

# *Building a System of Home Visiting in New Mexico*

The Next Three Years:  
2009-2012



*A report prepared for the New Mexico Children, Youth and Families Department*

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To develop the plan, a small group of knowledgeable people were invited to participate on a work group chaired by Angie Vachio. Work Group participants included:

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Other Resource Members were: Mark Edwards, Deputy Director, Family Services, Children, Youth and Families Department, Frances Varela, consultant and manager of the Early Childhood Action Network, Maureen N. Burns, Families FIRST Program Manager, NM Department of Health (NMDOH) Christina Carrillo, Director Office of Health Promotion & Community Health Improvement, NMDOH, Eirian Coronado, NM PRAMS Coordinator NMDOH, Dan Harris, Deputy Director Family Services CYFD, Susan Nalder, MCH Epidemiologist-Policy Analyst, Family Health Bureau, Public Health Division, NM DOH, Nancy Treat, Office of Child Development, CYFD and Vicki Johnson, founder of the First Bornâ Program, Silver City, New Mexico. Marg Elliston, was the consultant for the plan and Nandini Kuehn analyzed data and helped to keep the project moving. Celeste Parrish developed the project logo.

Rebecca Kilburn, Ph.D., Senior Economist and Director, RAND Child Policy, RAND Corporation and New Mexico resident, generously provided summaries of national best practice and guidance to the Work Group at two of its meetings. Ms. Kilburn also shared her expertise on design of evaluations and information on the Promising Practices Network (PPN) operated by RAND.

Annette Wisk Jacobi, J.D., Chief Family Support and Prevention Service, Oklahoma State Department of Health provided expertise on implementing and managing state-wide home visiting programs at the Planning Session on September 26, 2007. Other speakers at that meeting included Susan Herrera, Executive Director LANL Foundation, Susie Trujillo, Grant County Health Council, Katherine Freeman, Director of United Way of Santa Fe and Debbie Sanchez, co-executive director of PB and J Family Services.

The workgroup invited people from throughout the state to the Planning Session in September and later developed the Outcomes Document and Standards. Thanks to all who contributed experience, knowledge and best practice to this report.

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## Message from the Lt. Governor

If you knew a way to invest your money and get a 16 percent return on it, you'd jump at the opportunity. That's precisely the kind of profit that Nobel Laureate James J. Heckman, the esteemed economist, says we can reap by investing in programs for young children. The savings come from reductions in the need to provide special education, build jail cells or treat health problems in more advanced stages. Not only that, by investing in our children, we help create a higher-performing workforce of stable adults.

Everyone in society wins.

As chairwoman of the Children's Cabinet, I can assure you that few issues concern our members more than how we care for our children in their earliest years – and that means starting before they're even born. That's why we've invested in the home-visiting program and why we asked for this report on how to expand it to communities throughout the state.

Thank you to those who devoted time to this project.

Let's ensure every New Mexico child has a happy and healthy life.

Diane D. Denish, Lt. Governor

# Executive Summary

**Home Visiting works.** This is a service in which parents and children are visited by trained personnel who offer a combination of information, support, or training regarding child health, safety, development, and care.

**Home Visiting comes at the right time** – during the child’s first 3 years of life when the child’s brain is growing at the fastest rate of life.

**Home Visiting is offered in the right place** – the family home.

**Home Visiting is voluntary.** A family chooses to participate or not as their needs and desires dictate.

**Home Visiting is effective.** Scientific studies show that home visiting delivers a wide range of objectives, including healthy birth outcomes, improvement of the home environment, enhancing positive family development and functioning, and prevention of child abuse and neglect. It has been associated with the reduction of adverse childhood experiences that affects a child’s brain, social-emotional, and physical development, self regulation, early learning, and long-term health conditions.

House Bill 168 (2007, Representative Danice Picraux) established a planning work group to develop a comprehensive, long-range plan to phase in a statewide system of universal voluntary home visiting that serves families during pregnancy and may continue for up to three years. The Home Visitation Work Group (the Work Group) met during 2007-2008 to conduct a systematic review of scientific evidence concerning the effectiveness of early childhood home visitation, review the models present in New Mexico and in other states, establish standards and outcomes for effective home visitation in New Mexico, and develop the roadmap for a statewide system which offers easy to access comprehensive home visiting services to all families starting prior to birth and continuing up to age 3 based on families preferences, strengths, needs and risk factors.

