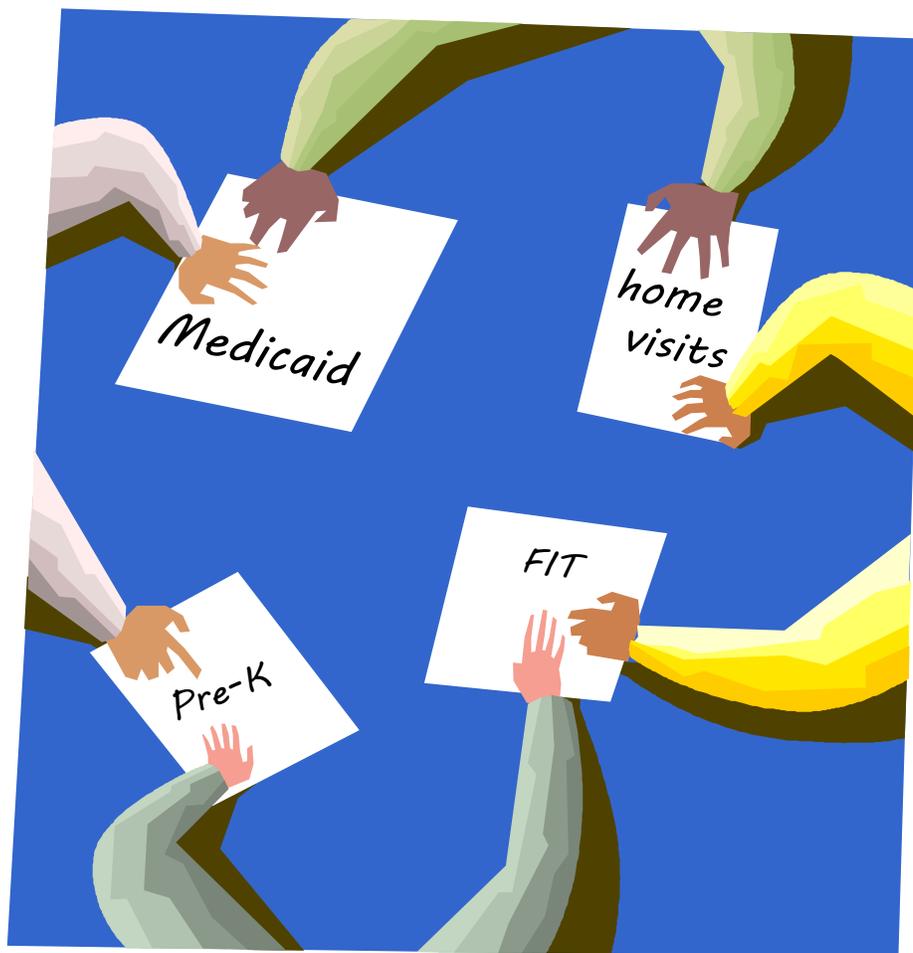


Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico



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Executive Summary

New Mexico ranks among the worst states in child well-being. Nearly one in four children in New Mexico lives in poverty. More than half of children birth to age 8 live in low-income households. New Mexico's rate of births to teens is among the highest in the country. Among children ages 4 months to 5 years, more than one in five are at moderate-to-high risk of developmental or behavioral problems. More than one quarter of young children have three or more risk factors that could impact their development.

There is no question that New Mexico families have unmet needs for more prevention, early intervention, and treatment services. Health, educational, developmental, and human services and supports are essential to helping families optimize child development and prepare children for success in school and life.

The nearly 140,000 young children (birth to 5 years) in New Mexico need strong families, communities, and public investment to assure their future. While New Mexico has been a leader in public investment in early childhood programs, the state can do more through leadership, systems development, and interagency coordination. Such actions will help to maximize the public and private sector funding.

Based on qualitative analysis of 25 key stakeholder interviews and detailed review of related documents, **the top four recommendations** are to:

1. Make Early Childhood a higher priority for the Children's Cabinet, including strong leadership and Cabinet oversight of early childhood activities and investments.
2. Support and enhance local early childhood "system of systems" development building on Early Childhood Investment Zone approaches and including use of state employees who serve in the local jurisdictions (e.g., health).
3. Establish common eligibility definitions and care pathways for the full range of children with disabilities and other special health needs. This should include services funded or coordinated by Medicaid, Children's Medical Services, Family Infant Toddler program, mental health, inclusive child care, and other relevant programs.
4. Ensure a broad vision for early childhood mental health planning and development by incorporating ideas from J. Paul Taylor Task Force, past early childhood mental health strategic plan, and current efforts to create a tiered approach to service delivery.

The following recommendations and opportunities are based on a detailed analysis of early childhood services, programs, and systems efforts. Interviews with 25 key stakeholders (inside and outside of government) and review of a large number of documents served as basis for the analysis. Note that recommendations are strongly supported by the findings of this analysis. Opportunities listed are actions that are available to New Mexico under federal and state law that may not be highest priority at this time.

Leadership and Infrastructure for Program and Fiscal Support

Leadership

Recommendations

- Devote time and focus of the Children’s Cabinet to lead development, implementation, and oversight of New Mexico’s early childhood investments, programs, and system of systems (e.g., have an early childhood section of agenda, make regular reports to governor, set up interagency structure for system oversight).

Opportunities

- Adopt a broader set of indicators for the Children’s Cabinet, which would give greater emphasis to each period of child development.
- Support from the Indian Affairs Department to promote, as appropriate, services for young Native American children in the early childhood system of systems.

Early Childhood System of Systems Framework

Recommendations

- Improve coordination among the Children, Youth, and Families Department, Public Education Department, Department of Health, and Human Services Department. In particular, Pre-K, Early Childhood Investment Zones, and early childhood mental health services offer a place to begin greater inclusion.
- Improve integration of health, mental health, and family support services into the system of systems, including giving attention to the inclusion of health leadership in Early Learning Advisory Council.
- Clarify roles and intentionally structure the relationships among the Early Learning Advisory Council, Early Childhood Comprehensive Systems, and other advisory bodies, while not losing capacity or federal resources. Currently there is duplication of effort and lack of clarity in roles related to the early childhood system of systems.

Opportunities

- Use Race to the Top as catalyst for more system development. The grant proposal has a broad vision and provides a somewhat unique opportunity for systems change and integration.
- Be the first state to create a modern, uniform early childhood data system, including unique identifiers.
- Consider physical co-location or a matrix organizational designed to more closely connect the work of early childhood program and project leaders across departments.

Support to Local Jurisdictions

Recommendations

- Coordinate state-funded and administered programs across local jurisdictions with differing capacity, resources, and challenges
- Use local coalitions developed in Early Childhood Investment Zones as the basis for rejuvenated Early Childhood Councils.
- Use “collective impact” strategies and processes in Investment Zones, with a backbone organization, shared goals, and common measurement as key elements.
- Maximize use of state-funded personnel who serve in local communities, especially health staff (e.g., public health nurses, community health workers, care coordinators).

Opportunities

- Match services to needs through continued use of geographic information system (GIS) mapping and related tools for planning.

Early Care and Education

Child Care

Recommendations

- Implement the FOCUS Tiered Quality Rating and Improvement System approach for all providers by 2016.
- Establish a framework for high-quality child care in statute through enactment and implementation of a Child Care Accountability Act.
- Adopt more extensive health, safety, and quality standards for registered child care homes.
- Increase the reach of child care subsidies to reduce waiting lists, aiming to reach all families with child care needs up to 200% of the federal poverty level.
- Continue investments in workforce development, particularly cross-system training for child care, Pre-K, home visiting, and others who work with young children.

Opportunities

- Adopt lessons learned from full-day, high-quality early care and education services for children birth to five years that integrate principles and best practices from Pre-K, child care, and Educare.
- Make child care, Pre-K, and Head Start quality information and licensing reports available to parents on paper and online, as well as in multiple languages.
- Adopt legislation similar to 31 other states to place restrictions on sex offender proximity to schools/and/or child care facilities.

Pre-K

Recommendations

- Strengthen collaboration between the Children, Youth, and Families Department and Public Education Department to reduce potential competition and duplication.
- Create an integrated Pre-K program, applying the same program standards across all publicly-funded early education initiatives.
- The Children and Families Department and Public Education Department should jointly design and oversee a data-driven, local level planning process that informs funding decisions.
- Examine service capacity for four year olds and maximize Pre-K, Head Start, child care, and other early care and education sites.

Opportunities

- Make childcare, Pre-K, and Head Start quality information and licensing reports available to parents on paper and online, as well as in multiple languages.

Other Early Care and Education

Recommendations

- Integrate Head Start and Early Head Start into the ongoing early childhood education system to the maximum extent possible (e.g., shared training, common measures).
- Maximize use of New Mexico Head Start Collaboration Office to increase oversight and coordination of Pre-K and Head Start for four year olds, without a change in federal authority.
- Reduce unnecessary competition or duplication of effort between Head Start and Pre-K providers through mechanisms such as local planning (see above).

Opportunities

- Supplement federal Head Start funding with state dollars.
- Continue state agency emphasis on workforce development.
- Continue the evaluation and monitoring of K-3 Plus.

Home Visiting

Recommendations

- Continue to use standards-based approach, with accountability.
- Include all home visiting programs in annual report from the Children, Youth, and Families Department.
- Address the needs of an array of at-risk families, not just first time parents.
- Integrate home visiting into quality rating and data systems.

Opportunities

- Use Medicaid financing for home visiting.
- Increase use of Early Head Start in the New Mexico home visiting system.

Health Services for Young Children

Medicaid – Prevention and Treatment

Recommendations

- Increase utilization of Early and Periodic Screening, Diagnosis, and Treatment well child “screening” visits for children birth to 5. Approaches might include incentives to Centennial Care plans, social marketing, and referrals from other early childhood program.
- Assure that developmental screening is being delivered according to American Academy of Pediatrics’ recommended schedule for infants and toddlers covered by Medicaid.
- Continue having Centennial Care Performance Improvement Projects related to the quality of Early and Periodic Screening, Diagnosis, and Treatment services.
- Clarify Medicaid coverage for mental health parent-young child therapy.
- Continue state support for Families FIRST pregnancy-related case management, ensuring that it is appropriately linked to Centennial Care plans and providers and that the program uses standardized risk assessments.

Opportunities

- Finance a portion of the cost of home visiting services with Medicaid.
- Extend Families FIRST to include interconception care. Focused on women with prior adverse outcomes, interconception care (also known as interpregnancy care) refers to services provided following the end of a pregnancy, typically for 18-24 months, to address risks for subsequent childbearing and reduce the impact of chronic conditions on women’s health.
- Maximize use of community health workers (e.g., promotoras) in prevention.

Medicaid – Administrative Supports

Recommendations

- Use more express-lane and streamlined enrollment strategies.
- Adopt diagnostic codes (DC:0-3R) designed to reflect developmental conditions among young children.
- Collect data for quality improvement and evaluation of the tiered case management approach.

Opportunities

- Ensure that families and providers are informed regarding the full range of treatment services covered by Medicaid under the Early and Periodic Screening, Diagnosis, and Treatment benefit, using paper and Internet communications.
- Develop a child health quality improvement collaborative that focuses on topics related to the health and development of young children (e.g., developmental screening and assessment, immunizations, maternal depression screening, trauma-informed services).

Early Childhood Immunizations

Recommendations

- Maximize use of immunization registry to monitor coverage.
- Educate families to reduce the number that decline vaccines due to misinformation about the safety and effectiveness of these life-saving, preventive interventions.

Opportunities

- Communicate to parents the importance of completion of the basic series for young children—send the message that vaccines are important for “every child by two”.
- Inform early care and education providers (including family child care homes) that work with children birth to three about the importance of timely immunization.

Services for Children with Disabilities and other Special Health Needs

Children with Disabilities and Special Needs Overall

Recommendations

- Establish common eligibility definitions and care pathways. This should include services funded or coordinated by Medicaid, Children’s Medical Services, the Family Infant Toddler program, mental health, and other relevant programs. The approach should build on strengths of Centennial Care tiered care management.
- Design and implement a coordinated continuum of services grounded in interagency collaboration.
- Clearly define who is payer of last resort under various conditions.
- Design and implement a cross-system, interdepartmental approach for assuring universal developmental screening at recommended intervals, with effective referrals as needed.

Opportunities

- Maximize available resources by using uniform central billing processes or mechanisms.

Family Infant Toddler Program

Recommendations

- Fully support the role of the Family Infant Toddler program in an integrated early childhood system of systems.
- Continue to *exclude* Medicaid payments to the Family Infant Toddler Program from Centennial Care.
- Further shorten the time between referral and eligibility determinations for the Family Infant Toddler program.

Opportunities

- Further integrate early childhood systems and services by adopting a uniform policy for services to children with developmental disabilities and special education needs birth to age 5, using the federal option to create a continuum of services and early interventions for children birth to 5.
- Give attention to challenges of families with children transitioning from Individuals with Disabilities Education Act Part C (Family Infant Toddler program in New Mexico) and Part B Preschool program.

Executive Summary: Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

Children's Medical Services

Recommendations

- Review and align eligibility criteria across programs for children with special needs and disabilities to close gaps and maximize available funding.
- Conduct a “census” of children with disabilities and special health needs, including those who: are eligible for the Family Infant Toddler program and preschool special education, qualify for Children's Medical Services, are identified through newborn screening, have Medicaid coverage for high cost services and disabilities, and others.
- Maintain universal newborn screening programs (i.e., genetic, metabolic, and hearing), assuring integration of follow up interventions and treatments as part of overall early childhood system.

Opportunities

- Use flexible funding in Children's Medical Services to support the full range of children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Early Childhood Mental Health

Recommendations

- Incorporate J. Paul Taylor Task Force recommendations and lessons from forthcoming New Mexico Project LAUNCH evaluation into any new early childhood mental health plan.
- Augment training to ensure that health, mental health, social services, child development, and other professionals working with young children and their families understand the continuum of early childhood mental health services and their role in delivering promotion, prevention, early intervention and treatment.
- Use widespread, cross-system early childhood mental health screening to identify more children at risk. The state should take a leadership role in development and implementation of a systems approach to early childhood mental health screening with objective tools. The Children, Youth, and Families Department, Department of Health, and Human Services Department each have a role to play.
- Integrate early childhood mental health services into local early childhood services, councils, Early Childhood Investment Zones, and related efforts.
- Maximize the existing workforce through licensing, authority, and training.

Opportunities

- Increase use of early childhood mental health consultation to early care and education provider sites (e.g., child care, Head Start).

Other Supports for Children with Disabilities and Special Health Care Needs

Recommendations

- Promote use of developmental screening through support for cross-system training, policies that recommend standardized tools, interagency agreements regarding referrals, and maximized use of available financing.
- Integrate screening/assessment for adverse childhood experiences into the practice of health, mental health, child protective services, home visiting, child development, and other professionals serving families with young children.
- Establish routine referral pathways reinforced with care coordination, quality assurance, and monitoring for children who have developmental screening or adverse childhood experience assessment indicating need for follow up.

Executive Summary: Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

- Provide cross-system training regarding developmental screening and adverse childhood experiences for professionals serving young children.

Opportunities

- Increase access to trauma informed services through training across early childhood programs and provider types.

Family Support for Families with Young Children

Temporary Assistance to Needy Families

Recommendations

- Designate families with pregnant women or infants who have a Temporary Assistance to Needy Families participation waiver as a priority group for other services in the early childhood system and develop transition plans.
- Continue efforts to implement the Family Violence Option.

Opportunities

- Use Temporary Assistance to Needy Families grant dollars for two-generation strategies, such as: child care quality initiatives, early childhood mental health consultation, family counseling, service coordination, and family support activities, and/or substance abuse treatment for parents.

Child Abuse Prevention, Protective Services, and Child Welfare Services

Recommendations

- Ensure that infants and toddlers with reported cases of abuse or neglect receive timely and comprehensive screening, assessment, and interventions.
- Offer training for all child welfare and protective services agency staff related to trauma-informed care in order to build and sustain a trauma-informed system.
- Include child welfare and protective services staff in statewide interdisciplinary training related to child development, early childhood mental health, Strengthening Families, and related topics.
- Sustain funding and increase use of Triple P and Strengthening Families to enhance parenting skills and reduce the incidence of child maltreatment.

Opportunities

- Improve tracking of referrals and outcomes among infants and toddlers referred to Family Infant Toddler program as a result of substantiated abuse or neglect.
- Maximize use of the Children's Trust Fund to intervene early and promote child and family well-being.
- Build upon the success of a pilot project using differential response approaches in child protective services for reducing the risk of child maltreatment.

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Contents

Introduction.....	2
Purpose of Analysis	2
Importance of Public Investment	3
Leadership and Infrastructure for Cross-system Program and Fiscal Support.....	4
Children’s Cabinet	5
Early Learning Advisory Council.....	6
Early Childhood Comprehensive Systems.....	8
Race to the Top	10
Early Childhood Investment Zones.....	11
Early Care and Education	13
Child Care	14
Pre-Kindergarten (Pre-K).....	16
K-3 Plus	17
Head Start and Early Head Start	18
Early Care and Education Workforce Development.....	20
Home Visiting	21
Health and Developmental Services for Young Children	23
Medicaid	23
Families FIRST	28
Childhood Immunization	29
Services for Young Children with Disabilities and Other Special Health Needs	30
Family Infant Toddler Program	31
Part B Preschool Special Education.....	32
Children’s Medical Services (CSM) for Children with Special Health Care Needs.....	33
Infant and Early Childhood Mental Health.....	34
Adverse Childhood Experiences and Trauma Informed Services	37
Developmental Screening	38
Family Support and Other Services for Families with Young Children	39
Temporary Assistance to Needy Families	39
Child Abuse Prevention and Treatment Act	40
Child Protective Services and Child Welfare Services	41
Summary of Findings and Recommendations	44
Appendix A. Reference and Resource List.....	54

Introduction

Purpose of Analysis

New Mexico is nationally recognized as a leader in efforts to improve early childhood health, development, education, and well-being. Yet more can be done to improve the efficiency, effectiveness, and overall impact of these efforts. The purpose of this analysis is to:

- Identify opportunities for improving collaboration;
- Determine where efforts are being duplicated;
- Identify areas where blended funding could produce better service delivery outcomes and cost effectiveness;
- Identify existing structures and processes that facilitate an integrated early childhood system of care in New Mexico;
- Identify successful projects and programs within or outside of New Mexico that can be replicated; and
- Identify populations which are not being reached by current statewide early childhood services.

