep and shaken baby syndrome in an effort to decrease SUID among infants with families that interact with child protective services. DOH also reported plans to move these trainings to a web-based format in 2018.

FIT may not be the most appropriate program for children with environmental risk compared to evidence-based home visiting.

Research indicates children in a deprived environment or with a higher number of adverse childhood experiences are more likely to have behavior problems and developmental delay,^{xxxi} and the earlier an intervention occurs to address delays, the better the outcomes for most children. However, early intervention programs such as FIT may not be the most appropriate service for these children if there is no evidence of a delay. Instead, evidence-based home visiting services that focus on the entire family may be a better fit.

Both home visiting and FIT have been operating, and potentially serving the same children, for the last 14 years. Currently, a little over one-quarter of home visiting providers also provide FIT services. While there are no caps on the number of children a provider can serve in FIT, providers do have a cap for the number of families they can provide home visiting to. There are not enough slots for all children enrolled in early intervention with environmental risk factors to receive state-funded home visiting. As a result, FIT is likely providing services for children with environmental risk factors for delays, where home visiting could instead.

Only one FIT provider operates an evidence-based home visiting model (the University of New Mexico Center for Development and Disability). Currently, there is no state guidance on the most appropriate way to serve children that qualify or benefit from both FIT and home visiting programs. While FIT staff report they have developed a draft guidance document, they have not finalized or released it. Without evidence of either program’s effectiveness, it is unclear whether children are better served through early intervention or home visiting. As such, DOH, ECECD, and CYFD should work together to determine how best to help these children as the programs transition into the new department.

Table 9. Early Intervention Providers Offering CYFD Home Visiting Services, FY18

Provider	Home Visiting Slots	Total FIT Children Served, FY18	Estimated FIT Children with Environmental Risk Factors
University of New Mexico Center for Development and Disability (CD&D)	250	276	68
La Vida Felicidad	51	412	102
Peanut Butter & Jelly Family Services	84	498	123
Las Cumbres Community Services	83	638	158
Tresco, Inc.	151	732	181
Presbyterian Medical Services	180	736	182
Eastern New Mexico Rehabilitation Services for the Handicapped, Inc. (ENMRSH)	161	907	224
Aprendamos Intervention Team	80	2,121	524
MECA Therapies, LLC	59	2,130	526

Note: Estimated children with environmental risk factors calculated by multiplying the overall proportion of FIT children with any environmental risk factors (24.7 percent) by the number of children served by the provider.
 Note: Children in FIT may have environmental risk factors in addition to other risk factors or demonstrated delays.
 Only CYFD home visiting services are listed.
 Source: DOH files and LFC FY19 Volume III

DOH is piloting an evidence-based, light-touch home visiting program that, if expanded, could serve as New Mexico’s centralized intake and referral system.

Research highlights the need for home visitors and early interventionists to work together to improve child and family functioning.^{xxxii} In January 2017, the U.S. Departments of Education and Health and Human Services released a joint statement on collaboration and coordination between the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and Individuals with Disabilities Education Act (IDEA) Part C programs.^{xxxiii} The statement gave recommendations for state action to increase collaboration and coordination between the two programs. One recommendation was for state program leaders for MIECHV and IDEA Part C to map the services and supports offered by both programs, and analyze the feasibility of a dual enrollment model to seamlessly meet all the needs of a family and avoid duplication of efforts.

Another recommendation was for states to develop centralized intake, screening, and referral systems to provide coordinated universal screening of pregnant women and infants and toddlers. Such a system should reduce duplication of services as well as streamline referrals. The statement specifically mentioned the 28-state Help Me Grow model of coordinated intake and referral as an example of this type of centralized system. Help Me Grow provides centralized screening, assessment, and referrals to link pregnant women and parents of young children with appropriate programs and

services. The model relies on an organizing entity such as a department of health to provide support, oversight, continuity, and facilitation of collective impact efforts. Local and statewide Help Me Grow systems are affiliates of the Help Me Grow National Network and receive ongoing technical assistance from the Help Me Grow National Center in implementing the model and related system enhancements.