The Work Group recognizes that a major focus of home visiting is relationship building, learning and integrated support for families. On the basis of strong evidence of effectiveness, the Work Group recommends that **early childhood home visitation be established throughout New Mexico to enhance health and child development, safety, parenting education, family support, early learning, and economic self sufficiency.**

State investment in early childhood home visitation programs is crucial. The Work Group recommends an **increase**

**in the State’s investment of \$2 million dollars a year over the next three years.** This will allow services to more than 2000 new families. The State, however, cannot be expected to fund and coordinate the entire system. **Continued partnerships with local entities, counties, municipalities, cities, maternal and child health councils, and private foundations are important to build the system for young children and families.**

While all parents want the best for their children, not all parents have the same resources to provide for their children. **Early childhood home visitation services should be targeted to populations of either the highest need or highest risk. The Work Group recommends that families on WIC be the first population served for all new Early Childhood Home Visitation programs, and that a sub-group of those receiving WIC, specifically school age teen parents giving birth before their 19th birthday, should also be considered a very high priority.**

Home visiting is an integral part of a state wide system for children and families. The Work Group recommends that the **billing structure for home visitation be changed to reduce barriers to service and encourage better linkages with the maternal and child health systems in local communities.** Greater coordination and joint planning at the local level with leverage available funding for young children and their families.

The Work Group defined **minimum standards** (appendix 2) and **mandated outcomes** (appendix 1) for state-funded home visiting programs to be applied to agencies contracting with the state. All programs funded by the state are required to have an **evaluation system**, using normed and validated evaluation instruments, to allow them to demonstrate that they met their own stated objectives and state standards. Evaluations will require that programs assess themselves from the participants’ points of view and make improvements according to data, participant and community response.

The Work Group recommends that an **advisory committee continue** to inform the growing early childhood home visitation system, and that **existing Home Visiting programs mentor emerging programs.**

A large body of scientific based evidence exists that links early childhood experiences with health and functioning throughout life. Home Visiting provides a vital component to establish the early years as ones that lead to good health and living, and to improve the lives of New Mexico’s children, families and communities.

# Building a System of Home Visiting in New Mexico: The Next Three Years – 2009-2012

A Home Visiting Work Group was convened in August 2007 to develop a long range plan for the implementation of Home Visiting services for children and their families starting during pregnancy and continuing for up to 3 years of age.

It is widely known that Home Visiting is a sound investment, saving future costs for remediation by helping families get on the right track with their new child. Home Visiting has proven to improve healthy birth outcomes, healthy child development and family functioning. It can reduce adverse childhood experiences that could affect a child's brain and physical development, self regulation, early learning and impact long-term health conditions well into adulthood.

The Work Group reviewed various home visiting strategies and models used both in New Mexico and throughout the country. The work group does not endorse any particular model but identifies the outcomes desired from any Home Visiting Program funded by the state and outlines minimum program standards to support home visiting programs to achieve the desired outcomes.

The system of home visiting recommended in this report is voluntary, that is, families should be offered the service and have the ability to accept or reject the offer. Home visiting programs should provide a continuum of service that increases or decreases in intensity and duration depending on families' preferences, needs, and risk factors throughout those three years. The system addresses the needs of two generations – parents and children – in the family.

This report contains the recommendations for the Home Visiting System including expected Outcomes for Home Visiting Programs, identification of families served, Home Visiting as part of the Maternal and Child health system, investment and financing of home visiting programs, minimum standards for home visiting and program evaluation. The appendix presents the detailed documents on Outcomes and Minimum Standards as well as birth outcome data and a description of three successful Home Visiting programs operating in New Mexico today.

In any new framework introduced for statewide Home Visiting Services, the workgroup recommends that an advisory group be convened to assist with the implementation of recommendations for outcomes, review standards, and develop consistent reporting back to the state on outcomes and evaluation.

## 1. Outcomes for Home Visiting Programs

The Work Group recommends that the State of New Mexico adopt a universal set of expectations, or outcomes that state-funded home visiting programs are expected to achieve. These outcomes are designed to assure that home visiting programs are working to achieve the goals established by the New Mexico Children's Cabinet. These goals are:

- ◆ All NM children birth to five will be physically and mentally healthy
- ◆ All NM children birth to five will be safe
- ◆ All NM children Birth to Five will learn the skills they need to be ready for school
- ◆ All NM children birth to five and their families will be supported
- ◆ All Children birth to five and their families will be Involved in their communities

The Outcomes for Home Visiting programs listed below are minimum expectations. Some Home Visiting programs may choose to focus on other measures in addition to these. However, all Home Visiting Programs should address these core outcomes, which are:

**Outcome 1:** Babies Are Born Healthy.

**Outcome 2:** Children Are Physically And Mentally Healthy.

**Outcome 3:** Children Who Receive Home Visiting Services Are Safe.

**Outcome 4:** Children Are Nurtured By Their Parents And Caregivers.

**Outcome 5:** The Family Is Connected To Formal And Informal Supports In The Community.

These outcomes will be measured as follows:

## Outcome 1: Babies Are Born Healthy.

The HV Program will be considered effective if:

Babies born to women who receive HV services are carried to term and have infants with a healthy birth weight (2,500-3,999 grams). Because birth weight is heavily influenced by health behaviors, home visiting programs should record and target the following outcomes.