The process included extensive review of documents, as well as interviews and virtual meetings to gather information regarding New Mexico's current efforts, priorities, and public policy framework. A list of the documents reviewed for this analysis can be found in Appendix A.

In this qualitative research project, 25 semi-structured interviews were conducted with state officials and key stakeholders from the private sector. Building from a list provided by the state-assigned project officer, a "snowball" method was used to identify key stakeholders.

The core questions used to structure the open-ended interviews were: 1) what are the opportunities to improve collaboration, coordination, and integration of early childhood services, programs, and financing? 2) what successful (and/or evidence-based) programs or strategies should be replicated in New Mexico (e.g. from other states, to additional communities)? and 3) what do you see as the priorities for action in the coming years to further improve early childhood services and systems?

Note that analysis of services for Native American children in New Mexico is beyond the scope of this report. Each of the 22 tribes—19 Pueblos, two Apache tribes, and the Navaho Nation—is a sovereign nation, has its own government, and has unique relationships to federal and state governments. Family income, school readiness, and access to early childhood services vary widely for young children in tribal communities, but many are disadvantaged in economic terms. The Indian Affairs Department has an opportunity to promote, as appropriate, services for young Native American children in the early childhood system.

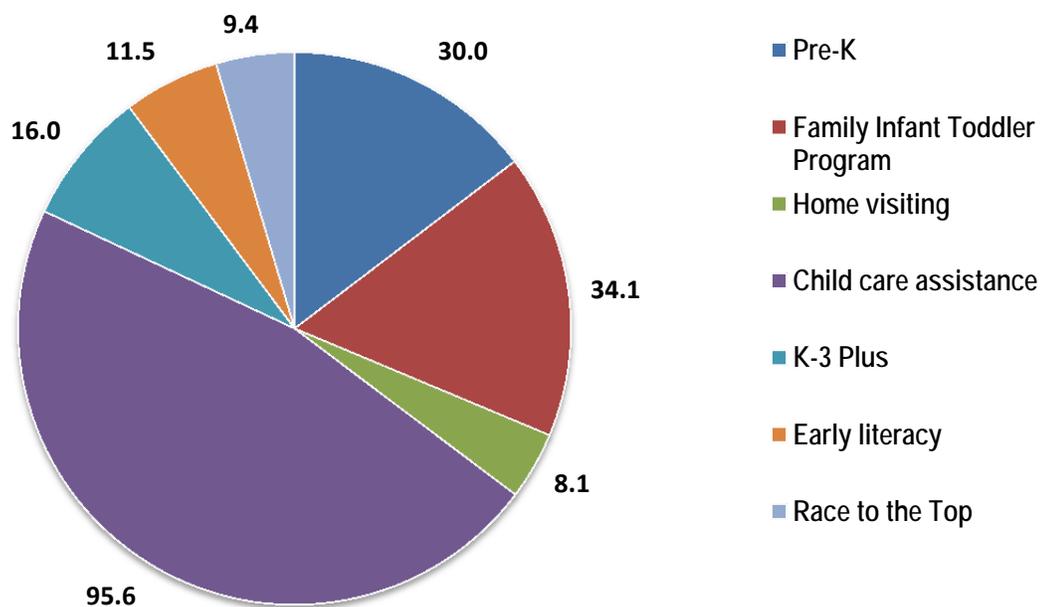
This work was conducted under contract to the New Mexico Department of Health between October 1, 2013 and June 30, 2014. All recommendations and content are the responsibility of Johnson Group Consulting, Inc. and do not necessarily reflect any positions or policies of any agency or entity within the State of New Mexico.

Importance of Public Investment

Young children in New Mexico need strong families, strong communities, and public investment to assure their future. It has been a goal of successive administrations from both political parties in New Mexico to achieve the goal stated by the Early Learning Advisory Council: “Every child in New Mexico will have an equal opportunity for success in school, based upon equitable access to an aligned and high quality early learning system.” Moreover, New Mexico’s children need equitable access to high quality health, mental health, social services, and special needs interventions in their early years. This requires public investment, along with planning and implementation of a coordinated and integrated “system of systems” (see discussion below) that truly leaves no child behind.

New Mexico has been a leader in public investment in early childhood programs. Figure 1 shows funding for selected early childhood programs in New Mexico. This cluster of programs forms the core of New Mexico’s early childhood initiatives. At the same time, millions of dollars are spent in a federal-state partnership to finance health care services for young children in Medicaid. Federal funding directly to Head Start and Early Head Start sites also supports early childhood education and development. Additional spending comes directly from federal sources such as the Supplemental Nutrition Program for Women, Infants, and Children (otherwise known as WIC) or the Indian Health Service.

Figure 1. Funding for Selected Early Childhood Programs, New Mexico, Fiscal Year 2014
(in millions of dollars)



Source: Legislative Finance Committee

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

The budget signed by the Governor at the end of the 2014 legislative session included a substantial 14 percent increase in funding for early childhood initiatives over Fiscal Year 2014 appropriations levels. The signed budget included, among other items, increased funding for home visiting, Pre-K, infant child care assistance rates, K-3 Plus, and early childhood teacher compensation and retention. These investments are further evidence of the extent to which New Mexico's elected officials increasingly understand the importance of early childhood development, education, health, and well-being.

This analysis and report does not recommend specific funding levels for any New Mexico programs. The state has, however, ongoing guidance from public and private sector experts. For example, the Legislative Finance Committee recommendations for Fiscal Year 2015 called for increasing funding for early childhood program initiatives by \$35 million, a 17% increase over Fiscal Year 2014 appropriations levels. Proposed additional funding included a range of programs, including: early literacy, K-3 Plus, Pre-Kindergarten (Pre-K), child care assistance, home visiting, and the Family Infant Toddler Program (early intervention services for infants and toddlers with or at risk for developmental disability operated under the Individuals with Disabilities Education Act, Part C). Professional training and education, as well as quality initiatives were also included. The Legislative Finance Committee recommendations are guided by research, knowledge of budget constraints, and a broad perspective on the needs of families with young children.

Leadership and Infrastructure for Cross-system Program and Fiscal Support

New Mexico has a long history of leadership in early childhood issues. For example, gubernatorial or cabinet level leadership led to creation of the: Office of Child Development and Child Development Board (1989), Task Force on Children and Families (1991), Early Childhood Alignment Task Force (2003), Early Childhood Action Network (2004-10), Children's Cabinet (2005), Early Childhood Investment Committee (2008), and Early Learning Advisory Council (2010/2013). This tradition continues.

In interviews conducted for this analysis, however, the single most often mentioned factor perceived as essential to the success of early childhood programs was strong leadership. In more than half of the 25 interviews with state officials and private sector stakeholders, state-level leadership was described as an important priority and/or need. Key stakeholders stressed the importance of having ongoing leadership from the top—the governor—and from the cabinet level.

A majority of key stakeholders interviewed also described the important role of leadership within and across agencies. For example, many urged greater involvement of health programs to strengthen interagency collaboration supporting early childhood initiatives. Some interviewed also described the important role that a single agency leader can play in serving as a change agent and catalyst for action.

As described in the New Mexico Race to the Top, Early Learning Challenge grant proposal: *“Hidden just beyond the postcard images and Tourist Board campaigns, New Mexico’s children grow up confronted with adverse childhood experiences that are rooted in a history of profound and pervasive poverty.”*

Only through continuous, strong, and effective leadership can New Mexico ensure that the next generation grows up stronger, more resilient, and more self-sufficient. The first and strongest

recommendation of this report is that senior executive branch leadership be informed about, promote funding of, foster infrastructure for, and provide oversight of the full array of early childhood programs and initiatives in New Mexico.

Children's Cabinet

The opportunity for improving early childhood services in New Mexico rests first and foremost in the work of the Children's Cabinet. Cabinet level discussions have the potential both to inform the governor about top priorities and to guide departmental action. A majority of key stakeholders interviewed believe that, given the pace and scale of investments, the Children's Cabinet could do more to lead development, implementation, and oversight of New Mexico's early childhood investments, programs, and system of systems. The Children's Cabinet could, for example, make early childhood system issues a routine agenda item in its meetings. It also might provide routine reports to the governor on early childhood issues, programs, and successes.

In its 2013 Report Card, the Children's Cabinet identified four priority areas. These are:

1. Early childhood development,
2. Health and nutrition,
3. Education and Pre-K-Grade 3, and
4. Child welfare and public safety.

Next steps proposed in the area of early childhood development were to: improve accessibility to prenatal and birthing services in rural and smaller urban areas of the state; improve health outcomes for infants and children, and provide earliest intervention possible to promote appropriate development of infants and children. The recommendations below in this report are consistent with these next steps proposed in the 2013 Report Card of the Children's Cabinet.

There is also an opportunity for the New Mexico Children's Cabinet to extend its use of results-based accountability. The areas previously identified for measurement by the Children's Cabinet include:

- Reducing the state's infant mortality rate,
- Confronting childhood obesity to give all New Mexico children a chance at a healthy life,
- Improving reading readiness so that our kids have a strong foundation for learning,
- Encouraging out-of-system adoption to provide caring families for kids in need,
- Curbing the high school dropout epidemic that is leaving far too many young people struggling to find work and succeed in our economy,
- Stopping the abuse of prescription drugs by teens, and
- Educating our students well, so that we can reduce the use of remedial classes in college

While important, these issues seem narrowly focused on a few indicators of risk. The Children's Cabinet needs a broader set of indicators, which gives greater emphasis to each period of child development (e.g., prenatal and infant, early childhood, early school age, adolescent). A strong indicators list which can guide results-based accountability would benefit decision making now and in the coming years.

Early Learning Advisory Council

The federal Head Start Reauthorization Act of 2007 encouraged establishment of State Early Childhood Advisory Councils, which have been supported with funding from the Administration on Children and Families, U.S. Department of Health and Human Services. These councils are charged with developing a high-quality, comprehensive system of early childhood development and care and ensuring coordination and collaboration among the array of early childhood programs, particularly early care and education. Under federal law, State Advisory Councils on Early Childhood Education and Care were required to:

- Conduct a periodic needs assessment.
- Identify opportunities for, and barriers to, collaboration and coordination of early childhood programs and services.
- Develop recommendations for increasing the overall participation of children in early childhood programs.
- Develop recommendations for a unified, statewide early childhood data collection system.
- Develop recommendations for a statewide professional development system.
- Assess the capacity and effectiveness of 2- and 4- year public and private institutions of higher education.
- Make recommendations for improvements to early learning standards and develop high-quality comprehensive early learning standards.

Federal law requires that the Council represents key leadership in early care and education (i.e., child care agency, state and local education agencies, institutes of higher education, local providers of early childhood education and development services, Head Start agency, and state director of Head Start collaboration). In New Mexico, other key stakeholders are included (e.g., business leaders).

The National Conference on State Legislatures reported that as Early Childhood Advisory Councils federal grants were nearing an end in Federal Fiscal Year 2013, state appropriations increased in Arizona, Florida, Illinois, Rhode Island and Washington. Other states (e.g., Florida, Michigan, Nebraska) build public-private partnerships, using small state general fund appropriations, foundation, and other private funds to support such early childhood councils or related initiatives.

In New Mexico in 2011, Senate Bill 120 —The Early Childhood Care and Education Act—was passed by the Legislature and signed by Governor Martinez. The Act established a New Mexico Early Learning Advisory Council to lead development of a comprehensive early childhood care and education system through an aligned continuum of state and private programs. This policy was designed to advance a comprehensive early childhood care and education system through an aligned continuum of coordinated state and private programs, including home visitation, early intervention, child care, pre-kindergarten, Early Head Start, Head Start, early childhood special education, and family support, as well as to maintain or establish the infrastructure necessary to support quality in the system’s programs.

The legislative purpose was grounded in the finding that: *“an early childhood care and education system is vital in ensuring that every New Mexico child is eager to learn and ready to succeed by the time that child enters kindergarten, that high-quality early learning experiences have been proven to prepare children for success in school and later in life and that cost-benefit research demonstrates a high return on investment for money spent on early childhood care and education for at-risk children.”* It further

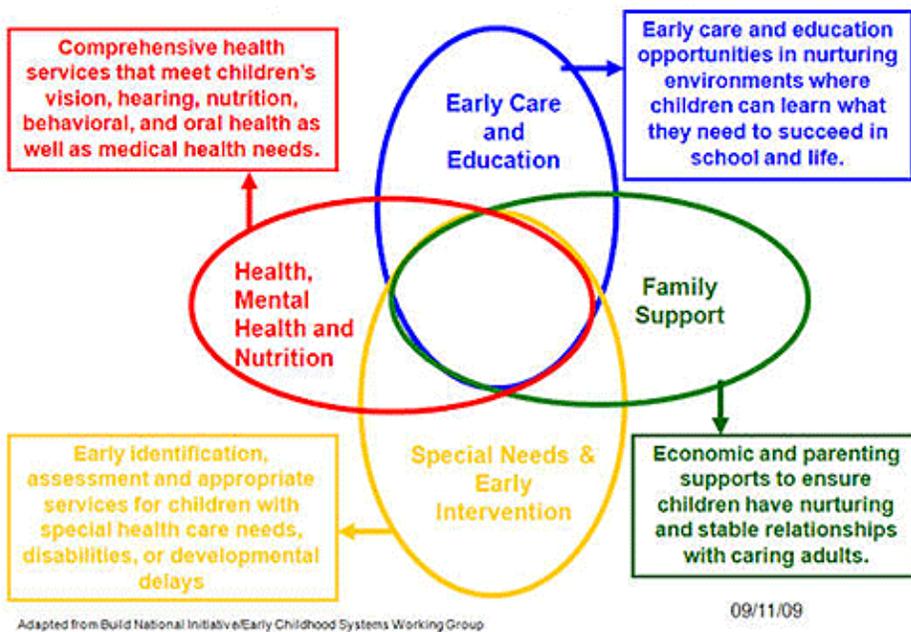
Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

calls for the early childhood care and education system to be: developmentally, culturally, and linguistically appropriate; comprised of program models, standards, and curriculum based on research and best practices; data driven; accountable; accessible; of the highest possible quality; aligned within each community; and family centered.

The early care and education system is one part of the “system of systems” that serves young children and their families. As shown in Figure 1, national leaders in early childhood participating in an Early Childhood Systems Working Group (including the author of this report) conceptualized a system of systems that includes: health, early care and education, family support, and services for special needs and early intervention. This report acknowledges the importance of each element in a system of systems.

Across the country, the breadth of responsibility for State Early Childhood Advisory Councils (the Early Learning Advisory Council in New Mexico) varies. Some concentrate heavily on early care and education, while others have merged with their Early Childhood Comprehensive Systems (see discussion below) infrastructure to create an entity that addresses not only education and development issues but equally includes health, child welfare, and other early childhood services.

Figure 2. Early Childhood System of Systems Framework



New Mexico’s Early Learning Advisory Council seems poised at a threshold for shaping its agenda over the coming years. It remains strongly grounded in early care and education but also has incorporated home visiting, early intervention, and family support issues. In order to extend a focus to the full early childhood system of systems, however, the integration of health issues into the routine consideration of the Early Learning Advisory Council is critical. The health system serves by far the greater number of children through well-child and other pediatric primary care visits. Fulfilling the vision for a system of

systems will be the challenge, and the Early Learning Advisory Council can be the leader and coordinating entity if it moves to incorporate all of the systems.

Early Childhood Comprehensive Systems

Beginning in Federal Fiscal Year 2003 and continuing over the past decade, the federal Maternal and Child Health Bureau, Health Resources and Services Administration launched the State Maternal and Child Health Early Childhood Comprehensive Systems Grant Program. The purpose of Early Childhood Comprehensive Systems funding is to assist States and territories in their efforts to build and implement Statewide Early Childhood Comprehensive Systems that support families and communities in their development of children that are healthy and ready to learn at school entry. The ultimate goal was for implementation of a Comprehensive Early Childhood Strategic Plan that promotes the health and well-being of young children, enabling them to enter school ready and able to learn. The federal Early Childhood Comprehensive Systems program was intended to bridge the gaps created by multiple, non-integrated funding streams for early childhood services through use an integrated framework, strategic planning, and coordination. These systems must address the five critical components of early childhood systems development, including: 1) access to health insurance and medical homes, 2) mental health and social-emotional development, 3) early care and education, 4) parenting education, and 5) family support.

Although the Early Childhood Comprehensive Systems program was not the first or only early childhood systems-building initiative, it has been unique in its reach to all states (and five other jurisdictions) and scope, including all facets of the system of systems. States were required to focus simultaneously on systems building across multiple sectors. The system elements, which states were to use, include governance, financing, communications, family leadership development, provider or practitioner support and professional development, and monitoring and accountability.

Given that each state began with different early childhood programs, initiatives, and administrative approaches, the Early Childhood Comprehensive Systems program always permitted flexible use of funds for planning and systems development (during the first decade no funds could be used for direct services). The Early Childhood Comprehensive Systems program was grounded in the idea that the greatest opportunities and biggest challenges for children and families involve a cross-sector approach. State implementation teams (councils, advisory bodies, etc.) included multi-sectored representation, and Early Childhood Comprehensive Systems leadership was generally included in other early childhood coordinating bodies.

The national evaluation of the Early Childhood Comprehensive Systems program found that in many states the program:

- Contributed to progress in all five focus areas, particularly social and emotional development, health, and early care and education.
- Encouraged states to examine financing of early childhood services and systems.
- Helped to spur leadership development.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

- Facilitated use of cross-system professional development.
- Contributed to standards development.
- Strengthened systems-building efforts at the community level.
- Strengthened data, monitoring, and accountability efforts.