DOH is currently piloting a Family Connects model program, which could serve as the New Mexico’s centralized intake and referral system. DOH is in the planning phases of implementing Family Connects - an evidence-based, universal, light-touch perinatal case management program. The Family Connects model, developed at Duke University, partners with state or local departments of health to provide access to one to three home visits by a registered nurse to every family with a newborn, typically when the infant is two- to 12-weeks-old. Family Connects nurses place families in need with longer-term home visiting services and other resources. Family Connects is operating or has plans to operate at 30 sites nationwide.^{xxxiv}

Chart 27. Effect of Family Connects on Number of Emergency Care Episode

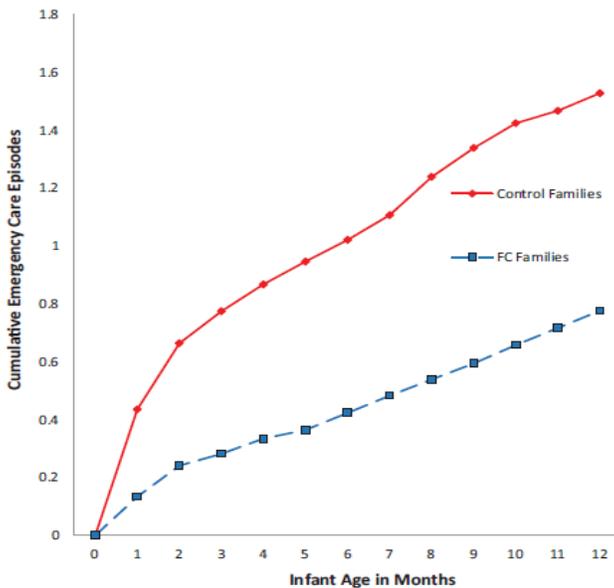


Figure 3. Mean cumulative number of emergency health care episodes for groups randomly assigned to Durham Connects or control (Dodge et al., 2013a). See the online article for the color version of this figure.

Source: Dodge, 2018

Research shows Family Connects leads to a decrease in maternal anxiety, reduced emergency health episodes, and lower rates of investigations for child abuse.^{xxxv} The U.S. Department of Health & Human Services classifies the Family Connects model as evidence-based and eligible for support under federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants. DOH currently estimates the cost of Family Connects program to be \$611 per client and estimates 50 percent of new mothers will receive at least one follow-up home visit.

Under a \$42 thousand private grant, DOH and Family Connects are in a 10-month planning, coordinating, evaluation, and training phase to set up the program. This initial phase, which will end July 2019, will include financial scaling and sustainability planning, where DOH and Family Connects will work together to explore revenue streams to support Family Connects operations (e.g., Medicaid, Title V, state general fund etc.) and develop a three-year business plan for the program. After that time, DOH plans to pilot the program in one zip code, 87105, located in the south valley of Albuquerque for an additional eight months, in preparation for full Family Connects certification in 2020.

As Family Connects is a universal program, it has the opportunity, if expanded, to serve as the state’s early childhood centralized intake and referral system. Based on a family’s unique needs and circumstances, Family Connects nurses use a single screening tool to determine which families could best benefit from individual programs. This centralized point of referral should help avoid the duplication of services like breastfeeding and family support services that are offered by a number of programs, hopefully saving a new family time from having to interact with too many programs and people that may provide similar or duplicative services. A centralized intake and referral entity should also add a needed level of comprehensive strategy to early childhood services—where referral and follow-up would be the responsibility of one entity, rather than

each program referring among each other in an ad hoc and uncoordinated manner.

The New Mexico Children’s Cabinet will provide a vehicle for DOH to collaborate on early childhood programming with other agencies.