- ◆ Mothers in Home Visiting services abstain from smoking while pregnant;
- ◆ Mothers in Home Visiting services abstain from drinking alcohol while pregnant;
- ◆ Mothers in Home Visiting services have an infant with normal birth weight (2500-3999 grams);
- ◆ Mothers in Home Visiting services have an infant who reaches full term (=>37 weeks gestation).

## Outcome 2: Children Are Physically And Mentally Healthy.

The HV Program will be considered effective if:

- ◆ Parent reports that their child's primary healthcare provider indicates the child is maintaining adequate growth.
- ◆ Children in the HV program are screened within six months for developmental, social and emotional milestones using appropriate validated and normed tools.
- ◆ All children not meeting milestones are referred to appropriate services.

## Outcome 3: Children Who Receive Home Visiting Services Are Safe.

The HV Program will be considered effective if:

- ◆ The home visitor records indicate that parents are aware of and practice safe care of their children.
- ◆ There is a decrease in substantiated reports of child abuse and neglect among families who receive Home Visits.
- ◆ Home visitors use the Medical Assistance Division (MAD) Recommended Anticipatory Guidance document that results in safety issues being adequately addressed.



## Outcome 4: Children Are Nurtured By Their Parents And Care Givers.

The HV Program will be considered effective if:

- ◆ Parents/Caregivers demonstrate developmentally appropriate expectations of their child's mental, physical and emotional development as measured by appropriate evaluation tools.
- ◆ Parents/Caregivers engage in joyful, appropriate, interactive play with their child.

## Outcome 5: The Family Is Connected To Formal And Informal Supports In The Community.

The HV Program will be considered effective if:

- ◆ Families know about, seek out and use formal and informal supports within their community.

Appendix 1 details these Outcomes as well as the indicators for measuring each outcome.

## 2. Home Visiting As Part Of The State-Wide System For Children And Families

The State of New Mexico currently funds home visiting programs in eleven counties in the state. Counties with state funded programs include Bernalillo, Sandoval, Valencia, Taos, Colfax, Grant, Chaves, Dona Ana, Rio Arriba, Santa Fe and Cibola.

At the present time, some existing programs face barriers that prevent them from reaching a significant percentage of their intended target population. The work group con-



cluded that these barriers could be reduced by, among other things, a revision in the billing structure for units of service, improved rate structure, and better linkages with the maternal and child health systems in their localities. The reduction of these barriers would be facilitated if accompanied by increased funding to allow existing programs to develop their capacity to reach a larger percentage of their eligible population. Programs should

serve teen parents eighteen and under, in coordination with other teen-serving programs in their local areas.

In addition to state funded home visiting, there are other programs in the maternal and child health system serving pregnant and parenting women or children 0-3. These include **Families First, FIT, and education-based programs.**

**Families First**, established in 1989 and administered by the NM Department of Health, offers home visiting as a component of its targeted case management for pregnant women and children 0-3 enrolled in the Medicaid Program. The Family Infant Toddler (FIT) program includes home visiting in its service array for 0-3 year olds with Developmental Delay or those At Risk for Delay, including those at environmental risk. Many home visiting programs refer children suspected of having a developmental delay to FIT. Other home visiting programs, some funded by the Office of Child Development, some funded by federal Early Head Start, serve young families to encourage early learning and child development.

Greater coordination and joint planning between Home Visiting programs and planning groups in the maternal and child health care system will leverage available funding for the mutual benefit of all programs. Building an effective community network of organizations that support young families and children will mean that the families receiving

home visiting services can expect to have their health, social support and educational needs met on a timely basis. As families explore opportunities to complete or expand their education or search for improved employment opportunities, home visitors can be effective in making the appropriate linkages.

Home visiting services would further benefit considerably through establishing working relationships with a number of existing services that serve similar populations. These include:

1. Maternal and Child Health Services
2. Women Infants and Children Program
3. Food Stamps
4. Health Clinics such as Federally Qualified Health Centers
5. Hospitals that provide prenatal care for their populations
6. County Health Services
7. Medicaid and SCHIP, Insurance programs
8. Employment agencies
9. Educational Institutions – high schools, community colleges.
10. Early Childhood programs, including child development and training and technical assistance programs.

These relationships often take time to develop. New Home Visiting programs should be encouraged to build these relationships in a start-up period so that they can receive referrals to women who are pregnant and are candidates for Home Visiting services on a timely basis. This will enable them to develop community capacity and facilitate referrals as their clients need them.