In New Mexico, the Early Childhood Comprehensive Systems grant led to changes during the period 2003-2012. Achievements included: development of an early childhood strategic plan, creation of a partnership through the Early Childhood Action Network (ECAN), development of a comprehensive annual early childhood policy agenda, development of a prototype early childhood report card, annual results-based accountability reviews, created of a Family Leadership Action Network, and catalyst for other systems development activities.

In the majority of states, the Early Childhood Comprehensive Systems grants supported the development of changed systems of governance and new policy directions in many states, including development of quasi-independent, public and public-private entities that played a prominent role in changing early childhood systems. In some states Early Childhood Comprehensive Systems entities merged with State Early Childhood Advisory Councils, while in others two separate groups were maintained and often became competitive. It was critical in these transitions to continue to include health and family supports in the early childhood system of systems approach in a given state.

In the most innovative states, a positive system dynamic and interactions developed, which were characterized by a climate supporting innovation and a broad commitment to system improvement. Although the federal Early Childhood Comprehensive Systems program has shifted directions, its strategic planning and convening role over the past decade helped to position New Mexico in this group.

For 2013, the federal Early Childhood Comprehensive Systems program was revised. The implementation of the federal Maternal, Infant, and Early Childhood Home Visiting program and new home visiting system development efforts resulted in reconsideration of how early childhood systems development funds might better support recent early childhood initiatives. Funds for Federal Fiscal Year 2013 were available to support states in the initiation and continuation of their Early Childhood Comprehensive Systems Development efforts; however, new, less comprehensive activities were defined. The revised activities include either: 1) the implementation of strategies designed to mitigate toxic stress and trauma in infancy and early childhood across two or more early childhood systems; 2) coordinate the expansion of developmental screening; or 3) improve state infant and toddler child care quality improvement efforts. In addition, federal incentive awards were given for projects that utilize pediatric health leadership at the state level. Finally, the voluntary collection of early childhood indicator data from states, counties, and the Maternal, Infant, and Early Childhood Home Visiting program communities was included in Early Childhood Comprehensive Systems.

Currently New Mexico and 14 other states are using their Early Childhood Comprehensive Systems grant to focus on improving expansion, coordination, and implementation of developmental screening. The federal purpose is to expand developmental screening in early care and education settings, while strengthening referrals and linkages to child health.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

The recommendation is for New Mexico to better integrate early childhood services across the system of systems. This would particularly include integrating and coordinating the scope of Early Childhood Comprehensive Systems with the work of the Early Learning Advisory Council. This report strongly recommends that health become a larger part of the planning, development, and implementation of an early childhood system of systems. The Early Learning Advisory Council should include health, developmental screening, mental health, oral health, and related services in their deliberations. The organizational relationships between Early Childhood Comprehensive Systems efforts and the Early Learning Advisory Council should be clarified and deliberately structured to maximize resources, while not losing capacity or federal resources.

Race to the Top

Federal Race to the Top, Early Learning Challenge grants provide competitive funding to states to work on development of a coordinated system of early learning and development for children birth to age 5. As part of a federal, interagency priority on early childhood, these grants are helping to solidify and implement plans for creating an interagency system of systems developed by state Early Childhood Comprehensive Systems and the Early Learning Advisory Council groups. In addition, new initiatives have emerged across the country as states plan for new levels of coordination and partnership.

The State of New Mexico received a \$37.5 million, four-year federal Race-to-the-Top Early Learning Challenge grant. New Mexico's Race to the Top initiative for young children has four primary goals. These are to:

- 1) Utilize the *New Mexico Early Learning Guidelines: Birth through Kindergarten* as the foundation of alignment of systems and improvement of program quality to close the school readiness gap.
- 2) Fully implement FOCUS, a newly revised Tiered Quality Rating and Improvement System to focus on children outcomes through the full implementation of New Mexico's Authentic Observation – Documentation - Curriculum Planning Process using the *Early Learning Guidelines* as criteria.
- 3) Establish Early Childhood Investment Zones (see discussion below) in areas where children are at greatest risk of school failure by aggregating and ranking community adverse childhood experiences, in combination with an assessment of community readiness indicators, to establish place-based models of community capacity building, infrastructure development, and the establishment of comprehensive and aligned early childhood care, health, and education services.
- 4) Expand and align our data systems so that they can inform early childhood policy and outcomes and support an aligned early childhood workforce development plan.

All four New Mexico Race to the Top goals reflect a commitment to the creation of an early childhood system of systems. New Mexico's plan is based on a strong commitment to create an early care, health and education "system of systems" that integrates and coordinates "siloes" programs that historically have segregated children and left service gaps into a coordinated system. The systems-approach focuses on the development of high-quality, comprehensive, community-based sites with a continuum of integrated services. Achieving these goals and adopting a system of systems approach will require unprecedented coordination, integration, partnerships, and leadership.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

One essential pillar of this work will be further development and implementation of quality approaches and tools. New Mexico has established Program Standards (known as FOCUS Tiered Quality Rating and Improvement System), Early Learning Standards (New Mexico *Early Learning Guidelines*), and Early Childhood Professional Standards (Licensure and Certification Competencies). New Mexico now plans to consolidate these under FOCUS so as to improve practices in all early education, learning and development child serving systems (e.g. child care, Pre-K, home visiting, and early intervention programs). The FOCUS Tiered Quality Rating and Improvement System approach will provide the central organizing framework of the early childhood system reform effort.

Another element essential for reaching the Race to the Top goals is an integrated data system. New Mexico has a clear and specific plan for an early learning data system that: includes a set of “essential data elements”; enables uniform data collection and easy entry of the essential data elements by participating state agencies and programs; and facilitates the exchange of data among participating state agencies by using standard data structures, data formats, and data definitions. Key stakeholders interviewed for this analysis showed great enthusiasm for the development of this integrated data base. These interviews indicated a very high level of state agency cooperation and dedication to completing its development. Other states have created integrated child database (e.g., Rhode Island, Iowa); however, New Mexico’s approach using a unique child identifier and newer technology holds unique and strong promise for its success. Having such an integrated data system will help to support continuous quality improvement, service integration, case management, streamlining service delivery, and otherwise reduce duplication and inefficiencies. The ability to make informed program decisions will be greatly enhanced.

The Race to the Top, Early Learning Challenge grants follow in the tradition of many federal incentive grant programs—they have lofty goals and short term funding. A key recommendation for New Mexico is to sustain investments in the FOCUS Tiered Quality Rating and Improvement System approach and data infrastructure, as well as the other innovative elements of this work. Without planning, evaluation, and sustainable funding, this work will not be translated into long term gains for New Mexico’s children and families.

Early Childhood Investment Zones

Across the nation, communities are coming together to create place-based initiatives, investment zones, Promise Neighborhoods, Best Baby Zones, and other similar initiatives designed to leverage the people power, ideas, and other resources they have to solve complex social challenges. These initiatives are similar in the ways they engage community leaders, seek to apply what works (evidence-based practices), created shared priorities and resources, and foster accountability for results. Many are showing improvement in outcomes for children and their families.

Early Childhood Investment Zones have been established in New Mexico. This strategy for concentrated investment permits the state to identify and prioritize communities where children are at greatest risk based on objective indicators and the community demonstrated the greatest will and capacity for creating continuum of high-quality early childhood programs. This work is intended to model the system of systems approach by transforming disconnected programs into a coordinated system.

The federal home visiting program called for identification of high risk communities in need of home visiting services. Building on this required process, New Mexico developed the Early Childhood

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

Investment Zone Initiative. In 2011-12, the Children, Youth, and Families Department, the Department of Health, and the Public Education Department conducted Early Childhood Investment Zones risk assessments to identify the highest risk counties and school districts in order to measure the level of need for home visitation services, Pre-K programs, and quality child care programs. The assessments used a combination of variables to produce a risk index at each geographical level. (Figure 3 shows an example of a map plotting child abuse and neglect in the Albuquerque area.) Next, geographic areas were ranked and program resources were targeted first on those areas of highest need.

Communities with highest priority are those where children are at greatest risk (based on aggregated measures of social-ecological risk) and where the community demonstrates the greatest will and capacity for creating a continuum of high quality early childhood programs. These communities are considered “ready” to model the Investment Zone approach.

Across the state, 35 school districts have been identified as Early Childhood Investment Zones. Work is currently underway in four communities, with five additional communities in their startup phase. The state supports planning, coordination, and action, giving community leaders and key stakeholders opportunities to work together to prioritize and take action on unmet needs. A results oriented, evidence-based planning model “Getting to Outcomes” is being used. Additional communities will be added over time as these efforts in initial sites mature.

Figure 3. Example of Early Childhood Services Interactive Map.



Early Childhood Investment Zones are a valuable approach in a state such as New Mexico with widely varying local capacity and many underserved areas. One recommendation is to better integrate health into Investment Zone community action and to better use local public health staff and other resources. The Department of Health deploys staff to local areas across the state, with many such staff having the capacity to address early childhood risks and needs. Better integration of local public health also will help to ensure that a full array of interventions to address early childhood risks is adopted at the local level.

Another recommendation is to use collective impact processes and strategies in Early Childhood Investment Zones. Collective impact is the result of having organizations from different sectors agree to solve a specific social problem using a common agenda, aligning their efforts, and using common measures of success. The collective impact process begins by setting a specific goal (e.g., decreasing child maltreatment or infant mortality by 10%), and then builds a network of government agencies, nonprofits organizations, schools, businesses, philanthropists, faith communities, and other community leaders who define common strategies and coordinate integrated activities among them to achieve the goal, over time. The five conditions for collective impact are: 1) a common agenda, 2) shared measurement system, 3) mutually reinforcing activities, 4) continuous communication, and 5) backbone organization support. Influential champions, dedicated resources, and a sense of urgency for change contribute to success. Communities across the country are developing tools for success and demonstrating how the collective impact process can accelerate progress toward achieving results. In the case of New Mexico's Early Childhood Investment Zones, there is potential to develop shared indicators, discuss progress, share resources, and align efforts to strengthen and support families.

In addition, this report recommends that the local coalitions being developed in Early Childhood Investment Zones become a pilot for revitalized Early Childhood Councils. Such councils might also become the backbone organization for collective impact efforts at the local level.

Early Care and Education

As reported by the Legislative Finance Committee, the Legislature increased early childhood funding by 69% between Fiscal Year 12 and Fiscal Year 15 in order to improve New Mexico's educational outcomes and close the "opportunity gap" for children in poverty. Moreover, public and private program leaders have been gathering ideas from across the nation about what works and applying lessons learned in New Mexico.

At the same time developing effective policy and programs in early care and education is challenging. Child care programs are often seen less as education and more as supervision to support parents' ability to work. Competition for educating 4 year olds is great, while services for the most vulnerable infants and toddlers, birth to age 3, are limited. (A recent increase in rates to subsidize infant and toddler services was intended to boost capacity.) Funding, whether from federal, state, or local sources, is limited and often constrains quality. The education and training of the work force varies greatly. Government does not regulate or license all sources of care (e.g., certain family child care homes). Public awareness of the importance of early care and education, starting from birth, lags behind scientific knowledge. Many of the challenges in New Mexico arise from these national trends.

Emphasis on quality is at the heart of improvements in the early care and education system of New Mexico. At the heart of quality are tools such as the New Mexico Early Learning Guidelines, which have been reviewed by several leading national organizations with expertise in early childhood services. The Early Learning Guidelines were developed to be used by early childhood practitioners in their work with children and families, to support children's growth and development birth to Kindergarten, and to serve as a common foundation for delivering services across early care and education programs.

Child Care

The Child Care and Development Fund block grants go to states on a formula basis to be used for child care subsidies to low-income working families, as well as for activities to improve the quality and availability of child care. To receive federal funds, states must meet match and maintenance-of-effort requirements. Consistent with a block grant approach, states have the flexibility to create child care programs and policies that best suit the needs of their populations, that help working parents make informed choices about child care, and that implement each state's health, safety, licensing, and registration standards. States are required, however, to spend a minimum of 4% of funds on initiatives that improve child care quality.

New Mexico has nearly four thousand registered childcare homes and one thousand licensed child care centers and homes. Licensed child care providers must meet basic licensing standards related to health, safety, and training. In addition, licensed providers are graded on a quality scale ranging from two through five stars. The "STARS" Quality Rating Improvement System calls for well-trained staff, appropriate learning activities, fewer children per adult (staff-to-child ratios), safe environments, family involvement, and ongoing assessment of children's progress. As part of the overall effort to improve early childhood systems, the FOCUS Tiered Quality Rating and Improvement System will have increasing impact on child care providers.

In contrast, registered child care homes (limited to no more than four non-resident children) are not required to meet minimal state licensing standards and do not participate in the state's Quality Rating and Improvement System. The Legislative Finance Committee evaluation found that roughly 70% of registered providers participating in the child care assistance program are related to the children for whom they provide care. Registered caregivers must attend six hours of training annually and complete first aid and CPR certification prior to registration. However, U.S. Department of Health and Human Services proposed regulations call for provider training that occurs pre-service to include topics in health, safety, and child development. The essential elements for quality are defined by the Children, Youth, and Families Department, based on research and national norms.

In March 2013, the Children, Youth, and Families Department reported that 19,500 children received child care assistance (subsidies), an estimated 20% of those eligible. About two-thirds of children receiving child care assistance are under the age of five, and 28 percent are preschool age (3-5). Subsidies for the cost of child care are available to all families at or below 150% of the federal poverty level, and families with income at or below 200% of the federal poverty level may remain in the program.

The number of children on waiting lists for child care assistance has been reduced. Still, many have called for guaranteeing eligibility for child care assistance up to 200% of the federal poverty level. This report recommends this as a priority to be implemented in tandem with child care quality activities.

Child care funding comes from three main sources in New Mexico. These are: 1) the federal Child Care and Development Fund, 2) the Temporary Assistance for Needy Families program, and 3) the state general fund. The National Conference of State Legislatures reported that New Mexico was one of 12 states that increased child care funding appropriations in Fiscal Year 2010-2012 and that the highest percentage increases for child care general fund appropriations were in Texas (12.4%) and New Mexico

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

(11.2%). Between Fiscal Year 2011-2013, the New Mexico Legislature increased general fund spending on child care assistance by over 61 percent from \$18.5 million to \$29.8 million.

In Fiscal Year 2013, the Children, Youth, and Families Department spent \$85.7 million overall to administer and subsidize the cost of child care for roughly 20 thousand children per month. In Fiscal Year 2014, the Children, Youth, and Families Department is expected to spend \$95 million total on child care assistance.

New Mexico has rightly placed emphasis on child care quality. While parents have the greatest influence on children's growth and development, the quality of child care matters. Researchers at the National Institutes of Health and others have found that young children participating in higher quality child care had better language and cognitive development during the first 4 ½ years of life. Moreover, those who participate in high quality child care as young children have higher academic achievement and fewer behavior problems as adolescents.

Questions have been raised about the extent to which past child care quality improvement efforts have had sufficient impact to improve children's educational outcomes (e.g., third grade math and reading standardized test scores). An evaluative report prepared by the Legislative Finance Committee in September 2013 concluded that the goals of child care subsidies were traditionally to enable the working poor to hold down jobs and to help low-income parents attend school so they could get good jobs, rather than to provide quality early care and education. The two goals — serving as many working parents as possible and educating children in a high-quality setting — can come into conflict as state agencies struggle to reach the maximum number of children with child care subsidies.

As discussed above, implementing FOCUS, a revised and improved Tiered Quality Rating and Improvement System, is a high priority for New Mexico. Phase One of FOCUS was launched in January, 2013. Training, local program recruitment and validation efforts are underway. Adaptation of FOCUS for home visiting and early intervention services is also ongoing. The pace of implementation, however, has been slower than originally planned. This report recommends acceleration of FOCUS implementation and incorporation of all child care programs by 2016.

The Legislative Finance Committee has recommended that a "Child Care Accountability Act" be adopted, and a variety of child serving organizations and child advocates have echoed this recommendation. A working group has been convened, including Children, Youth, and Families Department staff, New Mexico First, the Early Childhood Development Partnership, and other stakeholders, providers, and policymakers. Goals for such legislation have been described by a variety of stakeholders and would aim to: 1) increase access to high-quality child care for low- and moderate- income families 2) increase the proportion of low-income children in high quality child care, 3) adopt new approaches to provider payment rates, methods, and quality requirements, 4) define income eligibility with priority for low-income families, 5) increase the proportion of child care providers who accept child care assistance, and 6) advance quality rating and related initiatives. New Mexico has an important opportunity to link child care funding to performance in relationship to quality standards (e.g., child-to-caregiver ratios, staff qualifications, health and safety). This report also recommends adoption of such policies through legislation or regulatory action.

Pre-Kindergarten (Pre-K)

Research has shown that high quality Pre-Kindergarten (Pre-K) services can reduce disparities in school readiness for disadvantaged preschool age children, narrow early achievement gaps, and improve academic performance in school.