The 2005 Children’s Cabinet Act (32A-22-1 NMSA 1978) specifically tasks participating agencies, including DOH, to study and make recommendations for the design of a coordinated system to maximize children’s outcomes related to health and family support. The Act also authorizes Children’s Cabinet agencies to enter into joint powers agreements to implement this coordinated system. As such, the recent resurrection of the Children’s Cabinet by the Governor presents an ideal vehicle by which DOH could implement a number of recommendations listed in this report.

Statutorily, the Children’s Cabinet must meet at least six times per years and also report to the Legislature and Governor by September 1 each year. The Cabinet’s report is required to include a child and youth policy and inventory budget that identifies state programs and initiatives that affect the well-being of children and youth. For their 2019 report, the Children’s Cabinet should consider including DOH’s plans 1) for the successful migration of DOH programs to the new Early Childhood Education and Care Department and 2) for effective data sharing and use among DOH and ECECD programs in the future.

Recommendations

Through the Children’s Cabinet, administrators from the Department of Health; the Early Childhood Education and Care Department; the Children, Youth and Families Department; and the Public Education Department should:

- As required by the Children’s Cabinet Act (32A-22-3D NMSA 1978), inventory early childhood health-related programs to identify points of service duplication and clientele overlap.
- Organize a comprehensive state home visiting and early childhood support system that includes: 1) a universal centralized screening and referral entity, 2) a light-touch home visiting service for most families, 3) food, income and other social supports for families that require them, 3) early intervention services for children with developmental delays, and 4) more intensive home visiting services for families with higher needs.
- Oversee the completion of the pilot of Family Connects—a Medicaid-eligible, evidence-based program. If the pilot yields positive results, then the Early Childhood Education and Care Department should consider expanding Family Connects statewide so that it can serve as the state’s universal centralized screening and referral program. Early Childhood Education and Care Department administrators could then discontinue Families FIRST and transition active Families FIRST clients to Family Connects or another appropriate evidence-based service.
- Determine avenues to best co-locate or co-deliver existing early childhood and other social services targeted to mothers, families, and children.

-
- Hold meetings of the Children’s Cabinet at least six times a year, as mandated by the Children’s Cabinet Act. These meeting should be held following Open Meetings Act standards to maximize opportunities for collaboration both within and outside of state government.

Department of Health administrators should:

- Determine how to share relevant information across agencies to improve service delivery and accountability such as creating agreements with the new Early Childhood Education and Care Department, potentially using the existing agreement with the Human Services Department as a template.
- Leverage their involvement in the Children’s Cabinet to strengthen collaboration with other early childhood programs. Before August 1, 2019 Department of Health administrators should also share their plans with the Children’s Cabinet 1) for the successful migration of FIT and Families FIRST to the new Early Childhood Education and Care Department and 2) for effective data sharing and use among Department of Health and Early Childhood Education and Care Department programs in the future.
- Determine how the Maternal Health program can better target birthing workforce retention fund awards to areas of the state with the highest birthing workforce needs.
- Work with the New Mexico Human Services Department to leverage its federal Substance Abuse Prevention and Treatment Block Grant funding to combat maternal substance abuse.

Administrators from the Department of Health and Early Childhood Education and Care Department should:

- Complete the Family Connects pilot, including its evaluation. If the program yields positive results, then the Early Childhood Education and Care Department should transition the Families FIRST program into Family Connects and Human Services Department should approve Family Connects as a Medicaid-eligible home visiting service by amending their Medicaid application.

Family, Infant, Toddler program administrators should:

- Develop a policy wherein all children at risk for delay due to environmental risk factors are referred to a state-funded home visiting service with developmental screening continuing to occur at least annually.
- Limit FIT services for children who are only at-risk for delay due to environmental factors to those who do not live within a home visiting program service area.

Women Infant and Children program administrators should:

- Consider co-locating satellite clinics with Human Services Department and Early Childhood Education and Care Department services via satellite clinics.
- Develop innovative partnerships that allow for more accessible delivery of WIC benefits and services.