## 3. Families Targeted by Home Visiting Programs

Ideally, home visiting programs in New Mexico should be **universal and voluntary**, offered to all families in the state who want the service. However, given the reality of limited resources and the challenge of creating a program to serve everyone, services should be targeted to populations who are most likely to benefit from them as the first step in building and phasing in comprehensive Home Visiting services in New Mexico.

There are well functioning Home Visiting services in New Mexico that have defined their targeted populations and delivered comprehensive home visiting services for many years. The recommendations in this report are not intended to alter the focus of these programs. However, new state funding should be targeted to populations of either the highest need or highest risk who would benefit significantly from Home Visiting services. Data on births in New Mexico is readily available from the New Mexico Bureau of Vital Statistics in the Department of Health. Currently, Home Visiting services maximize their effectiveness by focusing on one or more

of the following populations:

- ◆ Women who are pregnant for the first time;
- ◆ Families in which one member is a first time parent;
- ◆ All women from low-income families because low-income families are more likely to face a variety of stressors;
- ◆ Teen mothers, especially those who are school age;
- ◆ Families who are assessed for being at high risk for child abuse or neglect; or
- ◆ Families eligible for Women's Infants and Children's Nutrition Program (WIC).

**The Work Group recommends that families on WIC be the first population served for all new Home Visiting Programs.** The WIC program targets low-income women who have incomes at or below 185% of the Federal Poverty Level (FPL) and demonstrate a need for help with nutrition for their developing child. A sub-group of those receiving WIC, specifically school-age teen parents giving birth before their 19th birthday, should also be considered a very high priority.

**The Work Group recommends that services be offered first to pregnant women and then to families with newborns.**

The rationale is that the earlier a family is engaged, the better their chances for learning new behaviors and succeeding as parents. If space is available in Home Visiting programs, families with children up to age two should be admitted.

## 4. State Investment in Home Visiting Programs

Home Visiting is an investment that will lead to stronger families in New Mexico, which in turn will build stronger communities. **The State of New Mexico should continue to increase its investment in Home Visiting Services over the next three years. An investment of \$2 million dollars a year for each of the next three years will allow at least 700 new families** to receive services each year for a total of more than 2000 **additional families** served at the end of Fiscal Year 2012. (This calculation is based on the assumption that the average cost per family for home visiting is currently \$3000 a year at \$75 a visit for 40 visits a year.) The work group strongly urges that units of service replace the current method of a fixed rate per visit.

Based on present experience, many more than these 2000 families will be touched by home visiting programs as some families choose to participate in the program for less than a year, (some leaving when their child is six months old) while others remain engaged for the entire three years. Some families are visited in the hospital, receive information about home visiting and chose not to participate in the program. As the home visiting program grows, accurate information

about duration of involvement and intensity of involvement by type of family and community will be available for future planning and service design.

In developing funding for home visiting services, the state should define specific components in the budget for the costs of start-up and planning, capacity building and community assessment activities. Without the time and the infrastructure to build their networks, these programs will not be able to garner the referrals they need to ensure they reach the optimum number of clients. In addition, (and as will be elaborated later in this report) consideration should be given to funding the costs of external evaluations of all home visiting programs.

## 5. Funding Home Visiting Programs

The State of New Mexico should continue to play a major role in the growth of the home visiting system and for that matter, the entire system serving young children and families. The Children Youth and Families Division will play a key role in providing core funding for these services. However, CYFD should continue to explore the availability of including home visiting support within all Medicaid programs, and specifically within the managed care Medicaid programs (MCOs). The philosophy of managed care is to focus on prevention and pro-active approaches to enhance health and well being of their clients to prevent more expensive "down-stream" health costs. Home Visiting could be an extremely helpful tool, especially in the prenatal phase and within the post partum phase where early detection of problems would be beneficial for the MCOs as well as the families.

Other opportunities to leverage state funds with federal Medicaid dollars should continue to be explored. Teen parents may be covered under the Early, Periodic, Diagnostic Screening and Treatment – EPSDT program. Post partum home visits performed by medical personnel provide another opportunity to use Medicaid for Medicaid eligible families receiving medically necessary services. Coverage afforded to families in the FIT program, mentioned above, may provide a model for coverage for families receiving home visiting services.

The state, however, cannot be expected to fund and coordinate the entire system. Continued partnerships with local entities, including counties, municipalities, cities, maternal and child health councils and private foundations are important to build the system for young children and families.

The opportunity for Public-Private partnerships is another area for exploration, from county governments, United Way, private foundations, churches, municipalities and others. The potential to garner the support of major businesses and corporations in this endeavor (since home visiting is linked to better educational outcomes that lead to a better workforce in the community) should be explored within their

communities by home visiting programs. A wide variety of sources of support is essential for the growth of a vital system of home visiting in our state.