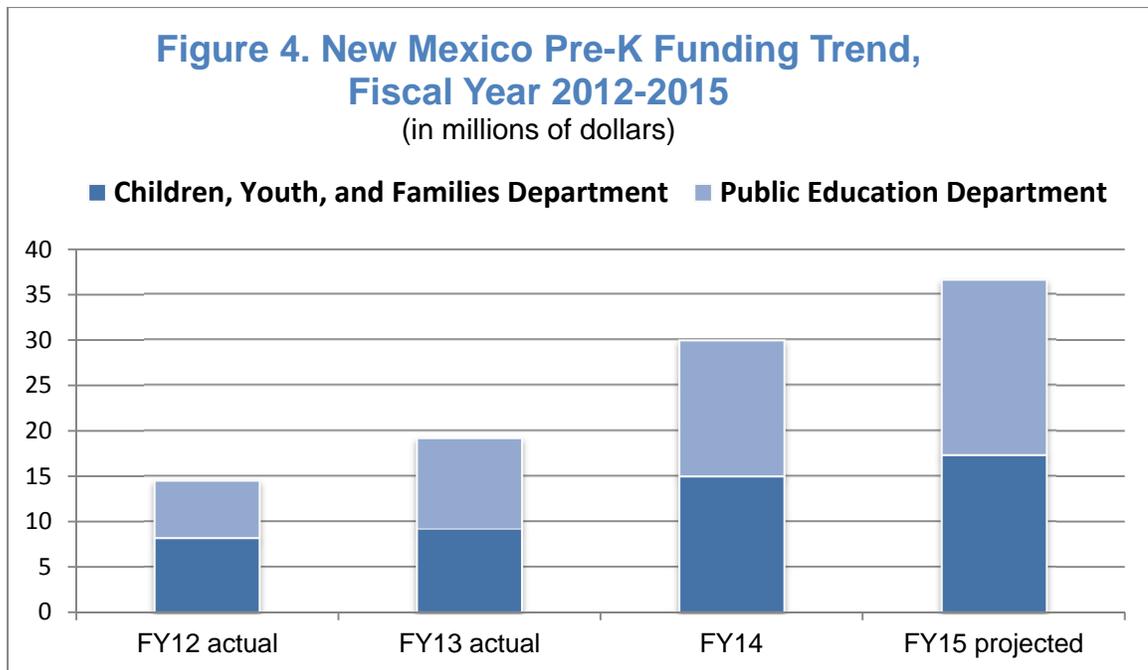
During the 2005 legislative session, the New Mexico legislature passed the New Mexico Pre-Kindergarten Act (Children's Code, Article 23, Sections 32A-23-18 NMSA 1978) and provided funding to develop and implement a voluntary Pre-K program for 4-year-old children in New Mexico. The Act calls for the Children, Youth, and Families Department and Public Education Department to cooperate in development and implementation of a Pre-K program, including promulgating rules, monitoring contracts, and reporting to the governor and legislature.

New Mexico Pre-K is a voluntary, public preschool program jointly administered by the Children, Youth, and Families Department and Public Education Department. In school year 2013-14, New Mexico Pre-K served more than 5,000 four year olds in school year 2012-13. In that year, the Public Education Department contracted with 28 school districts and charter schools and the Children, Youth, and Families Department contracted with 39 community-based providers (e.g., child care programs, Head Start agencies, municipalities, universities).

The purposes of New Mexico Pre-K are to: 1) increase statewide access to voluntary high quality early childhood programs; 2) prioritize the enrollment of children without access to high quality programs, 3) provide developmentally appropriate early learning activities, 4) focus on school readiness; 5) expand early childhood education community capacity; 6) support linguistically and culturally appropriate curriculum, and 7) provide Pre-K programs based on the comprehensive framework as described in the *New Mexico Pre-K Program Standards*.

The standards focus, along with development and implementation of the New Mexico Early Learning Guidelines helps to ensure Pre-K programs are promoting skills development across all five domains of child development (i.e., cognitive development and general knowledge, physical well-being and motor development, social emotional development, language and literacy development, and approaches to learning). In addition, the Early Learning Guidelines provide the platform for assessing practice and quality.

New Mexico Pre-K is targeted to serve children in communities in which at least two thirds of children live in a Title 1 elementary school attendance zone (i.e., those in which at least 40% of children qualify for free or reduced price school lunch). This effectively targets Pre-K funding to children living in low income communities where such services are likely to have greatest impact.



Source: Legislative Finance Committee

Figure 4 shows the funding trend for New Mexico Pre-K since Fiscal Year 2012. The commitment of public resources to the goals of Pre-K is visible in this trend with increased funding. The National Conference of State Legislatures reports that New Mexico was one of 10 states that increased Pre-K funding in recent years. In Fiscal Year 2012-13, for example, New Mexico had the second highest percent funding increase (33.5%), dedicating \$4.4 million to increase slots for state Pre-K program. This represents rapid growth and implementation of the program.

New Mexico has an opportunity to further extend its Pre-K services through coordination of resources at the local level. Early Childhood Investment Zones (see discussion above) are one important strategy for achieving greater coordination and impact at the local level. Interviews conducted for this analysis indicate that more could be done to reduce competition and duplication of services. The Children, Youth, and Families Department and Public Education Department should jointly design and oversee a community level (or county level) planning process to examine service capacity for four year olds, maximizing Pre-K, Head Start, child care, and other early care and education sites. Such a process holds the potential to reduce duplication of services, ensure quality services are available in all communities, and assist the departments in awarding contracts in a coordinated manner.

K-3 Plus

The purpose of New Mexico’s K-3 Plus is to provide increased instructional time to narrow the achievement gap and raise test scores for disadvantage students. In 2007, House Bill 198 established K-3Plus, a pilot project to permit schools with high numbers of disadvantaged students to expand the school year by 25 days for the kindergarten through third grade (K-3). In 2012, based on successful results,

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

House Bill 14 converted the pilot program to a program authority administered by the Public Education Department. The program is not remedial education, rather extra hours in the school day for students to have increased hours of high quality instructional time.

Currently the program targets students at risk for low performance through a requirement that funded schools have 80% or more students eligible for free or reduced-price lunch or that are a D or F school under the A-F school grading system on quality. Participating students are more likely to have low income (as indicated by eligibility for free or reduced-price lunch), to have been retained at least one grade, and/or to be Hispanic, Native American, and/or English language learners. The approach also takes into account special education Individualized Education Programs and the state's Response to Intervention framework.

Increased state appropriations permitted participation of an expanded number of schools since 2012. More than 7,000 students were served in 74 schools during the summer of 2012 alone.

The opportunity for New Mexico is to continue the evaluation and monitoring of K-3 Plus, which has shown results, including positive effects on third grade reading, writing, and math. The program also was found by Utah State University to have cost benefit.

Head Start and Early Head Start

Head Start is a national program which provides comprehensive developmental services for America's low-income, preschool children and social services for their families. Established in 1965, Head Start promotes school readiness for children, ages three to five, by offering educational, nutritional, health, social and other services. Head Start programs promote school readiness by educating children and by actively engaging parents in their children's learning, as well as assisting parents in making progress toward their own educational, literacy and employment goals.

The federally administered Head Start program in New Mexico serves approximately 10,000 children per year. New Mexico has 16 regional and 16 tribal Head Start/Early Head Start programs, as well as two Migrant/Seasonal Centers that are open part of the year. Only three of New Mexico's 33 counties do not have a Head Start Center (Catron, Harding, and Los Alamos).

Reports suggest that New Mexico's Head Start providers are not consistently meeting federal performance standards or quality benchmarks. For example, most New Mexico Head Start programs do not meet the federal regulation that half of Head Start teachers have a bachelor's degree or higher in early childhood education. Such findings point to a potential positive for greater state involvement and oversight, as well as further integration with Pre-K efforts. Taking steps to align the Head Start Child Development/Early Learning Framework with the New Mexico Early Learning Guidelines is one example of a proactive approach.

The expansion of Pre-K programs in New Mexico had a documented impact on Head Start programs. As noted by the Legislative Finance Committee: "Although Head Start is the largest public preschool program in New Mexico, many agencies have little collaboration with child care providers, school districts or Pre-K sites." The Legislative Finance Committee further concluded that: "A lack of Head Start cooperation and coordination results in inefficient resource allocation and potentially hinders school

readiness.” Unnecessary competition and limited coordination between Head Start and Pre-K providers resulted in a loss of federal Head Start funds and loss of early care and education capacity for communities in New Mexico.

Greater collaboration and integration of Head Start into a system of public preschool education is imperative for New Mexico in order to reduce duplication of effort, maximize available funding, and ensure that all families have access to appropriate early care and education. Federal law calls for these Head Start State Collaboration Offices to encourage Head Start agencies to collaborate with entities involved in state and local planning processes, with a variety of responsibilities including engagement in innovative collaborative initiatives for training and professional development. This is one approach used by other states. For example, states have developed projects that coordinate with child care and Pre-K programs, grants to support multi-agency partnerships, and agreements with Pre-K or child care sites to identify roles and responsibilities for coordination and collaboration. Without a change in federal authority, the state could increase oversight and collaboration through the New Mexico Head Start Collaboration Office.

Another approach used by other states to improve the quality, coordination, and availability of Head Start is to supplement federal funds with state dollars. Previously, New Mexico appropriated supplemental state funds for Head Start and Early Head Start (e.g., more than \$1 million in Fiscal Year 2007, 2008, and 2009); however, no such funding is currently available. Given the substantial investment in Pre-K programs, it seems unlikely that New Mexico would seek to use state general funds to supplement Head Start for preschool age children.

Since 1995 Early Head Start has provided child and family development services for low-income infants, toddlers, pregnant women and their families. Early Head Start programs enhance children's health and development and support parent's efforts to fulfill their parental roles and to help parents move toward self-sufficiency. Early Head Start has three distinct program options: 1) center-based, 2) home-based, and 3) family child care. Most Early Head Start participants in New Mexico are served in center-based program sites.

Given the positive results from past evaluations, home-based Early Head Start is one of the evidence-based home visiting program models qualifying for federal the Maternal, Infant, and Early Childhood Home Visiting program funding. New Mexico serves only a small proportion of children in home-based Early Head Start, however, and currently does not use the Maternal, Infant, and Early Childhood Home Visiting program funds for this purpose. While this is an opportunity in New Mexico, it would require substantial program growth given the low level of existing capacity for home-based Early Head Start.

The Early Head Start program option designed to support partnerships with family child care homes can expand capacity and enhance quality of early care and education for the youngest children, as well as maximize federal and state funding. Evaluation of these efforts suggests that success requires planning, strong partnerships, alignment of standards, staff training, and use of quality rating systems. Federal law permits braiding child care subsidies and Early Head Start funding, so long as eligibility rules are met and there is no duplicate payment for the same service. Some states have demonstrated how to use quality standards and braided financing to improve infant-toddler care (e.g., Oregon, West Virginia). This is an opportunity for New Mexico to increase the availability and quality of family child care homes and Early Head Start for infants and toddlers.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

Building on efforts under the Race to the Top, Early Learning Challenge grant, New Mexico has an opportunity to improve partnerships and collaboration among additional early childhood programs. For example, the state might enhance the involvement of Head Start and Early Head Start in early childhood training activities, home visiting system development, and Early Childhood Investment Zones. A strong recommendation is to integrate Head Start and Early Head Start into the ongoing early childhood education system to the maximum extent possible. Other states have achieved this, and now is the time for New Mexico to make progress in this area, regardless of the direct federal funding and oversight authority.

Early Care and Education Workforce Development

The early care and education workforce has wide variations in training, credentials, and content knowledge. Assuring quality requires an appropriate workforce. New Mexico has made a commitment to improving the quality of early care and education staff. This work is underway through a number of initiatives and programs.

For example, in 2011, New Mexico reconfigured and consolidated its Early Childhood Training and Technical Assistance Programs from eight programs to four programs that will provide statewide services to Early Learning and Development Programs. As a result, \$1 million of state funding and \$250,000 from the W.K. Kellogg Foundation were applied to accelerate implementation of the FOCUS Tiered Quality Rating and Improvement System implementation, with emphasis on cross-sector and interdisciplinary training.

The New Mexico Professional Development Initiative, operated by the Children, Youth, and Families Department, Office of Child Development, supports a legislative mandate to articulate and implement training and licensure requirements for individuals working in all recognized early care and education settings with children from birth to age eight. This includes all those working in home-based and center-based child care programs, Head Start, home visiting programs, public school programs for children in preschool through third grade, as well as early intervention programs for children with or at risk for special needs and their families. The initiative defines career pathways, from the foundational level of an associate degree through more advanced education and degrees, for early childhood educators (serving ages birth-4 and 3-8), infants and toddler specialists, and program administrators. Core competencies and common core content ground these efforts.

New Mexico is one of 21 states that offer T.E.A.C.H.® scholarships through a national program operated by Child Care Services Association in Chapel Hill, North Carolina. The New Mexico T.E.A.C.H. scholarship program (operated by the New Mexico Association for the Education of Young Children) provides tuition assistance to early childhood professionals pursuing college degrees in early childhood education and financial incentives for successful completion of academic programs. T.E.A.C.H. scholars come from child care, Head Start, Pre-K, special education, and Kindergarten programs. Funding for T.E.A.C.H. comes from a combination of the Children, Youth, and Families Department, Public Education Department, local funding, state general revenues, and private philanthropy. The budget was cut dramatically in 2010-11; however, T.E.A.C.H. received a \$300,000 funding increase in Fiscal Year 2015.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

New Mexico leaders envision and are aiming for a universal, fully-articulated professional development system to produce and support a high-quality early childhood workforce. Continued investment in workforce development should be a priority in New Mexico. The quality of early care and education depends upon having a well-trained workforce. Moreover, the field of early care and education offers job opportunities for many low-income mothers returning to work, as well as others in search of community-based employment with a career ladder.

Home Visiting

New Mexico has a long history of providing home visiting services to families with young children and a large array of programs in operation. On April 2, 2013, Governor Martinez signed Senate Bill 365, the Home Visiting Accountability Act into law, granting statutory authority to the Children, Youth, and Families Department for establishment of a statewide system of home visiting services. The law defines home visiting as a program strategy that delivers a variety of information, educational, developmental, referral and other support services to promote child well-being and prevent adverse childhood experiences. Particular strengths of the Home Visiting Accountability Act include its standards-based approach, cross-cutting goals, and annual outcomes report requirement. This law and a decade of work by New Mexico leaders that preceded it, position the state as a top leader in home visiting accountability and system development.

New Mexico has adopted a standards-based approach and is considered a national model for advancing this approach. The nine overarching standards are: program participation, relationship-based practice, culturally competent practice, family and child goal setting, program management, staff qualifications, curriculum and service delivery, community engagement, and data management. Equally important is the commitment of the Children, Youth, and Families Department to consistent quality in home visiting services. For example, home visiting programs in New Mexico are using standardized and objective screening tools with a majority of clients (e.g., Ages & Stages Questionnaire, Ages & Stages Questionnaire: Social Emotional, Woman Abuse Screening Tool, and Edinburgh Postnatal Depression Scale).

Since Fiscal Year 2006, funding for home visiting has increased from \$500,000 for a small pilot program to \$8.5 million in state and federal funds in Fiscal Year 2014. These funds are used to support direct services and infrastructure and administrative costs (e.g., professional development, data system development). In Fiscal Year 2013, the Children, Youth, and Families Department received \$5.9 million in state and federal funds. These funds support 24 home visiting programs with the capacity to provide openings and services to approximately 1,000 families at any one time and approximately 2,000 families over a year.

The National Conference of State Legislatures reports that 21 states—including New Mexico—increased general fund state appropriations for home visiting between Fiscal Year 2012 and 2013. New Mexico also was one of the five states with largest federal grant increases. Across the nation states also tapped into other federal funding sources for home visiting programs. Iowa, Florida and Louisiana increased Temporary Assistance for Needy Families allocations for home visiting, while Louisiana and Michigan increased Medicaid expenditures for home visiting. Louisiana and Tennessee also dedicated more Title V

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

Maternal and Child Health Services Block Grant funds. The potential for New Mexico to use Medicaid financing for home visiting is discussed below in the section regarding Medicaid.

The University of New Mexico Center for Education Policy Research reports that the average cost per client served in state funded programs was \$2,998, and the average cost per client served in federally funded Maternal, Infant, and Early Childhood Home Visiting program sites was \$5,614. The difference reflects contract approach; that is, the state contracts with agencies to provide home visiting services for \$3,000 per client, while the Maternal, Infant, and Early Childhood Home Visiting program federal funds are used for contracts based on actual costs.

In Fiscal Year 2013, the Children, Youth, and Families Department contracted with 20 home visiting providers funded by state general funds and by federal the Maternal, Infant, and Early Childhood Home Visiting program funds, operating in 22 of the state's 33 counties. Home visiting programs are also operated by approximately 42 other providers supported by federal, municipal, and district resources in 16 counties. In addition, private funders, including St. Joseph Community Foundation and Kellogg Foundation, support home visiting sites in a number counties. An estimated 24 of the total home visiting sites provide services to Native American families in 8 counties.

Table 2. The Cost Benefit of Home Visiting Programs for Prevention of Child Maltreatment in New Mexico

Selected Evidence-Based Programs	Benefits/Cost Ratio
Nurse Family Partnership (NFP)	\$9.70
Parent-Child Home Program	\$0.53
Parents As Teachers (PAT)	\$1.54
Triple P Positive Parenting Program (all levels)	\$9.28
Other Home Visiting Programs	\$1.49

Source: Legislative Finance Committee. *Results First: Evidence-Based Options to Improve Outcomes*. April 2014.

Home visiting programs may be implementing national evidence-based models approved under federal rules for the Maternal, Infant, and Early Childhood Home Visiting program, research-based home visiting curricula, or a mixed service delivery model. New Mexico home visiting providers offer an array of program approaches to serve families with varied needs. Some are designed to serve families having their first child, beginning with first time pregnant women (e.g., Nurse Family Partnership, First Born), while others reach families with one or more young children to improve parenting skills and reduce risks of child maltreatment (e.g., Triple P Positive Parenting Program). Some focus more on toddlers and preschoolers to promote school readiness (e.g., Parent-Child Home Program, Parents As Teachers). In sum, while most home visiting models and programs have multiple goals, they vary in emphasis and are not “one size fits all” approaches.

Some stakeholders have proposed that New Mexico use a more universal approach, with contact, screen and offer services to all first time expectant women and new parents regardless of family income or risk factors, with more targeted and intensive services offered and provided to those families with the greatest

need. A universal home visiting approach with a targeted follow up program would help to ensure that more families receive services they need. However, to use a universal approach for first time parents would require a substantial upfront investment and different staff and outreach approaches. It also might miss families at high-risk who have other children, for whom evidence-based programs have been shown to reduce child abuse, improve health, and promote good parenting practices. This report recommends that New Mexico use existing resources to reach those at higher risk, including first born and others, particularly families with identified risks for child abuse and neglect and inadequate parenting skills and supports.

Health and Developmental Services for Young Children

Medicaid

General health services

Medicaid is an important source of health coverage for low income children and families. The Early and Periodic Screening, Diagnostic and Treatment benefit is the child health component of Medicaid. Federal statutes and regulations specify that children under age 21 who are enrolled in Medicaid are entitled to the Early and Periodic Screening, Diagnostic and Treatment benefit and that States must cover a broad array of preventive and treatment services, including medical, dental, developmental, and mental health services. Unlike private insurance, the Early and Periodic Screening, Diagnostic and Treatment benefit is designed to address problems early, ameliorate conditions, and intervene as early as possible. The design of the Early and Periodic Screening, Diagnostic and Treatment benefit encompasses the 1967 vision of President Johnson and the Congress in order "to discover, as early as possible, the ills that handicap our children" and to provide "continuing follow up and treatment so that handicaps do not go neglected."