MICHELLE LUJAN GRISHAM
GOVERNOR



KATHYLEEN M. KUNKEL
CABINET SECRETARY

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

Dear Mr. Abby,

Thank you for the opportunity to respond to the May 8, 2019 LFC report on the Department of Health's Role in the Early Childhood System. We would like to extend our thanks to the program evaluators, Ms. Micaela Fisher, Ms. Sarah Dinces, and Mr. Brian Hoffmeister, and the Legislative Finance Committee (LFC) for their professionalism and collaboration in conducting this evaluation. We appreciate the thoughtful evaluation, the critical eye, and recommendations brought forward.

This year will bring significant changes for the early childhood programs for the Department of Health as two of the evaluated programs will be headed to the new Early Childhood Education and Care Department. We are committed to ensuring that these programs are in the best shape possible prior to their transfer. This will include the development of data sharing agreements and collaboration plans across departments and programs as necessary.

The Department of Health (DOH) has identified many similar problems across the evaluated programs as the LFC and we are working diligently to manage these issues. We are committed to working toward improving in all areas noted by the LFC's report. The Department looks forward to working collaboratively with the LFC and other agencies on behalf of all New Mexico's children and to improve outcomes in as many areas as possible.

In the sections below, we have taken the opportunity to provide some highlights of the positive aspects of each of our valued programs and to illustrate the efforts which are already in progress to achieve the identified goals and to discuss our plans forward to address additional concerns brought forth in the evaluation.

Families FIRST

- Families FIRST uses a perinatal case management model, a model that has a long history of providing improved outcomes for high risk pregnant women and their infants. This is different from most home visiting models in that women are enrolled early in pregnancy so that they can be supported and linked to services even before their baby is born. Although the program can continue to work with a family until the child turns 3, approximately 2/3 of Families FIRST clients are pregnant women. Touching a family as early as possible is especially important for high risk pregnancies and is a critical part of improving child wellbeing and breaking the cycle of childhood trauma and substance abuse.

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- DOH is excited to be piloting the Family Connects program and we think public health nurses are the perfect people to provide the service. It is another piece in the spectrum of services and fills an important niche since it is universal, and many families do not need or want full blown home visiting but would be happy with 1-3 postpartum visits. We do not agree that Families FIRST should be transitioned to Family Connects, however, as they each serve a separate and important purpose.
- Families FIRST has put a detailed plan into motion to address the decreased caseload, including maximizing inter-agency referrals, outreach to OBs and Pediatricians, becoming a car seat distributor, establishing close relationships with the new MCOs, and working with HSD to get lists of eligible clients. We are already seeing caseloads beginning to increase from these efforts.

MCH Epidemiology

- We appreciate the LFC acknowledging that MCH Epidemiology is a tremendous asset to the early childhood system, and we agree. MCH Epi provides many important services to the early childhood system, including analysis and evaluation support for Families FIRST, WIC and Family Connects, as well as conducting and analyzing the PRAMS surveys, and leading the Title V grant application, report and statewide needs assessment.
- NM PRAMS has been recognized by the CDC as having the highest response rates in the nation, something the program worked hard to achieve over many years.
- New Mexico is one of only four states that have developed a follow-up to PRAMS (toddler study at age two). This new study will provide unique data on the first two years of life that is currently not available in any other data source.
- We would be happy to have MCH Epi evaluate outcomes across early childhood and possible duplication of services. However, we do not currently have funding to complete such activities. More importantly, we do not have access to all the early childhood data necessary. We would appreciate support from the LFC for MCH Epi to access the multiple data systems that we currently do not have access to and provide funding for this analysis.

Women Infant and Children (WIC)

- We understand the LFC has concerns related to the MOSAIC data system currently utilized by WIC. However, we believe many of these issues were related to the timing of the system roll-out. We would like to emphasize some of the positive aspects of this system.
 - The MOSAIC partnership has been recognized by FNS as a model for other states. \$7.1 Million of federal funds paid for two different MOSAIC systems, the Management Information System (MIS) and Electronic Benefit Transfer (EBT). Partnering with Texas and Louisiana in this endeavor allowed us to leverage funds, providing huge saving to tax payers, and gave us a much better system than we could afford on our own.
 - Due to the MOSAIC program, regional WIC managers now have access to all reports to help make the best data-driven decisions for their regions - unlike the old Legacy system, in which we only had a handful of reports and they all had to be generated by IT.