## 6. Targeting Need

As more resources for home visiting services become available, New Mexico should target services based on a number of factors that reflect need. The work group reviewed data on total number of births statewide (see Appendix 3) and then considered the following factors as those which could benefit most from a risk reduction perspective from home visiting services:

- ◆ Births to school-aged teen mothers up to age 18. Evidence shows that this population benefits greatly from Home Visiting programs. School-aged school mothers are a vulnerable population. A high percentage of teen mothers are also included in the Medicaid and WIC numbers. Two thousand eight hundred fourteen (2,814) school aged teens comprised 9 % of all births in 2006.
- ◆ Low or no prenatal care, i.e. women receiving fewer than five prenatal visits before delivery. Adequate prenatal care positively correlates with the health of the infant. In 2006, 3431 babies or 11% of the 29,918 babies born in New Mexico had low or no prenatal care. Again, there is evidence that home visiting services could enhance compliance with prenatal care.
- ◆ Low Birth Weight – babies born weighing less than 2500 grams. Low Birth Weight correlates negatively with the health of the infant. In 2006, 2,669 babies or 9% of the total live births had a low birth weight. Home visiting services can address factors most commonly associated with low birth weight (smoking, alcohol consumption, poor nutrition).
- ◆ Percent of population giving birth enrolled in both Medicaid and WIC. Both of these percentages are indicators of the economic status of families giving birth in a particular county. Medicaid or SCHIP is available for families with incomes up to 235% of the Federal poverty level who must demonstrate that they are citizens or have green cards. WIC is nutrition assistance available to families with incomes up to 185% of the federal poverty level and/or demonstrate need for nutrition assistance. In 2006, 46% of all women giving birth participated in



the WIC program. Home Visiting services can ensure that families remain enrolled in these programs that provide access to essential food and nutrition services for the mother and infant and provides access to medical services as needed.

Using these factors, we analyzed birth outcomes by county in New Mexico. The tables generated from this analysis are in Appendix 3 at the conclusion of this report.

When we ranked the ten New Mexico counties with the greatest number of births to school aged teens, families on the WIC program, low birth weight babies and women receiving low or no prenatal care, we found a direct correlation to the population of the counties. The ten most populous counties had the most mothers showing risk factors. In fact, the ten most populous counties produced 73% of all births in 2006.

When we compared the **number** of births to women receiving low or no prenatal care to the **percentage** of births with

low or no prenatal care in the county of residence, we found that the top ten counties had 80% of the births with low or no prenatal care while those with the greatest percentage had 29% of all births in New Mexico and 43% of all births to those with low or no prenatal care.

Because there is not one set of data that could be used to absolutely direct resources for home visiting services, applicants for funding should be asked to discuss strategies for improving outcomes for births to school-age teens, reducing numbers of women receiving low and no prenatal care and reducing the number of low birth weight babies as well as achieving the five home visiting outcomes. Applicants should demonstrate strategies for

reaching pregnant women and keeping them engaged in the program.

The work group recommends that existing Home Visiting programs should mentor emerging programs and advise them in their efforts to develop a curriculum, build networks, build capacity and recruit new candidates for home visiting.

There are eight counties with less than 100 children born in a year – Catron, DeBaca, Guadalupe, Harding, Hidalgo, Mora, Sierra and Union. These counties should be encouraged to design home visiting services as part of a general public health initiative where a maternal and child health generalist or a Families First provider could offer an extended educa-

tion program for isolated women. Again, existing programs in neighboring counties might provide developmental support as needed.

## 7. Home Visiting Standards

The Work Group has defined minimum standards for state-funded home visiting programs. These standards define the basic elements for services offered by agencies contracting with the state. These standards include practices to produce the outcomes stated above and expectations for the home visiting services with respect to families and their community. Recommended Home Visiting standards are presented in Appendix 2. These standards address the following:

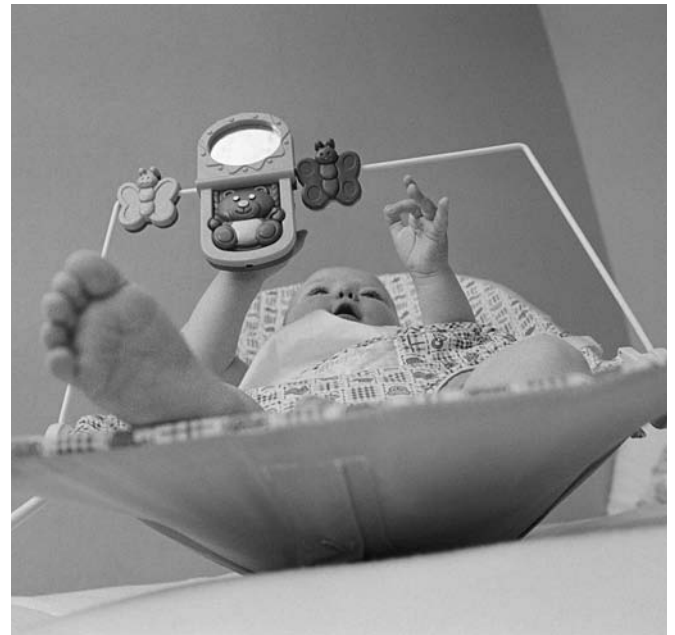
- ◆ Home Visiting program design including frequency and duration of Visits
- ◆ Home Visiting curriculum covering the pre-natal period, post-partum, infancy, toddlers and transition
- ◆ Family Recruitment, Selection and Enrollment
- ◆ Home Visiting Staff
- ◆ Agency Records
- ◆ Program Evaluation.