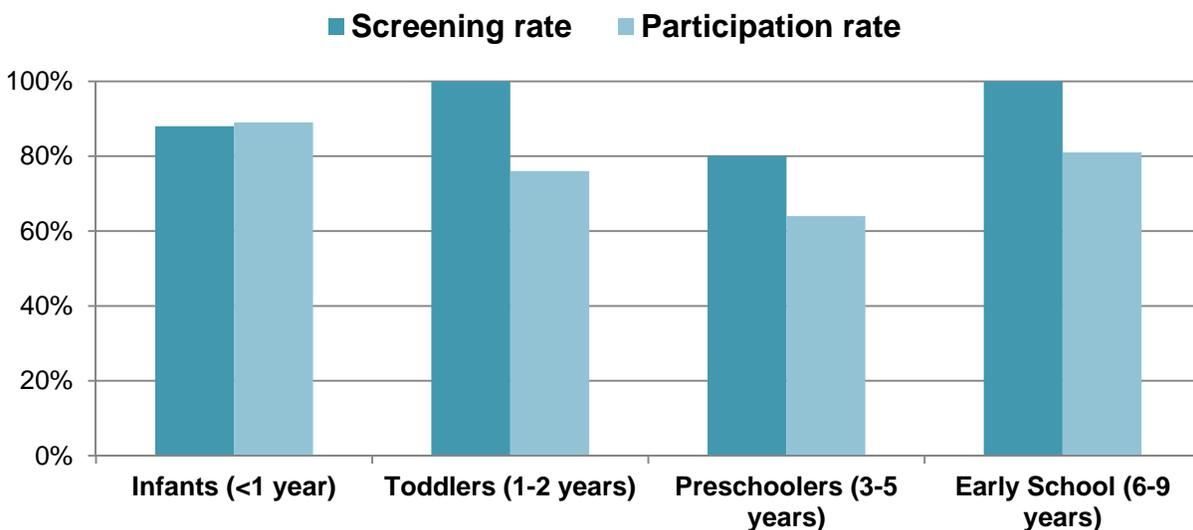
As a result of the Early and Periodic Screening, Diagnostic and Treatment benefit in Medicaid, poor children's access to health care is similar to that of non-poor, privately insured children and child Medicaid beneficiaries use care in approximately the same pattern as their privately insured counterparts. Moreover, spending per child is low compared with working-age adults and seniors covered by Medicaid.

New Mexico launched its new Medicaid managed care program, Centennial Care, in January 2014. As administered by the New Mexico Human Services Department, Centennial Care offers opportunities to promote and protect the health of young children. Over the past two decades, many states have adapted managed care approaches to fulfill the requirements of the Early and Periodic Screening, Diagnostic and Treatment benefit and improve child health, and New Mexico has applied lessons learned.

New Mexico reports annually to the Centers for Medicare and Medicaid Services, U.S. Department of Human Services regarding the number of children who receive comprehensive well child visits (known as Early and Periodic Screening, Diagnostic and Treatment screens). In Federal Fiscal Year 2013, prior to expansion of Medicaid or adoption of Centennial Care, 210,198 young children birth through age 9 were eligible for the Early and Periodic Screening, Diagnostic and Treatment preventive, diagnostic, and treatment services. This included more than 19,000 infants, 41,000 toddlers, 65,000 preschoolers, and 83,000 children in the early school years. Figure 5 shows the Early and Periodic Screening, Diagnostic and Treatment well child screening visit rates for Federal Fiscal Year 2013. The well child screening rate

reflects the number of children eligible for a screening visit, adjusted for the expected rate of visits and the duration of participation. The participation rate is the number of eligible children who received at least one Early and Periodic Screening, Diagnostic and Treatment screening visit. For example, the state periodic visit schedule for New Mexico calls for 2 visits per year for toddlers, which is reflected in the screening rate. At the same time, only 76% of toddlers had at least one visit in a given year, as shown in the participation rate. Some populations need enhanced focus in terms of Early and Periodic Screening, Diagnostic and Treatment screening visits. For example, the Protective Services Division of the Children, Youth, and Families Department has set an objective to increase the percentage of children who have Early and Periodic Screening, Diagnostic and Treatment comprehensive, well child screening visits completed within 30 days of being taken into state custody.

Figure 5. New Mexico Early and Periodic Screening, Diagnostic and Treatment Rates for Children Birth to 9 Years, Federal Fiscal Year 2013



Source: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Early and Periodic Screening, Diagnostic and Treatment 416 Data Report for New Mexico.

Data on Medicaid dental screening and treatment services delivered to children in New Mexico do not show a strong pattern of performance. This despite national recommendations to begin preventive and other dental services at age one.

Measures from the Healthcare Effectiveness Data and Information Set (generally known as HEDIS) are used by 90% of U.S. health plans to measure performance and quality. New Mexico's HEDIS data also indicate a need for progress in Medicaid well child visit rates. The set has multiple child health indicators, including well child care visits for first 15 months, well child visits in the third, fourth, fifth,

and sixth year of life, and childhood immunization status. These data are reported by each Centennial Care health plan.

In Federal Fiscal Year 2013, 85% of young children (birth through 9) were enrolled in managed care. For these children, the contractual requirements in the agreements between Human Services Department and the participating managed care organizations allow for a substantial impact on the care and services children receive. The Early and Periodic Screening, Diagnostic and Treatment section of the New Mexico Medicaid managed care contracts reflects federal law, requiring that plans provide: periodic comprehensive screening and diagnostic services to determine physical and behavioral health needs as well as the provision of all “Medically Necessary Services” defined under federal law (i.e., listed in section 1905(a) of the Social Security Act) even if the service is not available under the State’s Medicaid plan.

Going beyond basic federal law requirements, New Mexico has identified a set of activities proposed to reward Centennial Care members with incentives to promote good health and healthy behaviors. This includes, but is not limited to, the following: (a) compliance with scheduled medical well-child visits (Early and Periodic Screening, Diagnostic and Treatment); (b) compliance with scheduled dental exams for children; (c) compliance with scheduled office visits with the assigned medical home or primary care provider; (d) participation in weight loss programs; (e) participation in programs to support blood pressure control; (f) participation in smoking cessation programs; (g) participation in health literacy classes; (h) making and keeping appointments; (i) compliance with care plans; and (j) compliance with prenatal visits and care plans. Medicaid provider training and outreach is another obligation under Medicaid managed care contracts in New Mexico.

New Mexico also has an opportunity, under recent changes in federal law, to maximize use of community health workers, including promotoras, doulas, lactation consultants, and others. Community health workers can facilitate access to care, provide health education, and deliver preventive services. Some states defined standards, training requirements, or other characteristics of community health workers (e.g., Minnesota). New Mexico has a history of using community health workers in the context of managed care and can do more with new federal flexibility and managed care organization partners.

Treatment Services

Federal statutes and regulations specify that children under age 21 who are enrolled in Medicaid are entitled to Early and Periodic Screening, Diagnostic and Treatment benefits and States must cover a broad array of treatment services. All types of conditions—medical, mental, developmental, acute, and chronic—must be treated, including conditions not newly discovered or those detected outside of an Early and Periodic Screening, Diagnostic and Treatment comprehensive well-child screening visit. Moreover, for the Early and Periodic Screening, Diagnostic and Treatment benefit, the medical necessity standard used to approve services must assure a level of coverage sufficient not only to treat an existing illness or injury but also to prevent the development or worsening of conditions, illnesses, and disabilities.

Many State Medicaid agencies are working to improve access to treatment services using a variety of strategies. New Mexico has opportunities to use Medicaid treatment coverage to enhance early childhood services and ensure that children have access to the broad array of covered treatment services. One particular opportunity through Centennial Care is to provide access to robust care coordination as determined through a comprehensive needs assessment process. Children in Centennial Care who have

more complex needs, are assigned to a higher level of care coordination. Some key requirements within this higher level of coordination include development of a comprehensive care plan; visits to the home and more frequent telephonic contact.

Also key is to inform both providers and families about the range of services covered, through printed, online, and other informing approaches. Most states and health plans place strong emphasis on communicating the importance of Early and Periodic Screening, Diagnostic and Treatment well-child screening visits. Informing related to treatment services often receives less attention.

Within New Mexico Centennial Care the managed care contracting organizations have incentives to identify when children are in one of three tiers of need. Tier I includes those generally in good health who need little in the way of treatment interventions, Tier II is those requiring early intervention and more treatment, and Tier III is those who require the most intervention. This is consistent with the way many plans and agencies are organizing services. (See Figure 6 below).

Through the Early and Periodic Screening, Diagnostic and Treatment benefit, New Mexico also can use effective treatment. For example, New Mexico could clarify Medicaid rules to cover parent-child therapy for younger children. No federal law prohibits state Medicaid programs from financing so-called “family therapy” for a child at risk for or diagnosed with a mental or behavioral health condition. Coverage of parent-child treatment in the case of children younger than age 6 makes sense in clinical terms. Experience since 1999 in Florida, through an Infant Mental Health Pilot Project and subsequent implementation or revised guidelines, indicates that Medicaid financing for parent-child therapy in the case of very young children is both clinically appropriate and fiscally feasible. Florida made a simple change to the service description from “individual therapy” to “individual and family therapy”. The evidence for dyadic, parent-child therapy and favorable cost-benefits supported this change.

Based on the Florida Strategic Plan for Infant Mental Health, the Florida Agency for Health Care Administration (i.e., Medicaid) now encourages use of DC:0-3R (originally known as the Zero to Three Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood) as a diagnostic classification system for early childhood mental health services delivered to infants and toddlers. In Wisconsin, work on early childhood mental health needs led to Medicaid adoption of DC:0-3R. No additional funding was needed to develop a crosswalk to the ICD-9 and/or ICD-10 codes and to use these more appropriate diagnostic codes for young children. The recommendation is for New Mexico to adopt DC:0-3R.

Eligibility and Enrollment

Facilitating completion of Medicaid enrollment for newborns and infants is an important way to get the first year off to a good start in terms of health. Federal law requires automatic enrollment into Medicaid for infants with a Medicaid-financed birth. States have used a variety of mechanisms to fulfill this mandate. The Centennial Care contracts have mechanisms to ensure that newborns have continuous coverage. For example, the contracts require that when a child is born to a mother enrolled in Centennial Care, the hospital or other provider completes a “Notification of Birth-MAD Form 313” (from the Medical Assistance Division of the New Mexico Human Services Department) prior to or at the time of discharge from the birthing facility. Human Services Department then expedites eligibility determinations to ensure that the process commences immediately and the newborn is enrolled into his or her mother’s managed care organization.

Federal Medicaid also requires continuous eligibility through the first year of life for Medicaid eligible newborns. Centennial Care contracts require and provide administrative mechanisms for coverage to Medicaid eligible newborns, as well as for Medicaid-eligible infants born to mothers with coverage in the New Mexico Health Insurance Exchange.

Streamlining enrollment for toddlers and preschoolers, as well as other children and adolescents, is equally important. Responding to guidance from the Centers for Medicare and Medicaid Services (May 17, 2013) and options for greater flexibility in enrollment methods, some states are employing a new approach for facilitating Medicaid enrollment of eligible individuals to conduct an “administrative transfer” to Medicaid while they complete implementation of their eligibility and enrollment systems. This method uses Supplemental Nutritional Assistance Program income information that states already have to identify individuals who are likely eligible for Medicaid and the Children’s Health Insurance Program. The Centers for Medicare and Medicaid Services reports that as of the end of April 2014, five states (Arkansas, California, Illinois, Oregon, and West Virginia) had implemented this strategy and more than 500,000 individuals (about half from California) have been determined eligible for Medicaid or the Children’s Health Insurance Program as a result of this new authority. This is one type of “express lane” enrollment. New Mexico has an opportunity to adopt this approach for streamlining and accelerate eligibility determinations using Supplemental Nutritional Assistance Program income information. Some states use Head Start enrollment information in a similar fashion.

The recommendation is for New Mexico to use additional strategies for outreach for enrollment, streamlined enrollment and recertification processes, and express-lane enrollment. New policies and practices could help to reach the thousands of children eligible but not enrolled in Medicaid.

Assuring Quality

Across the country, Medicaid managed care contracts call for quality improvement efforts and performance improvement projects. Among the minimum requirements for New Mexico managed care contractors is to have a performance improvement projects for services to children and a performance improvement projects focused on Early and Periodic Screening, Diagnostic and Treatment. In addition, contractors must report using HEDIS measures, which include well child and other pediatric measures (see above). Continuing to hold Medicaid managed care organizations accountable for reporting on children’s utilization and outcomes is important for New Mexico and every state.

Home visiting as an option in Medicaid

In New Mexico, some key stakeholders have promoted the idea of using of Medicaid to finance home visiting programs. While not currently under consideration by the Children, Youth, and Families Department for the programs it administers, it is an opportunity for New Mexico. To do so would require collaboration between the Human Services Department and the Children, Youth, and Families Department.

This is an option used in at least 15 states. This count includes states that fund at least one home visiting program/model (e.g., Nurse-Family Partnership, Children First, Healthy Families America, and a variety of state-based programs). It also includes states that extensively use managed care arrangements. This group does not reflect the more than 30 states that finance prenatal and infant Medicaid case management similar to New Mexico’s Families FIRST program (see discussion below).

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

Three primary mechanisms are most often used by states to extend Medicaid financing in home visiting programs. These mechanisms may be used through fee-for-service or managed care contract arrangements. Medicaid may pay for all or a portion of a home visit, and states use varying procedure codes to reflect their approach.

1. *Targeted case management* – Also known as medical assistance case management, this benefit includes assessment, development of care plans, referrals, and monitoring/follow-up for Medicaid enrollees. States may specify targeted groups to receive targeted case management in a state plan amendment to the Centers for Medicare and Medicaid Services. This is the most often used mechanisms for Medicaid financing of home visiting services. The Federal Medical Assistance Percentage matching rate is received for this benefit (69.2% in New Mexico in Federal Fiscal Year 2014).
2. *Administrative case management* – This benefit is intended to help Medicaid beneficiaries gain access to medical and related services. It may include eligibility determinations, outreach, coordination of transportation benefits, and assistance with securing authorizations for needed services. The federal matching rate is the administrative rate of 50%.
3. *Traditional medical assistance services* – Medical assistance can include a wide array of services, including home visiting as an optional service. No state plan amendment is needed for offering services in the home; however, it must be offered by an enrolled Medicaid provider. Typically, it is offered as a preventive service benefit. A subset of this category is enhanced prenatal benefits; optional services which states may provide based on a state plan amendment. The Federal Medical Assistance Percentage matching rate (69.2%) is used for this approach.

Families FIRST

New Mexico, as many states, has integrated public health and Medicaid resources to support a maternal-infant case management program known as Families FIRST which provides voluntary home visits, health education, needs assessment, care plans and more to pregnant women and children birth to three years in Medicaid. A primary purpose of these services is to assist clients in gaining access to medical, social and educational services that are necessary to foster positive pregnancy outcomes and promote health and development among young children. Families FIRST began statewide expansion in July 1998 through a network of providers comprised of Department of Health Local Public Health Offices and private community health agencies. In the transition to Centennial Care, some Medicaid managed care organizations are continuing this work.

Continuing Families FIRST or a similar pregnancy-related case management service should be a priority for the state. Fostering positive pregnancy outcomes and improving infant health is still a pressing need in New Mexico. Across the nation, such programs have shown benefit in the context of managed care or as a fee-for-service benefit. Adequate contracts, payment rates, and training for case management staff are keys to success.

Another opportunity is to foster partnerships and integration of Families FIRST with home visiting programs. The activities are distinct but have substantial overlap in target groups, purposes, and potential

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

impact. By assuring effective linkages, referrals, and continuity for families, Families FIRST and home visiting programs can optimize impact and outcomes.

In addition, New Mexico has an opportunity to extend Families FIRST as a strategy to promote interconception care. Focused on women with prior adverse outcomes, interconception care (also known as interpregnancy care) refers to services provided following the end of a pregnancy, typically for 18-24 months, to address risks for subsequent childbearing and reduce the impact of chronic conditions on women's health. For example, diabetes, hypertension, sexually transmitted diseases, obesity, smoking, heavy alcohol use, and depression all affect a woman's long term health and increase the risk of infants being born too small, too soon, or very sick. Moreover, the single best predictor for having a preterm birth is having had a prior preterm birth. A number of research projects (e.g., Atlanta, GA; Maricopa County AZ; Chicago, IL) have shown promising results in using interconception care. In Medicaid, Georgia and Louisiana have implemented interpregnancy/interconception care demonstration waiver projects, and other states are extending interconception case management without a waiver.

Childhood Immunization

Childhood immunizations save millions of lives each year. Childhood vaccines are highly effective, safe, and cost-effective. The Centers for Disease Control and Prevention estimates that every dollar spent on immunizations saves \$6.30 in direct medical costs. Success in reducing and eliminating vaccine preventable diseases depends on public-private partnerships involving researchers, policy makers, vaccine manufacturers, health professionals who administer vaccines, and, of course, families who participate in immunization programs.

Federal policy supports our childhood immunization system through the National Immunization Program at the Centers for Disease Control and Prevention, whose responsibilities include program support to states, and the Vaccines for Children program. The Vaccines for Children program makes available those vaccines recommended by the Advisory Committee on Immunization Practices. Through the Vaccines for Children program, the Centers for Disease Control and Prevention bulk purchases vaccines at a discount and distributes them to states, who in turn distribute vaccines to private physicians and public health clinics. The Vaccines for Children program ensures that recommended vaccines are available at no cost for children who are uninsured, in Medicaid, Native American, or underinsured and served at federal qualified health centers and similar clinics. The program reduces barriers related to the cost of vaccine. Moreover, while physicians can set a fee for administration of the vaccine, families who cannot afford the fee must be excused. New Mexico has a robust Vaccines for Children program involving a wide range of pediatric health care providers.