- We are excited that MÓSAIC is now mobile, so WIC staff are able to provide services out in the public including grocery stores, Head start events, SNAP Offices, and other similar locations.
- WIC acknowledges the decrease in caseload and is actively working to increase enrollment as much as possible. We have a detailed plan to increase caseload, including working closely with HSD on a joint online application. Since HSD says that 68% of Medicaid clients enroll online we believe this is the most efficient way to increase caseload than trying to expand WIC sites into INS offices.
- WIC is addressing food insecurity in three ways: piloting food delivery with Five Sandoval Indian Pueblo; piloting on-line ordering and curbside pickup at grocery stores; and working closely with food banks.
- WIC is continuously analyzing caseloads and staffing and adjusting and moving positions as needed. Caseloads are reviewed before an FTE is hired to make sure the demand can support the hire.
- WIC clerks, EI, and nutritionist were reclassified, per SPOs request in 2016-2017, to increase salaries and make jobs more competitive. SPO is currently conducting another analysis and may adjust again.

Family Health Bureau

- The Family Health Bureau in DOH is the lead agency for Maternal Child Health in the state, and houses both the Title V Director and the Title V Children with Special Needs Director, which are HRSA-designated positions of MCH Leadership for each state. Title V programs provide population-based MCH services that attempt to work across all MCH domains including prenatal, infant, child, adolescent and children with special healthcare needs. This broad reach across the lifespan is a requirement of the grant and is what makes it unique and challenging to administer.
- The FHB has worked diligently to promote interagency collaboration as well as community alignment around child and infant wellbeing using a two-generation family-centered approach. Examples of this work include the CARA task force for infants born exposed to substances, the NM Perinatal Collaborative, the J Paul Taylor task force, and Collaboration and Innovation Network multi-state initiative to improve infant mortality through addressing social determinants of health, and many more.
- FHB and CYFD have a strong partnership in many ways. The 2018 Safe Sleep meeting which was led by our two Cabinet Secretaries was successful and we were instructed to develop a statewide interagency safe sleep plan, which is currently in draft form. This will coordinate the goals and strategies of the various agencies addressing safe sleep in NM and will ensure consistent messaging. The CARA partnership between DOH and CYFD has also been extremely successful. Both agencies provided support for the passage of HB230 and both agencies are jointly providing trainings for hospitals and medical providers at a wide variety of venues over the next 9 months. We are also working on a joint portal for online reporting of infants born exposed to substances. The increased partnership with CYFD has been very valuable and much appreciated.