## 8. Evaluation

External evaluation of Home Visiting programs in New Mexico should be an essential component of all programs to ensure consistent and standardized outcomes. Home Visiting providers, investors, community members and families all deserve to know the value added by these programs. Funding must be available for the evaluation process. One recommendation from the work group is that 10% of the budget for home visiting programs should be dedicated for an outside evaluation of the program. If the evidence in early learning studies bears out in New Mexico, providing a mother and her infant this kind of support until the child turns 3 will have life-long positive impacts for the family and the communities in which they live.

Programs should also be asked to demonstrate that they met their own stated objectives and state standards. There should be ongoing data collection so that the state has information on numbers served as well as the intensity and duration of involvement with each family to show whether the program is being willingly accepted by new families and is being used at the level that makes it cost effective. In addition, programs should assess themselves from the participants' points of view. Well structured satisfaction surveys that identify specific program objectives and are administered by a third party to both those who complete the full program course and those who left early can demonstrate whether the program is meeting the needs of most clients and where improvements may be made.

Finally, programs should be able to report on the impact on the community of specific programs, including what proportion of families and infants with Home Visiting programs actually sign up for health coverage, remain enrolled, have consistent health care, and maintain a set of healthy habits that the programs can help with. All of these outcomes have a social benefit and should be a common objective of all programs. These should also be available through data that will be provided by each program.



## Conclusion

It is time to invest in what works to support families in New Mexico. Home Visiting is one of the services that work. It is time to grow our investment in Home Visiting and grow our investment in our young families to improve the well being of all New Mexicans.

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# Appendices

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1. *Outcomes For Home Visiting Programs In New Mexico*

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## APPENDIX 1

### OUTCOMES FOR HOME VISITING PROGRAMS IN NEW MEXICO

#### Background

Home Visiting programs have been associated with a number of positive outcomes for families and children served from prenatal to age three. The most common outcomes linked to home visiting programs are:

- Increase in healthy births
- Improved health for mother and child,
- Early identification of risks for the infant that benefit from early intervention
- Reduce unintended pregnancies
- Enable parents to provide a safe and nurturing environment resulting in improved school readiness for children.

Performance Outcomes for all state funded Home Visiting programs are identified within the following context:

#### **1. Eligibility for Accessing a Home Visiting Program:**

Existing Home Visiting programs with an evidence based approach targeting specific populations may continue to target their populations as defined by their program philosophy. All other state funded Home Visiting programs are encouraged to recruit their target population from WIC (Women, Infants and Children) eligible or from WIC enrolled mothers. This includes WIC programs in tribal lands. The WIC program targets low-income woman who are pregnant, breastfeeding or have an infant under 1 year or a child less than 5 years – the exact population that would benefit most from Home Visiting programs.

#### **2. Outcomes from Home Visiting Programs**

There are two long-term outcomes from good home visiting programs that make children and communities strong. There is evidence that a good home visiting program can (a) reduce or mitigate the impact of adverse childhood events<sup>1</sup> and (b) build resiliency and coping skills<sup>2</sup>. Program Outcomes selected for state funded Home Visiting services will focus on behaviors that can be impacted during client participation in Home Visiting services and which inherently

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<sup>1</sup> Adverse Childhood Events refers to a range of serious physical and mental stresses (physical and sexual abuse to experience with foster care) that have a significant negative impact on the behavioral, mental and physical health of adults.

<sup>2</sup> Resiliency refers to coping strategies that enable children to overcome the negative impact of ACE and of life stresses and challenges.

feed into these two long term goals beyond the duration of the client's participation in the service.