The New Mexico Statewide Immunization Information System is part of a nationwide system of registries used by states and providers to track doses of vaccine, monitor coverage rates, and provide information for management and quality improvement. Under current the Centers for Disease Control and Prevention regulations, all Vaccines for Children providers must use this system to account for doses of program purchased vaccine.

One important national goal is to have 90% of children up-to-date on the recommended series of vaccines by age 2 (age 24-35 months) in order to protect them against 14 vaccine preventable diseases. Under the current recommendations, by age 2 all children should have received 4 doses of diphtheria-tetanus-

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

pertussis (DTaP), 3 doses of polio, 1 dose of measles-mumps-rubella (MMR), 3 doses of Hepatitis B, 3 doses of Haemophilus Influenza, type B (Hib), 1 dose of Varicella (chickenpox) vaccine, and 4 doses of pneumococcal conjugate vaccines (PCV). This series is referred to in shorthand as the “4:3:1:3:3:1:4” series. In New Mexico, a survey of providers showed that in 2013, at least 21 counties had reached at least 80% coverage and, of these, 9 counties had had immunization rates of 90% or above. These rates, however, reflect only those children who have a medical home and regular source of pediatric care. The National Immunization Survey data for New Mexico indicates that 71.6% toddlers were up-to-date on their immunizations in 2012, above the national average of 68.4% but below the national goal.

New Mexico continues to experience cases of vaccine preventable disease. In 2011-13, a high level of pertussis (whooping cough) cases were reported, an outbreak reaching almost epidemic levels. Hepatitis A cases also have been reported in recent years, in part reflecting low coverage rates among toddlers for this particular vaccine. In early 2014, an increase in chickenpox cases was reported in the Albuquerque area.

One opportunity for New Mexico to improve its immunization rate is to emphasize completion of the basic series for young children—to send the message that vaccines are important for “every child by two”. Data show that rates for individual vaccines are not low but suggest that families are not completing the full recommended series. Also, this report recommends continuing to educate families to reduce the number that decline vaccines due to misinformation about the safety and effectiveness of these life-saving, preventive interventions.

Services for Young Children with Disabilities and Other Special Health Needs

As shown above, the early childhood system of systems includes programs for children with disabilities and special health needs. While all young children and their families need health, early care and education, and family support, only a subset has needs above the norm. At the same time, the opportunities are great for prevention and early intervention services that can reduce disabilities and result in cost savings.

National surveys indicate that one out of every 11 New Mexico children birth to 5 years has a special health care need. Among New Mexico children ages 4 months to 5 years, 22.7% are at moderate of high risk of developmental or behavioral problems. Nearly one in three (28.4%) has had two or more adverse childhood experiences. Many infants, toddlers, and preschool age children have mental health needs and developmental disabilities that need intervention.

Unfortunately, the array of federal and state programs with varying and overlapping eligibility criteria for children with disabilities and other special needs result in a disjointed service system, gaps that exclude some children, and uneven support for families. For example, national survey data for New Mexico indicate that among children who were screened and found to have a special health need (i.e., medical, behavioral, or other type of health condition that has lasted or is expected to last 12 months or longer), one third has a problem getting referrals when needed

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

While the origins of children's special needs and disabilities vary (e.g., some have biological or hereditary origins and others are the result of external, environment effects), all should have access to: a pediatric medical home, child-centered early intervention and treatment services, trauma informed care, providers using a strengths-based approach, family-centered care, and a coordinated continuum of services grounded in interagency collaboration and partnerships. Tailoring services to the needs of children and their families and assuring care coordination yields the best results.

Services and supports for children with disabilities and other special health needs are one of the four core areas of an early childhood system of systems. In addition to program specific policy and finance approaches, this report recommends some systems-level action. First, New Mexico should establish common eligibility definitions and care pathways, including services funded or coordinated by Medicaid, Children's Medical Services, the Family Infant Toddler Program, mental health, and other relevant child health programs. Common eligibility definitions and care pathways also serve as the basis for a coordinated continuum of services grounded in interagency collaboration. Second, New Mexico should design and implement a cross-system, interdepartmental approach to developmental screening and referrals based on the work of the Developmental Screening Initiative. Third, in the context of financing, New Mexico should clearly define which funding source (e.g., Medicaid, the Family Infant Toddler Program, private insurance) is payer of last resort under various circumstances and care plans. There is also an opportunity to maximize available resources by using uniform central billing processes or mechanisms. This has been done successfully by the Family Infant Toddler Program and could be done for other programs and services.

Family Infant Toddler Program

Under Part C of the Individuals with Disabilities Education Act, the federal government gives limited funds to assist states in developing and implementing statewide, comprehensive, coordinated, multidisciplinary, interagency systems to provide early intervention services for infants and toddlers with disabilities and their families. States choosing to participate in the program must serve (i.e., provide an entitlement to services for) infants and toddlers with developmental delays or disabilities, or with a high probability of developmental delays or disabilities, who meet state determined criteria. States also have the option to serve children at risk for developing delays or disabilities (e.g., children with combinations of demographic, familial, or environmental risk factors). Only a small number of states (3-5) offer eligibility to children at risk.

New Mexico has become nationally recognized for its plan to address environmental risk factors and using a protocol and assessment tool for identifying children at risk. It also has been recognized for efforts to work with tribes and Native American families to adopt culturally and linguistically appropriate services.

The New Mexico Family Infant Toddler Program provides a statewide system of early intervention services for children birth to three with: developmental delays, developmental disabilities, and biological, medical and environmental risks for developmental delay. Family Infant Toddler Program services are provided through a network of 34 community-based providers. Providers are available in every county, with some serving a small regional cluster of three to five counties. More than 14,000 children benefit from Family Infant Toddler Program services.

While many other federal programs require only child-focused plans, the Part C Early Intervention law requires an individualized family services plan. Thus, infants and toddlers in New Mexico have the benefit of such plans when they are determined eligible for the Family Infant Toddler Program.

In every state, federal funds cover only a fraction of the cost of early intervention services to eligible children. In Fiscal Year 2013-15, federal Individuals with Disabilities Education Act funding was approximately \$3 million, with state funding, Medicaid, private insurance making up the greater share of expenditures. Medicaid is a payer, as are private insurance plans. The Family Infant Toddler Program is “carved out” of Centennial Care, meaning that the Family Infant Toddler Program services and providers are paid on a fee-for-service basis rather than as part of a capitated rate through managed care.

As discussed above, as a result of the Race to the Top initiative, the Family Infant Toddler Program has become part of a systems development initiative together with early care and education and home visiting programs. The Family Infant Toddler Program is part of the FOCUS Tiered Quality Rating and Improvement System approach which will use a similar framework and essential elements to guide quality improvement efforts. New Mexico is the first and only state to include its infant-toddler early intervention program in an early childhood Quality Rating and Improvement System. The Family Infant Toddler Program also will contribute substantially to the integrated early childhood data system being developed under Race to the Top.

All states have the option to merge their Individuals with Disabilities Education Act, Part C and Part B preschool programs to provide a continuum of services and early interventions for all children from birth to age 5. The 2004 reauthorization of the Individuals with Disabilities Education Act permits states to allow a child to stay in the Part C program until kindergarten instead of moving to the Part B Preschool Program at age 3. Such continuation programs would apply only to children and their families who had previously participated in Part C, and services must be in place to promote school readiness until the children enter (or are eligible under state law to enter) kindergarten. Under such a policy, children 3-5 years would receive a somewhat broader array of benefits. Under this approach, state dollars, which already comprise more than one-third of most Part C programs, can be used to facilitate continued coverage of at-risk children. New Mexico has the opportunity to further integrate early childhood systems and services by adopting a uniform policy for services to children with developmental disabilities and special education needs birth to age 5.

Part B Preschool Special Education.

The Individuals with Disabilities Education Act Part B, Section 619, Preschool Special Education Program provides formula grants to states for special education and related services for children with disabilities aged 3 through 5. Similar to the program for infants and toddlers, it provides entitlement services to children identified as eligible based on state criteria. Similar to the Part C Early Intervention program, federal funds cover only a fraction of the cost of services.

Notably, however, the Part B Preschool Program uses definitions comparable with those for older children who have special education needs. Thus, as currently structured, there is no possibility of reaching out to and serving at-risk preschool age children. This means that there is no continuity for at-risk children served under Part C, the Family Infant Toddler Program, when they become preschool aged,

although, as noted above, states have the option to improve continuity and create a more seamless program for children birth to 5 years.

Children's Medical Services (CSM) for Children with Special Health Care Needs

The Title V Maternal and Child Health Services Block Grant provides grants to help state public health agencies maintain and strengthen their leadership and infrastructure for planning, promoting, coordinating, and evaluating service systems for pregnant women, mothers, infants, and children who do not have access to adequate health care and to coordinate or provide health services to children with special health care needs and their families. Title V funding has been used by states for more than 75 years.

Every state Title V program has both a Maternal and Child Health unit and a Children with Special Health Care Needs unit that receive core block grant funding and, on a competitive basis, special grant initiative funds. The Title V Block Grant funds are allocated to states on the basis of a matching formula that requires a \$3 state match for every \$4 in federal funds. Many states “overmatch” with state general funds exceeding this level. At least 30% of each state’s federal block grant allocation must be spent on activities for children with special health care needs, and an additional 30% must be dedicated to children’s primary health care services.

Children with special health care needs are generally defined as: children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally. National survey data for 2009-10 indicate that among New Mexico children birth to 5 years 8.6% have a special health care need, broadly defined. As is true nationally, New Mexico children with special health needs are distributed across the income spectrum and the range of racial/ethnic groups.

Under Title V federal law, however, each state has the flexibility to define which categories of special needs children will be eligible for the programs and services for children with special health care needs. Typically, these categories include children with chronic illnesses, genetic conditions, and physical disabilities, and less often children with social-emotional and mental health conditions.

In New Mexico, the Title V Children with Special Health Care Needs program is known as Children’s Medical Services and is administered by the Department of Health. New Mexico children and youth birth to 21 with chronic illnesses or medical conditions that require surgical or medical treatment and that could limit their activity are medically eligible for Children’s Medical Services (e.g., including but not limited to asthma, blood disorders, cancer, cerebral palsy, cleft lip and palate, diabetes, hearing loss, and thyroid disorders). Children’s Medical Services finances and provides services to diagnose and treat chronic illness and reduce the incidence of disabling conditions among children. Social workers coordinate health, medical, and other community resources based on child and family care plans and goals. Pediatric specialty clinics are held in public health offices in rural areas to improve access to specialty care for children who may not have the resources to travel to Albuquerque to receive this care.

Financial eligibility is set at 200% of the federal poverty level for direct service coverage. Children’s Medical Services acts as the last payer after insurance and does not provide financing for services covered

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

by Medicaid. Care coordination services and clinic visits are available to any child with an eligible condition, regardless of income.

This program served 1,209 young children birth to age 8 in Fiscal Year 2013. These young children received some type of service, either where Children's Medical Services was the payer for services, the child received services at a Children's Medical Services multi-disciplinary pediatric specialty clinic, and/or the families received care coordination from a Children's Medical Services social worker.

In addition, as in many other states, New Mexico has incorporated the Newborn Hearing Screening Program and the Newborn Metabolic Screening Program into Children's Medical Services, along with the Title V program. These programs are designed to identify health conditions that may not be visible at birth for which early intervention, diagnosis, and treatment can reduce long term impact. The funding for both types of newborn screening is different than for children with special health care needs. All New Mexico newborns receive both hearing screening and metabolic screening. Children's Medical Services partners with the University of New Mexico, Mountain States Genetic Network, and Oregon State Public Health Laboratory to provide expanded screening and follow-up services for children with 27 identified metabolic and genetic disorders. Children's Medical Services provides follow-up of all children identified on newborn screening as having a genetic, metabolic, endocrine or hemoglobin disorder. More than 28,000 children are served annually.

The opportunity for New Mexico is to align eligibility criteria across programs for children with special needs and disabilities to close gaps and maximize available funding. In the case of Children's Medical Services, funding is more flexible than for Medicaid, the Family Infant Toddler Program, or Preschool Special Education entitlement programs. Thus, a review of the range of services directly financed by Children's Medical Services and the range of eligible conditions in relationship to other parallel programs is recommended. Such a review should include both Children's Medical Services eligible conditions and those identified through newborn screening.

Infant and Early Childhood Mental Health

Infant or early childhood mental health has been defined as the psychological, social, and emotional well-being of infants and toddlers formed in relationships to their caregivers, environment, and culture. While most young children develop age-appropriate social and emotional skills through everyday interactions with parents, caregivers, siblings, and others, there are some children who, absent intervention, will not outgrow their problems.

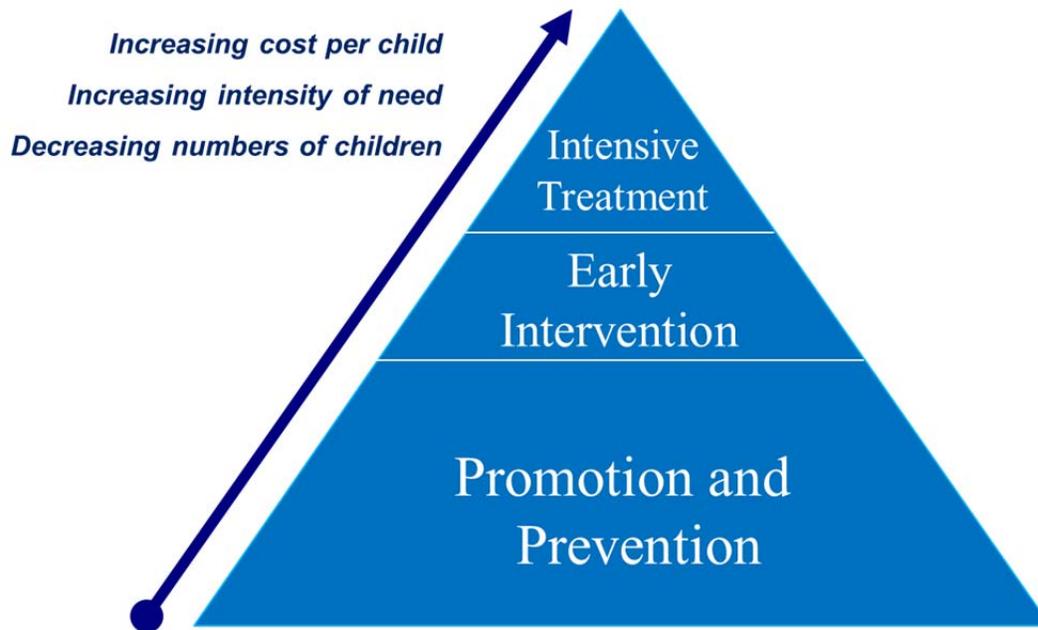
The earliest years with infants and toddlers are the time of opportunity when public investments have the greatest payoff. Research tells us that social, emotional, and cognitive learning are intertwined for young children. Improving the capacity of young children to regulate their emotions is a critical pathway to improve cognitive and early academic learning.

Promoting social and emotional competencies and well-being in young children is essential to help them succeed in school and in life. Just as there are deliberate strategies to promote early literacy, so there are strategies to promote optimal early social and emotional development. There is a powerful body of scientific knowledge showing the consequences of failure to address early signs of risk factors and documenting how to address early risks. While they cannot solve every problem, early childhood mental

health interventions, especially those that are grounded in strengthening positive relationships, can often make a critical difference in promoting resilience, school readiness, and lifelong success.

Research evidence and best practice documents the importance of three broad types of strategies or interventions. (See Figure 6.)

Figure 6. A Continuum of Early Childhood Mental Health Services



Source: Johnson K and Knitzer J. 2005.

- 1) *Promotion and prevention strategies targeted to all children, but especially low-income children.* Such strategies are designed to help families and caregivers foster young children’s social skills, emotional health, and positive behaviors. Evidence-based strategies include, but are not limited to: anticipatory guidance by pediatric primary care providers, parent education through home visiting, social and emotional skills-building curricula in preschool programs, positive parenting education programs, and community-based programs such as Strengthening Families.
- 2) *Early intervention strategies for young children who face special, elevated risks.* Young children at elevated risk include: those with disabilities, those whose parents face depression and other serious mental health problems, those whose parents are incarcerated or abuse drugs, and those who experience child maltreatment. Screening and assessment tools that focus on age appropriate social and emotional functioning, as well as provide full-scale diagnostic evaluations, are important in identifying young children in need of early intervention or treatment and should be widely used across the early childhood system of systems. Providing trauma informed services is important for a large proportion of these young children.

- 3) *Treatment strategies sufficiently intensive to help young children with serious social, emotional, and behavioral problems and their parents (or other primary caregivers) and siblings.* Such treatment interventions include access to case management, mental health, and other treatment services that can help families stay together and ensure the safety and healthy development of young children.

In New Mexico efforts are underway to use a three-tiered approach. With training and technical assistance from the Center on the Social and Emotional Foundations for Early Learning (a federally funded center at Vanderbilt University), state leaders are adopting new ways of working and engaging an array of professionals who work along the continuum of early childhood mental health services. The recommendation is to continue this work, ensuring that health, mental health, social services, child development, and other professionals understand the continuum of early childhood mental health services and their role in promotion, prevention, early intervention and treatment. Child care, Head Start, Pre-K, home visiting, the Family Infant Toddler Program, mental health, child welfare, and other programs should be part of a network of support for families in need of early childhood mental health services.

A strategic plan on infant (early childhood) mental health developed through collaboration of key stakeholders and released in 2003 built on an earlier wave of national interest in promoting the social-emotional well-being of the youngest children. Its emphasis was coordination and development of a continuum of resources to promote and provide early childhood mental health services on a statewide basis. Among other things, the report concluded that “implementing infant mental health strategies in New Mexico does not require a wholesale remaking of early childhood programs throughout the state.” An array of professionals – social workers, psychologists, early childhood specialists, public health nurses, pediatricians, and others – can provide a range of early childhood mental health prevention and treatment services. This underscores the importance of cross-system training. The state also can maximize the existing workforce through amendments to licensing, practice standards, and related authority.