Family Infant Toddler (FIT) Program

- The Family Infant Toddler (FIT) Program is one of 31 states and territories that received the highest rating of 'Meets Requirements' from the US Department of Education, Office of Special Education Program (OSEP) for its high performance in its Annual Performance Report (APR) indicators. The FIT Program submits an Annual Performance Report on eleven (11) performance indicators, that include: timelines for getting children determined eligible and an Individualized Family Service Plan (IFSP) plan developed (within 45 days); all services provided within 30 days of the IFSP, along with the percentage of children served birth to age 1 and birth to 3.
- The FIT Program is utilizing funding under the Preschool Development Grant Birth – 5 to develop and provide training statewide on evidence-based early intervention practices that utilizes video-based coaching.
- The growth in the FIT program has been partly due to the increased developmental screenings by medical providers, home visitors, child care providers and others, that has resulted in a significant increase in the number of referrals received by the FIT Program. The FIT program also administers a robust child find and public awareness campaign to inform referral sources and families about the importance of early intervention and how to make a referral. The increase in funding appropriated to the FIT Program is the result of flat legislative appropriations for several years despite steady year-to-year increases in the number of children served and resulting cost of services.
- The FIT Program has rigorous eligibility criteria in the FIT rules (NMAC 7.30.8) and standards that providers must follow that includes the use of the Infant -Toddler Developmental Assessment statewide. The eligibility of children served is monitored through audits of FIT provider agencies every 3 years to ensure that all children are appropriately determined eligible. The FIT Program is confident that children served meet the FIT Program's eligibility criteria.
- The FIT Environmental Risk Assessment tool was developed based on the risk of developmental delay of 1 or more risk factors, while other states utilize a simple list of risk factors. A limitation to using an Adverse Childhood Experiences (ACE) tool is that such a tool measures experiences that may lead to long term health, mental health and socio-economic outcomes for individuals, rather than risk for developmental delay. This could result in many more children being eligible for the FIT Program due to the high percentage of children in New Mexico experiencing ACEs.
- While the DOH agrees that the difference in the percentage of children served by county should be further analyzed to determine the factors involved in those differences, we have to also take into account that the small number of children residing in some counties can mean that the addition of a few eligible children can result in a relatively large percentage change in children served.
- The FIT Program data can be disaggregated to analyze data for at-risk children. The Early Childhood Outcomes performance measure included in the Annual Performance Report to OSEP is reported both for all children served and separately for children identified as at-risk for comparing performance across all states and territories. The FIT Program can

explore additional tools that could be used to measure other outcomes for children eligible under environmental risk – such as measures of positive parent-child interactions.

- DOH agrees that further joint guidance with CYFD is needed to FIT providers and home visiting providers regarding decisions about whether a child and family could benefit from both services without duplication and that leads to enhanced child and family outcomes. Joint presentations have been made at the home visiting and FIT program conferences, however formal written guidance will be beneficial to ensure consistency.
- CYFD and the FIT Program has encouraged FIT providers to apply to provide home visiting services to expand the statewide network of home visiting providers as FIT provider agencies have a long history and experience in working with families of young children. Under the new Early Childhood Education and Care Department (ECECD) it is likely that more provider agencies will provide multiple early learning services in order to provide quality early learning services to young children and families in their communities.
- The DOH is open to looking for a tool to measure outcomes for children eligible under the environmental risk category in addition to measuring their developmental progress, such as measures of positive parent-child interactions.
- The DOH would recommend that any decision to eliminate the FIT Program's environmental risk eligibility category be made by the new Early Childhood Education and Care Department. If that decision is made, the ECECD can then develop a transition plan that would result in children and their families being served through state home visiting, as home visiting services are expanded into communities statewide.

As you can see, we've made significant strides in working toward improving these programs. We are committed to sending the Family, Infant, Toddler program and the Families FIRST program to the new Early Childhood Education and Care Department ready to succeed. The Department of Health looks forward to partnering with the LFC and other agencies to continue improving our agency and its early childhood programs for the benefit of all New Mexico children and families.

Sincerely,



Kathyleen M. Kunkel
Cabinet Secretary



Appendix A: Evaluation Scope and Methodology

Evaluation Objectives.

- Analyze the program scope and funding of six DOH maternal and child health programs
- Analyze performance and impact of those six programs
- Explore current and potential connections of those programs to other early childhood services

Scope and Methodology.

- Reviewed:
 - Applicable laws and regulations
 - LFC file documents
 - Information obtained from outside sources, including Internet searches
 - SHARE information
 - Agency and federal policies and procedures
 - Agency financial audits
 - Agency and federal program reports
- Compared practices other states' maternal and child health programs
- Interviewed DOH administrators and program staff
- Conducted site visits and interviewed field staff
- Reviewed relevant performance measures, administrative data, and related documents

Evaluation Team.

Micaela Fischer, Lead Program Evaluator
Sarah Dinces, Program Evaluator
Brian Hoffmeister, 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 Conference. The contents of this report were discussed with the Secretary of the Department of Health and her staff on April 30, 2019.

Report Distribution. This report is intended for the information of the Office of the Governor, Department of Finance and Administration, 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.

Jon Courtney
Deputy Director for Program Evaluation

Appendix B: Citations

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