Home Visiting programs should incorporate the following features:

- As a priority, programs should emphasize the enhancement of nurturing, joyful parent-child interactions and relationships as the organizer for all areas of health and development for young children. Enhanced parent-child interactions (which lead to positive health outcomes for the child) can best be supported through the development of a parallel nurturing relationship between the home visitor and the family that supports each parent to focus on their interactions with their baby. The visit should be more than checklists and structured teaching.
- Outcomes identified should be in areas that the home visitor can reasonably influence and which can yield the best physical and mental health outcomes for the child and the family. Asking the home visitor to develop systems of care is not a realistic expectation.
- The Home Visiting Program will be expected to meet performance standards that focus on its advocacy responsibilities (for example, to identify lack of appropriate services where mothers and children in need can be referred), as well as to demonstrate that the program is responsive to the culturally specific needs of the populations it serves.

Home Visiting programs will be expected to achieve five Outcomes. The first outcome targets women who enter the program during the prenatal period; the second, third and fourth outcomes targets the newborn through early childhood, and the fifth looks at the family as a whole.

The following are proposed Core Outcomes of a State-funded Home Visitation Program. Home Visiting programs may track additional measures as they choose. Detailed descriptions of expected activities and programmatic measures follow.

Population measures available from Department of Health Bureau of Vital Statistics and the New Mexico Pregnancy Risk Assessment Monitoring System (PRAMS) provide useful data to compare the population of the Home Visiting Program (HV) to that of the county in which services are offered.

#### Outcome 1: **Babies Are Born Healthy.**

*The HV Program will be considered effective if:*

Babies born to women who receive HV services are carried to term and have infants with a healthy birthweight (2,500-3,999 grams). Because birthweight is heavily modified by health behaviors, home visiting programs should record and target the following outcomes.

- Mothers in Home Visiting services abstain from smoking while pregnant;
- Mothers in Home Visiting services abstain from drinking alcohol while pregnant;
- Mothers in Home Visiting services have an infant with normal birthweight (2500-3999 grams);

- Mothers in Home Visiting services have an infant who reaches full term (=>37 weeks gestation).

**Outcome 2: Children Are Physically And Mentally Healthy.**

*The HV Program will be considered effective if:*

- Parent reports that their child's primary healthcare provider indicates the child is maintaining adequate growth;
- Children in the HV program are screened within six months for developmental, social and emotional milestones using validated and normed tools.
- All children not meeting milestones are referred to appropriate services.

**Outcome 3: Children Are Safe.**

*The HV Program will be considered effective if:*

- The home visitor records indicate that parents are aware of and practice safe care of their children.
- There is a decrease in substantiated reports of child abuse and neglect among families who receive Home Visits.
- Home visitors use the Medical Assistance Division (MAD) Recommended Anticipatory Guidance document which results in safety issues being adequately addressed.

**Outcome 4: Children Are Nurtured By Their Parents And Caregivers.**

*The HV Program will be considered effective if:*

- Parents demonstrate developmentally appropriate expectations of their child's mental, physical and emotional development as measured by appropriate evaluation tools.
- Parents engage in joyful, appropriate, interactive play with their child.

**Outcome 5: The Family Is Connected To Formal And Informal Supports In The Community.**

*The HV Program will be considered effective if:*

- Families know about, seek out and use formal and informal supports within their community.

**OUTCOME 1: BABIES ARE BORN HEALTHY**

The HV Program will be considered effective if:

Babies born to women who receive HV services are carried to term and infants have a healthy birthweight (2,500-3,999 grams). Because birthweight is heavily modified by health behaviors, home visiting programs should record and target the following:

- Mothers in Home Visiting services abstain from smoking while pregnant;
- Mothers in Home Visiting services abstain from drinking alcohol while pregnant;
- Mothers in Home Visiting services have an infant with normal birthweight (2500-3999 grams);
- Mothers in Home Visiting services have an infant who reaches full term (=>37 weeks gestation).

**TARGET OF HV SERVICE:** Women who receive home visiting services during their pregnancy.

	PROGRAM ACTIVITIES CONDUCTED BY HOME VISITORS	HV PROGRAMS ARE EXPECTED TO DEMONSTRATE
1	Pregnant women are encouraged and supported to have early, adequate and consistent prenatal care, and are provided with information about health and nutrition during prenatal period, as well as information on childbirth, early childhood development, and preparing for the new infant.	HV Record documents that mother reports: <ul style="list-style-type: none"> <li>• She has pre-natal provider; and</li> <li>• She keeps prenatal appointments; and</li> <li>• She has made arrangements for delivery, including a plan for early labor.</li> </ul> HV Record documents that Home Visitor has: <ul style="list-style-type: none"> <li>• Assisted with arranging prenatal care as needed and supported client's regular participation; and</li> <li>• Asked regularly about the prenatal visits, including issues the mother would like to discuss and plans being made for delivery and discharge home.</li> <li>• Supported the mother with education about the availability of prenatal classes, early childhood development, attachment issues and other nurturing behaviors.</li> </ul>