Another key coordination approach was to develop interagency agreements that advance early childhood mental health services and supports. Integration of early childhood mental health services into local early childhood services, councils, Early Childhood Investment Zones, and related efforts is recommended.

Assuring a statewide approach to consistent and universal screening for social-emotional-mental health risks is another priority. This will require participation of health providers, early care and education programs, and other community programs serving infants, young children and their families. The state should take a leadership role in development and implementation of a systems approach to early childhood mental health screening with objective tools. Protocols and care pathways should be developed to support referrals for diagnostic assessment, treatment interventions, and care coordination as necessary. The Children, Youth, and Families Department (e.g., home visiting, early care and education, child protective services), Department of Health (e.g., the Family Infant Toddler Program, Children’s Medical Services), and Human Services Department (e.g., Medicaid) each have a role to play.

The 2003 strategic plan also called for more efficient use of existing sources of finance and support for early childhood mental health services. Identified strategies included: maximizing Medicaid financing for prevention and treatment, building mechanisms into Medicaid managed care arrangements, using the

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

DC:0-3R, maximizing use of the Family Infant Toddler Program children’s mental health, and Title V Children’s Medical Services funding, and coordinating training funds.

The J. Paul Taylor Early Childhood Task Force reviewed existing programs and policies and made recommendations to the New Mexico Legislature in 2013. Established by the legislature, the Task Force aimed to develop outcomes and a community-based early childhood mental health plan. The list of initial recommendations was extensive and affected an array of programs and systems. Key recommendations included the following:

- 1) Establish community and state networks, including community health councils with early childhood subcommittees (see related recommendation above under Early Childhood Investment Zones);
- 2) Identify and serve more at-risk children and families through more widespread screening;
- 3) Increase linkages between primary and behavioral health;
- 4) Support comprehensive workforce training and trauma informed systems of care in health and child welfare;
- 5) Increase the availability of high quality mental health services to young children, particularly those enrolled in Centennial care, home visiting, and the Family Infant Toddler Program programs;
- 6) Promote evidence-based and promising practices;
- 7) Collect and make available data and support evaluation; and
- 8) Decrease child abuse and neglect through a statewide prevention plan, modified contracts with early childhood providers, improved child protective services referral processes, and other mechanisms.

The recommendations from the Task Force should be incorporated into current strategic planning for early childhood mental health. The recommendations of this report are aligned with those above.

Adverse Childhood Experiences and Trauma Informed Services

Many children also have one or more adverse childhood experiences, such as physical or sexual abuse, neglect, parental substance abuse or depression, and exposure to violence. Adverse childhood experiences and “toxic stress” caused by such conditions can weaken the architecture of the developing brain, with long-term consequences for learning and both physical and mental health. A history of adverse childhood experiences can affect lifelong health. Research suggests a high proportion of adults live with the consequences of adverse childhood experiences. As the number of adverse childhood experiences increase, the risk for adult health problems (e.g., heart disease, depression, smoking, intimate partner violence, risky sexual behavior, eating disorders, alcohol or drug abuse) increases. The cost to society has been estimated at more than \$100 billion annually.

Caring adults, including health, mental health and social service providers, can provide support, responsive relationships, and interventions to prevent or reverse the potentially damaging effects of both toxic stress and adverse childhood experiences. Taking action can minimize the negative effects of adverse childhood experiences and toxic stress.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

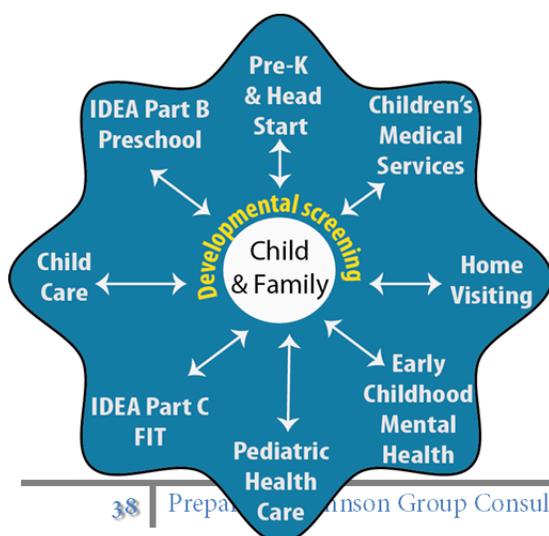
Assessment for adverse childhood experiences can help to identify the need for intervention. It is a place to begin to reverse the potential damage from adverse childhood experiences. The recommendation is to integrate screening/assessment for into the practice of health, mental health, child protective services, home visiting, child development, and other professionals serving families with young children.

New Mexico also has an opportunity to increase the availability of “trauma informed care” for young children and their families. A trauma-informed child- and family-service approach is one in which all parties involved recognize and respond to the impact of adverse childhood experiences, trauma, and toxic stress on children, caregivers, and service providers. Trauma-informed service providers: 1) screen for trauma exposure and related symptoms; 2) use culturally appropriate, evidence-based assessment and treatment for traumatic stress and associated symptoms; 3) make resources available to children, families, and providers on trauma; 4) engage in efforts to strengthen the resilience and protective factors of children and families affected by and vulnerable to trauma; 5) address parent and caregiver trauma and its impact on the family system; 6) emphasize continuity of care and collaboration across systems; and 7) maintain an environment for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience. Incorporating trauma-informed services across the early childhood system of systems will require training, support, and supervision for an array of professionals.

Developmental Screening

Developmental screening is an essential early childhood service strategy for promoting each child’s development, decreasing the school readiness gap, and assuring optimal childhood outcomes. The American Academy of Pediatrics recommends that children receive developmental screening using an objective, standardized tool during well child visits at ages 9, 18, and 30 months. Child development professionals also use developmental screening in a variety of early care and education settings to identify unmet needs and tailor educational strategies. Research has clearly demonstrated that standardized developmental screening tools are needed to identify children with risks or delays, and start the process for further assessment when indicated. With standardized screening tools, 70-80% of developmental concerns can be identified. Screenings and assessments can also give parents, families, caregivers and others who work with children a better understanding of a child’s strengths and needs.

Figure 7. Developmental Screening: Creating a System Utility



New Mexico is aiming to assure that no child reaches kindergarten with an undetected developmental condition. Such a system would: support use of recommended, objective, and standardized screening tools; share information among providers (with parent permission); enhance family understanding of child development; refer and link children and their families to a range of follow up services; and maximize available finance and personnel resources. New Mexico’s Developmental Screening Initiative is built on a shared mission to help children develop to their full potential, the concept that early

intervention is prevention, and the conviction that a cross-system, interdisciplinary and coordinated approach is essential. The Developmental Screening Initiative promotes sustainable developmental screening practices, cross-agency networking, and rapid referral of children suspected of having developmental delays.

Developmental screening can be considered a system utility, like electricity and water services which are available to all with minimal effort, have affordable cost, and enable other work to be done. Figure 7 illustrates some of the connections and system interactions which are related to developmental screening. For example, developmental screening information should be communicated to all entities concerned and involved (e.g., parents, health providers, early care and education providers, FIT). Routine referral pathways should be established and reinforced with care coordination, quality assurance, and monitoring. Cross-system training regarding developmental screening should be routinely available for professionals serving young children, including pediatric primary health care providers. Specific objective, standardized screening tools should be recommended in appropriate state policies (e.g., Medicaid/Early and Periodic Screening, Diagnostic and Treatment visits, the Family Infant Toddler Program). Various financing mechanisms should be applied. For example, developmental screening is a required component of Medicaid/Early and Periodic Screening, Diagnostic and Treatment well-child visits and a recommended component for well child visits as described above. Centennial Care plans and other publicly subsidized health care should routinely provide developmental screening as recommended.

Family Support and Other Services for Families with Young Children

Temporary Assistance to Needy Families

Adopted under the welfare reform legislation—Personal Responsibility and Work Opportunity Reconciliation Act of 1996—the Temporary Assistance for Needy Families program replaced the Aid to Families with Dependent Children entitlement program. The Temporary Assistance for Needy Families program provides formula-based grants, giving states greater flexibility to use funds in any manner that promotes family self-sufficiency. Many states have used Temporary Assistance for Needy Families dollars to support child care activities, either by directly using Temporary Assistance for Needy Families or by transferring funds (up to 30 percent per year) to either the Child Care and Development Fund or the Social Services Block Grant.

Currently in New Mexico the Temporary Assistance for Needy Families program offers families with pregnant women or infants a Temporary Assistance for Needy Families work participation waiver. Families with such a Temporary Assistance for Needy Families waiver should be designated as a priority group for other services in the early childhood system (e.g., home visiting, developmental assessment, Early Head Start). Transition plans should be developed that include not only strategies to re-enter the workforce but also identification of child care, nutrition, health care, and other supports.

The state also has implemented the Family Violence Option of the Temporary Assistance for Needy Families program in an effort to reduce the impact of family violence on families. New Mexico should continue to use this option.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

New Mexico and other states have opportunities to use Temporary Assistance for Needy Families dollars for two-generation strategies, such as: 1) child care quality initiatives, 2) early childhood mental health consultation to early care and education programs, 3) family counseling, service coordination, and family support activities (e.g., family resource centers), 4) funding home visiting programs for families with young children at risk, or 5) substance abuse treatment for parents, as part of their efforts to reduce dependency and prepare for work.

Child Abuse Prevention and Treatment Act

The Child Abuse Prevention and Treatment Act provides grants to states with flexible funding to improve child protective service systems (e.g., improve the investigative process, management of cases, information systems, staff or provider training, prevention and treatment).

The Community-Based Child Abuse Prevention Program, authorized under Child Abuse Prevention and Treatment Act in 1996, provides funds to States to develop, operate, expand, and enhance community-based, prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect. While the amount of Community-Based Child Abuse Prevention Program funds available is small, they offer some non-entitlement support for states. For example, states may choose to finance the development of a continuum of preventive services through public-private partnerships, financing the start-up, maintenance, expansion, or redesign of child abuse prevention programs, and financing public education activities that focus on the promotion of child abuse prevention.

New Mexico uses Community-Based Child Abuse Prevention Program and state general funds to support child abuse and neglect prevention services (e.g., services for fathers, teen parents, and/or incarcerated parents). The state has embraced the Community-Based Child Abuse Prevention Program emphasis on evidence-based and evidence-informed programs. The implementation of Triple P Positive Parenting Program and Strengthening Families approaches is at the center of these efforts and should be sustained. In addition, the state has given emphasis to integration and coordination of prevention services with other child welfare and child protective services.

Child Abuse Prevention and Treatment Act has important provisions in federal law requiring that children under age 3 in substantiated cases of abuse or neglect be referred to services funded under Individuals with Disabilities Education Act Part C Early Intervention program (the Family Infant Toddler Program in New Mexico). Each state submits a plan and determines its own approach for this important program linkage. With this requirement comes a responsibility for states to re-examine Part C Early Intervention programs and to increase the capacity of early intervention systems to provide trauma informed services.

In New Mexico, substantiated abuse and neglect was already included on the list of conditions that place a child at risk for developmental delays and disabilities and make them eligible for Family Infant Toddler Program services. Thus, the state was prepared to improve services to infants and toddlers using the framework and mandate of these Child Abuse Prevention and Treatment Act provisions. New Mexico has been nationally recognized for developing a plan, flow chart for referrals, protocol, assessment tool, professional training, and interagency approach and Memorandum of Understanding for implementing Child Abuse Prevention and Treatment Act to Family Infant Toddler Program referrals. In addition, the program is assuring comprehensive developmental evaluations for the referred children, not just screening as is done in some other states.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

One opportunity for New Mexico is to more formally track referrals and outcomes among the children referred as a result of substantiated abuse or neglect. This opportunity may be fulfilled through completion of the more uniform, integrated early childhood program database described above.

Child Protective Services and Child Welfare Services

Several federal programs form the basis for child protective services and child welfare services in states. Title IV-B of the Social Security Act has two parts: 1) the standard Title IV-B program finances services for both families in care and families at risk, and 2) the Promoting Safe and Stable Families program, which is designed to prevent separation of children and their families. Part 1 of Title IV-B provides grants to states for child welfare services, including preventive intervention, temporary placements and permanent homes through foster care or adoption, and reunification services to return home children who have been removed from their families for reasons of safety. Under Part 2 of Title IV-B the Promoting Safe and Stable Families program goals are to prevent the unnecessary separation of children from their families and ensure permanency for children by reuniting them with their parents or by facilitating adoption or another permanent living arrangement. To be eligible for funds, states (and Native American tribes) are required to ensure certain protections for all children in foster care. Title IV-E Foster Care is an open-ended entitlement program that provides funds to assist states with the costs of foster care and adoption assistance for eligible children; administrative costs (maximum of 10%); and training for public agency staff, foster parents, and private agency staff. The Community-Based Child Abuse Prevention Program (see description above) is another important element of this work.

In New Mexico, the Protective Services Division of the Children, Youth, and Families Department administers child protective services/child welfare services, which are provided in every geographic area in the state. The program's mandate is to receive and investigate reports of children in need of protection from maltreatment (abuse and/or neglect) and to take action to protect those children whose safety cannot be assured in the home. The New Mexico approach goes beyond this mandate, with emphasis on protection, timely action, pursuing permanent situations, and promoting well-being for children.

As in many states, New Mexico also has a Children's Trust Fund financed by the state general fund, license plate fees, marriage license fees, and Trust Fund interest income. The purpose of the Children's Trust Fund is to increase access to innovative services that strengthen families and prevent child abuse. With a greater focus on prevention, the Children's Trust Fund offers opportunities to intervene early, use evidence-based approaches, and promote child and family well-being.

Since 2009, the Children, Youth, and Families Department has been active in the Piñon Project to develop a Child Welfare Practice model that engages and works together with children, youth, families, and stakeholders to create an environment that focuses on the safety permanency, and well-being of children and their families. The project approach is based on principles and practices that support a system of care that is: child-focused, family-centered, trauma-informed, strengths-based, community-based, and culturally competent. Through this project training, technical assistance, administrative review, and ongoing quality assurance are being carried out. The work is being launched successively in "implementation zones" which focus on data-driven, results-oriented projects.

This report recommends that the state offer training related to trauma-informed care to a wide variety of professionals serving young children in order to build and sustain a trauma-informed system. In

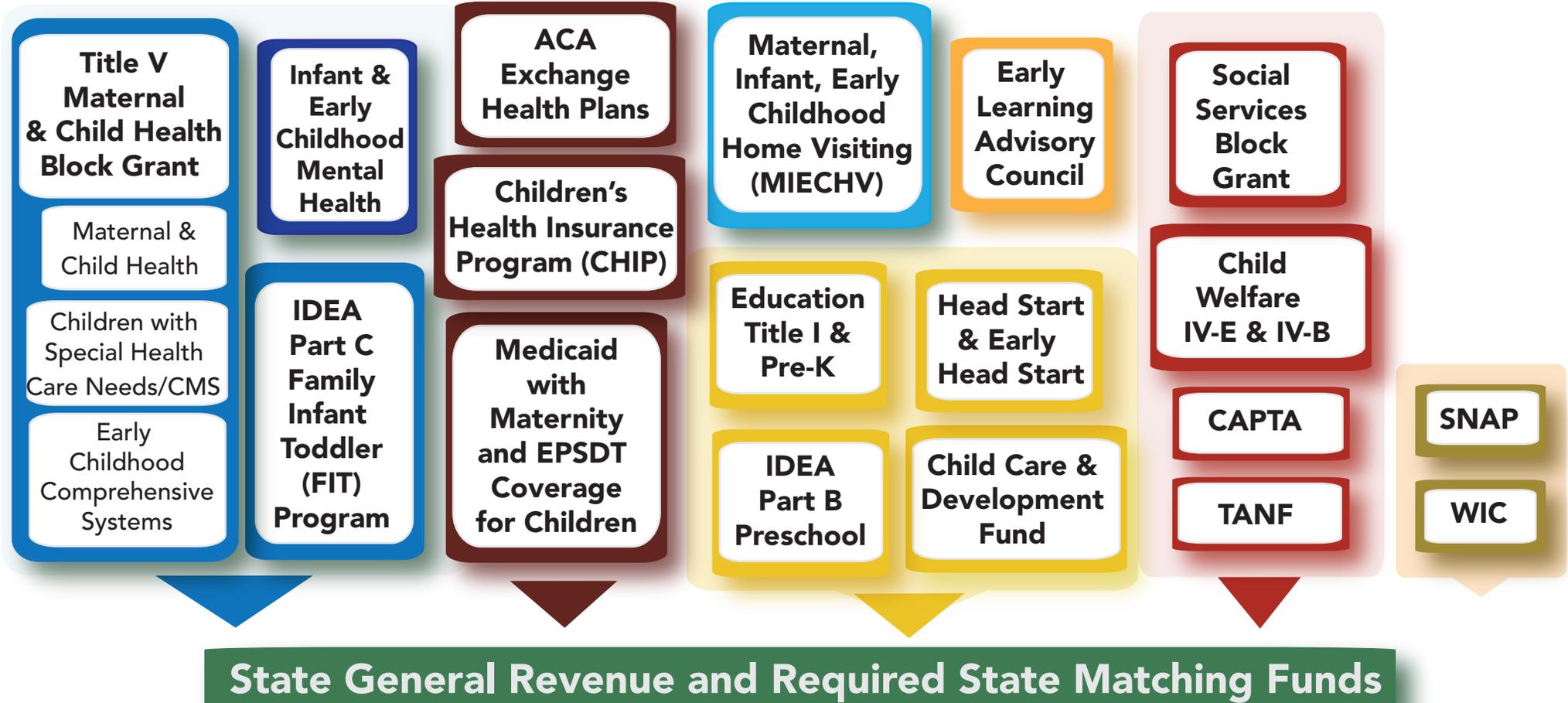
Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

particular, child welfare and protective services staff should be required to participate in interdisciplinary training related to child development, early childhood mental health, and trauma-informed care.

Another option for New Mexico is to build upon the success of a pilot project in using differential response approaches in child protective services for reducing the risk of child maltreatment. By redesigning the ways in which child protective services agencies respond to reports alleging child maltreatment, differential response approaches offer more flexibility, potential for using multiple responses simultaneously, and pathways for greater family engagement.

Figure 8. Spending Smarter in New Mexico

To Finance High Quality Early Childhood Services & Systems



State General Revenue and Required State Matching Funds

Blend and braid funds to maximize resources.

Leverage federal dollars with state and local, public and private funds.

Develop administrative mechanisms to permit state and local flexibility, as appropriate.

Translate aggregate dollars into support for effective and efficient local service systems.

Make investments and provide financing sufficient to support and sustain quality.

Include R&D, CQI, data systems, and evaluation.

Summary of Findings and Recommendations

According to Kids Count reporting by the Annie E. Casey Foundation, New Mexico ranked among the worst states in child well-being in 2012 and 2013. The state has approximately 140,000 young children birth to 5 years. Nearly one in four children in New Mexico lives in poverty. More than half of children birth to age 8 are living in low-income households (below 200% of the federal poverty level). New Mexico's rate of births to teen parents is among the highest in the country. Among New Mexico children ages 4 months to 5 years, more than one in five are at moderate-to-high risk of developmental or behavioral problems. More than one quarter have three or more risk factors that could impact their health and development. There is no question that New Mexico families have high levels of risk, unmet needs, and could benefit from more prevention, early intervention, and treatment services.

At the same time, New Mexico's public resources are not limited by federal budget decisions, state budget decisions, and the overall economy. Thus, to do more, the state needs to spend smarter. Spending smarter means: maximizing efficiencies through systems approaches, capturing dollars that already exist in federal funding streams, blending and braiding funds, leveraging both smaller grant funds and entitlement dollars, using flexible funds to fill gaps in systems of care, and paying for appropriate, effective services. (See Appendix B for a Spending Smarter checklist prepared in January 2014.) While not making specific budget recommendations, this report provides recommendations to aid the state in applying these approaches and strategies. Figure 8 illustrates some key funding pathways from federal to state to local services in New Mexico.

The following findings, recommendations and opportunities are discussed throughout the report. This includes some key findings relevant to the recommendations. Note that recommendations are strongly supported by the findings of this analysis. Opportunities listed are actions that are available to New Mexico under federal and state law that may not be high priorities at this time.

Leadership and Infrastructure for Program and Fiscal Support

Leadership

Key Findings

- New Mexico needs strong leadership and infrastructure to support and guide its early childhood system.
- Key stakeholders believe the greatest potential now is for improving early childhood services and outcomes rests first and foremost in the Children's Cabinet.

Recommendations

- Devote time and focus of the Children's Cabinet to lead development, implementation, and oversight of New Mexico's early childhood investments, programs, and system of systems (e.g., have an early childhood section of agenda, make regular reports to governor, set up interagency structure for system oversight).

Opportunities

- Adopt a broader set of indicators for the Children's Cabinet, which would give greater emphasis to each period of child development.
- Support from the Indian Affairs Department to promote, as appropriate, services for young Native American children in the early childhood system of systems.

Early Childhood System of Systems Framework

Key Findings

- New Mexico has made a start in fostering a system of systems but needs to have more elements integrated into this work.
- The Race to the Top Early Learning Challenge grant program provides for linkages between early care and education, home visiting, and early intervention and offers a strong base.
- Health programs are not well integrated into the system of systems vision for early childhood services.

Recommendations

- Improve coordination among the Children, Youth, and Families Department, Public Education Department, Department of Health, and Human Services Department. In particular, Pre-K, Early Childhood Investment Zones, and early childhood mental health services offer a place to begin greater inclusion.
- Improve integration of health, mental health, and family support services into the system of systems, including giving attention to the inclusion of health leadership in the Early Learning Advisory Council.
- Clarify roles and intentionally structure the relationships among the Early Learning Advisory Council, Early Childhood Comprehensive Systems, and other advisory bodies, while not losing capacity or federal resources. Currently there is duplication of effort and lack of clarity in roles related to the early childhood system of systems.

Opportunities

- Use Race to the Top as catalyst for more system development. The grant proposal has a broad vision and provides a somewhat unique opportunity for systems change and integration.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

- Be the first state to create a modern, uniform early childhood data system, including unique identifiers.
- Consider physical co-location or a matrix organizational designed to more closely connect the work of early childhood program and project leaders across departments.

Support to Local Jurisdictions

Key Findings

- New Mexico has extreme variations in local system capacity, including areas which are underserved in early childhood system capacity across several domains (e.g., health, early care and education, family support, and services to address special needs).
- Early Childhood Investment Zones offer an approach to infrastructure, resource, and community development.

Recommendations

- Coordinate state-funded and administered programs across local jurisdictions with differing capacity, resources, and challenges.
- Use local coalitions developed in Early Childhood Investment Zones as the basis for rejuvenated Early Childhood Councils.
- Use “collective impact” strategies and processes in Investment Zones, with a backbone organization, shared goals, and common measurement as key elements.
- Maximize use of state-funded personnel who serve in local communities, especially health staff (e.g., public health nurses, community health workers, care coordinators).

Opportunities

- Match services to needs through continued use of geographic information system (GIS) mapping and related tools for planning.

Early Care and Education

Child Care

Key Findings

- New Mexico is working assertively on child care quality and should continue to give it high priority attention.
- Child care should be seen as a part of early education, not just as custodial care for working parents.
- New Mexico leaders envision and are aiming for a universal, fully-articulated professional development system to produce and support a high-quality early childhood workforce.

Recommendations

- Implement the FOCUS Tiered Quality Rating and Improvement System approach for all providers by 2016.
- Establish a framework for high-quality child care in statute through enactment and implementation of a Child Care Accountability Act.
- Adopt more extensive health, safety, and quality standards for registered child care homes.
- Increase the reach of child care subsidies to reduce waiting lists, aiming to reach all families with child care needs up to 200% of the federal poverty level.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

- Continue investments in workforce development, particularly cross-system training for child care, Pre-K, home visiting, and others who work with young children.

Opportunities

- Adopt lessons learned from full-day, high-quality early care and education services for children birth to five years that integrate principles and best practices from Pre-K, child care, and Educare.
- Make child care, Pre-K, and Head Start quality information and licensing reports available to parents on paper and online, as well as in multiple languages.
- Adopt legislation similar to 31 other states to place restrictions on sex offender proximity to schools/and/or child care facilities.

Pre-K

Key Findings

- New Mexico has made investments in Pre-K that can be expected to have return on investment.
- The state is poised to close gaps for 4-year-olds, but local competition and potential duplication are issues to address.

Recommendations

- Strengthen collaboration between the Children, Youth, and Families Department and Public Education Department to reduce potential competition and duplication.
- Create an integrated Pre-K program, applying the same program standards across all publicly-funded early education initiatives.
- the Children, Youth, and Families Department and Public Education Department should jointly design and oversee a data-driven, local level planning process that informs funding decisions.
- Examine service capacity for four year olds and maximize Pre-K, Head Start, child care, and other early care and education sites.

Opportunities

- Make childcare, Pre-K, and Head Start quality information and licensing reports available to parents on paper and online, as well as in multiple languages.

Other Early Care and Education

Key Findings

- New Mexico K-3 Plus has the potential for positive results.
- The state can do more to integrate Head Start without a change in federal authority.
- New Mexico leaders envision and are aiming for a universal, fully-articulated professional development system to produce and support a high-quality early childhood workforce.

Recommendations

- Integrate Head Start and Early Head Start into the ongoing early childhood education system to the maximum extent possible (e.g., shared training, common measures).
- Maximize use of New Mexico Head Start Collaboration Office to increase oversight and coordination of Pre-K and Head Start for four year olds, without a change in federal authority.
- Reduce unnecessary competition or duplication of effort between Head Start and Pre-K providers through mechanisms such as local planning (see above).

Opportunities

- Supplement federal Head Start funding with state dollars.
- Continue state agency emphasis on workforce development.
- Continue the evaluation and monitoring of K-3 Plus.

Home Visiting

Key Findings

- New Mexico has a long history of providing home visiting services and an array of programs in operation.
- The Home Visiting Accountability Act is a model for system development.
- Using a standards approach, New Mexico is applying the principle that “a rising tide lifts all boats” rather than close existing home visiting programs not financed with federal the Maternal, Infant, and Early Childhood Home Visiting Program funds.

Recommendations

- Continue to use standards-based approach, with accountability.
- Include all home visiting programs in annual report by the Children, Youth, and Families Department.
- Address the needs of an array of at-risk families, not just first time parents.
- Integrate home visiting into quality rating and data systems.

Opportunities

- Use Medicaid financing for home visiting.
- Increase use of Early Head Start in the New Mexico home visiting system.

Health Services for Young Children

Medicaid – Prevention and Treatment

Key Findings

- Young children do not receive all recommended well child visits.
- New Mexico’s Centennial Care uses many effective approaches for child health as demonstrated in other states, as well as some innovative strategies.

Recommendations

- Increase utilization of Early and Periodic Screening, Diagnostic and Treatment well child “screening” visits for children birth to 5. Approaches might include incentives to Centennial Care plans, social marketing, and referrals from other early childhood program.
- Assure that developmental screening is being delivered according to American Academy of Pediatrics’ recommended schedule for infants and toddlers covered by Medicaid.
- Continue having Centennial Care Performance Improvement Projects related to the quality of Early and Periodic Screening, Diagnostic and Treatment services.
- Clarify Medicaid coverage for mental health parent-young child therapy.
- Continue state support for Families FIRST pregnancy-related case management, ensuring that it is appropriately linked to Centennial Care plans and providers and that the program uses standardized risk assessments.

Opportunities

- Finance a portion of the cost of home visiting services with Medicaid.
- Extend Families FIRST to include interconception care. Focused on women with prior adverse outcomes, interconception care (also known as interpregnancy care) refers to services provided following the end of a pregnancy, typically for 18-24 months, to address risks for subsequent childbearing and reduce the impact of chronic conditions on women's health.
- Maximize use of community health workers (e.g., promotoras) in prevention.

Medicaid – Administrative Supports

Key Findings

- New Mexico uses required eligibility and enrollment practices, but more could be done to reach and enroll young children.
- Centennial Care assessment, case management, and tiered approach has outstanding promise.
- Centennial Care has incentives to promote health and healthy behaviors.

Recommendations

- Use more express-lane and streamlined enrollment strategies.
- Adopt diagnostic codes (DC:0-3R) designed to reflect developmental conditions among young children.
- Collect data for quality improvement and evaluation of the tiered case management approach.

Opportunities

- Ensure that families and providers are informed regarding the full range of treatment services covered by Medicaid under the Early and Periodic Screening, Diagnostic and Treatment benefit, using paper and Internet communications.
- Develop a child health quality improvement collaborative that focuses on topics related to the health and development of young children (e.g., developmental screening and assessment, immunizations, maternal depression screening, trauma-informed services).

Early Childhood Immunizations

Key Findings

- New Mexico has had outbreaks of vaccine preventable disease.
- Improvement is needed in immunization coverage by age two, which is the basis for prevention of 14 diseases.

Recommendations

- Maximize use of immunization registry to monitor coverage.
- Educate families to reduce the number that decline vaccines due to misinformation about the safety and effectiveness of these life-saving, preventive interventions.

Opportunities

- Communicate to parents the importance of completion of the basic series for young children—send the message that vaccines are important for “every child by two”.
- Inform early care and education providers (including family child care homes) that work with children birth to three about the importance of timely immunization.

Services for Children with Disabilities and other Special Health Needs

Children with Disabilities and Special Needs Overall

Key Findings

- Federal and state programs with varied and overlapping eligibility criteria result in a disjointed service system, gaps that exclude some children, and uneven support for families.
- All should have access to: a medical home, early intervention and treatment services, trauma-informed care, strengths-based approaches, and family-centered care.

Recommendations

- Establish common eligibility definitions and care pathways. This should include services funded or coordinated by Medicaid, Children’s Medical Services, the Family Infant Toddler Program, mental health, and other relevant programs. The approach should build on strengths of Centennial Care tiered care management.
- Design and implement a coordinated continuum of services grounded in interagency collaboration.
- Clearly define who is payer of last resort under various conditions.
- Design and implement a cross-system, interdepartmental approach for assuring universal developmental screening at recommended intervals, with effective referrals as needed.

Opportunities

- Maximize available resources by using uniform central billing processes or mechanisms.

Family Infant Toddler Program

Key Findings

- New Mexico is to be congratulated as one of only five states that include infants and toddlers in the “at-risk” category.
- The Family Infant Toddler Program is among the first to actively integrate into early childhood system and the first to be part Quality Rating and Improvement System.
- The Family Infant Toddler Program has achieved statewide provider coverage.

Recommendations

- Fully support the Family Infant Toddler Program role in an integrated early childhood system of systems.
- Continue to *exclude* Medicaid payments to the Family Infant Toddler Program from Centennial Care.
- Further shorten the time between referral and eligibility determinations for the Family Infant Toddler Program.

Opportunities

- Further integrate early childhood systems and services by adopting a uniform policy for services to children with developmental disabilities and special education needs birth to age 5, using the federal option to create a continuum of services and early interventions for children birth to 5.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

- Give attention to challenges of families with children transitioning from Individuals with Disabilities Education Act Part C (the Family Infant Toddler program in New Mexico) and Part B Preschool program.

Children's Medical Services

Key Findings

- New Mexico uses traditional definitions for this group of children, similar to many states.
- Children's Medical Services serves approximately 1,200 young children birth to age 8.
- Newborn screening programs have adequate structure and array of conditions.

Recommendations

- Review and align eligibility criteria across programs for children with special needs and disabilities to close gaps and maximize available funding.
- Conduct a "census" of children with disabilities and special health needs, including those who are eligible for the Family Infant Toddler Program and preschool special education, qualify for Children's Medical Services, are identified through newborn screening, have Medicaid coverage for high cost services and disabilities, and others.
- Maintain universal newborn screening programs (i.e., genetic, metabolic, and hearing), assuring integration of follow up interventions and treatments as part of overall early childhood system.

Opportunities

- Use flexible funding in Children's Medical Services to support the full range of children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Early Childhood Mental Health

Key Findings

- New Mexico has multiple planning efforts focused on early childhood mental health.
- Stakeholders support a continuum of services, tiered and with emphasis on prevention and early intervention.
- Provider capacity is a challenge in most communities.

Recommendations

- Incorporate J. Paul Taylor Task Force recommendations and lessons from forthcoming New Mexico Project LAUNCH evaluation into any new early childhood mental health plan.
- Augment training to ensure that health, mental health, social services, child development, and other professionals working with young children and their families understand the continuum of early childhood mental health services and their role in delivering promotion, prevention, early intervention and treatment.
- Use widespread, cross-system early childhood mental health screening to identify more children at risk. The state should take a leadership role in development and implementation of a systems approach to early childhood mental health screening with objective tools. The Children, Youth, and Families Department, Department of Health, and Human Services Department each have a role to play.
- Integrate early childhood mental health services into local early childhood services, councils, Early Childhood Investment Zones, and related efforts.

Opportunities to Strengthen Early Childhood Services, Programs, and Systems in New Mexico

- Maximize the existing workforce through licensing, authority, and training.

Opportunities

- Increase use of early childhood mental health consultation to early care and education provider sites (e.g., child care, Head Start).

Other Supports for Children with Disabilities and Special Health Care Needs

Key Findings

- New Mexico public and private sector leaders have worked for more than a decade on assuring developmental screening for all infants and toddlers.
- Family understanding and delivery of developmental screening is too low.
- A substantial proportion of New Mexico's young children is affected by adverse childhood experiences and need appropriate interventions.

Recommendations

- Promote use of developmental screening through support for cross-system training, policies that recommend standardized tools, interagency agreements regarding referrals, and maximized use of available financing.
- Integrate screening/assessment for adverse childhood experiences into the practice of health, mental health, child protective services, home visiting, child development, and other professionals serving families with young children.
- Establish routine referral pathways reinforced with care coordination, quality assurance, and monitoring for children who have developmental screening or adverse childhood experience assessment indicating need for follow up.
- Provide cross-system training regarding developmental screening and adverse childhood experiences for professionals serving young children.

Opportunities

- Increase access to trauma informed services through training across early childhood programs and provider types.

Family Support for Families with Young Children

Temporary Assistance to Needy Families

Key Findings

- New Mexico's Temporary Assistance for Needy Families program is aligned with federal requirements.
- The state has opportunities to use some of the flexibility of Temporary Assistance for Needy Families funding to enhance support for families with young children.

Recommendations

- Designate families with pregnant women or infants who have a Temporary Assistance for Needy Families participation waiver as a priority group for other services in the early childhood system and develop transition plans.
- Continue efforts to implement the Family Violence Option.

Opportunities

- Use Temporary Assistance for Needy Families grant dollars for two-generation strategies, such as: child care quality initiatives, early childhood mental health consultation, family counseling, service coordination, and family support activities, and/or substance abuse treatment for parents.

Child Abuse Prevention, Protective Services, and Child Welfare Services

Key Findings

- New Mexico has had a series of child protective services innovations and initiatives underway.
- Implementation of Child Abuse Prevention and Treatment Act requirement of referrals to the Family Infant Toddler Program is exemplary.

Recommendations

- Ensure that infants and toddlers with reported cases of abuse or neglect receive timely and comprehensive screening, assessment, and interventions.
- Offer training for all child welfare and protective services agency staff related to trauma-informed care in order to build and sustain a trauma-informed system.
- Include child welfare and protective services staff in statewide interdisciplinary training related to child development, early childhood mental health, Strengthening Families, and related topics.
- Sustain funding and increase use of Triple P Positive Parenting Program and Strengthening Families to enhance parenting skills and reduce the incidence of child maltreatment.

Opportunities

- Improve tracking of referrals and outcomes among infants and toddlers referred to the Family Infant Toddler Program as a result of substantiated abuse or neglect.
- Maximize use of the Children's Trust Fund to intervene early and promote child and family well-being.
- Build upon the success of a pilot project using differential response approaches in child protective services for reducing the risk of child maltreatment.

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