	<p><b>PROGRAM ACTIVITIES CONDUCTED BY HOME VISITORS</b></p>	<p><b>HV PROGRAMS ARE EXPECTED TO DEMONSTRATE</b></p>
<p>2</p>	<p>Pregnant women receive anticipatory guidance to support health behaviors that are optimal for healthy births. Topic areas may include the following:</p> <ul style="list-style-type: none"> <li>▪ Impact of alcohol, tobacco or drug use on the baby</li> <li>▪ Use of seatbelt during pregnancy</li> <li>▪ Birth control issues after pregnancy</li> <li>▪ Attachment, relationship</li> <li>▪ Breastfeeding</li> <li>▪ What to do if labor starts early</li> <li>▪ Oral health for mother and infant</li> </ul>	<p>HV records indicate appropriate information was shared on each issue as relevant.</p>
<p>3</p>	<p>Pregnant women are screened for:</p> <ul style="list-style-type: none"> <li>• Depression; and</li> <li>• Domestic violence</li> </ul>	<p>HV records indicate:</p> <ul style="list-style-type: none"> <li>• Screening with appropriate tools occurred at appropriate time; and</li> <li>• Positive results were discussed with supervisor; and</li> <li>• Referrals were made as appropriate.</li> </ul>
<p>4</p>	<p>Pregnant women receive information and access to services to assure that nutritional status is adequate:</p> <ul style="list-style-type: none"> <li>▪ Links with the WIC and Food stamp programs</li> <li>▪ Need for vitamins (e.g. folic acid to prevent birth defects)</li> <li>▪ Other risk issues are discussed to reinforce advice from prenatal care provider: diabetes, weight gain, oral health etc.</li> </ul>	<p>HV records indicate appropriate information was shared on each issue as relevant.</p>

**OUTCOME 2: CHILDREN WHO RECEIVE HV SERVICES ARE PHYSICALLY AND MENTALLY HEALTHY**

The HV Program will be considered effective if:

- Parent reports that their child's primary healthcare provider indicates the child is maintaining adequate growth;
- Children in the HV program are screened within six months for developmental, social and emotional milestones using validated and normed tools.
- All children not meeting milestones are referred to appropriate services.

	<b>PROGRAM ACTIVITIES CONDUCTED BY HOME VISITORS</b>	<b>HV PROGRAMS ARE EXPECTED TO DEMONSTRATE</b>
5	<ul style="list-style-type: none"> <li>▪ Mother and/or primary care giver are encouraged and supported to receive recommended care from a consistent health care provider;</li> <li>▪ Mother is provided the opportunity for anticipatory guidance regarding future pregnancies.</li> <li>▪ Mother or primary care giver is provided anticipatory guidance for maintaining nutrition including:                             <ul style="list-style-type: none"> <li>- Maternal nutrition</li> <li>- Breastfeeding</li> <li>- Diabetes risk, weight gain</li> <li>- Other community resources that offer food or other assistance.</li> </ul> </li> </ul>	<p>HV Record documents that mother/primary care giver reports:</p> <ul style="list-style-type: none"> <li>▪ She attended post-partum appointments; and</li> <li>▪ Relationship with a consistent health care provider is established and being used as indicated including to discuss nutrition and future pregnancies.</li> </ul> <p>HV Record documents that Home Visitor has:</p> <ul style="list-style-type: none"> <li>▪ Assisted with arranging post-partum care as needed and supported mother/primary care giver to participate in healthcare; and</li> <li>▪ Asked as appropriate about mother/primary care giver's health, including issues the parent would like to discuss and support needed to access appropriate services.</li> <li>▪ Lack of appropriate resources are documented and reported to supervisors.</li> </ul>

**OUTCOME 2 (continued): CHILDREN WHO RECEIVE HOME VISITING SERVICES ARE PHYSICALLY AND MENTALLY HEALTHY**

	PROGRAM ACTIVITIES CONDUCTED BY HOME VISITORS	HV PROGRAMS ARE EXPECTED TO DEMONSTRATE
6	<p>Mother is screened/provided anticipatory guidance after the baby's birth regarding the effects of the following on children's physical and mental health:</p> <ul style="list-style-type: none"> <li>▪ Maternal depression, and</li> <li>▪ Domestic violence</li> </ul>	<p>HV records indicate:</p> <ul style="list-style-type: none"> <li>▪ Screening with appropriate tools occurred at appropriate times; and</li> <li>▪ Positive results were discussed with supervisor; and</li> <li>▪ Referrals were made as appropriate.</li> </ul>
7	<p>Mother and/or primary care giver are supported to assure that the child receives recommended care from a consistent health care provider, including oral health.</p>	<p>HV Record documents that mother/primary care giver reports:</p> <ul style="list-style-type: none"> <li>▪ Recommended well child visits have occurred; and</li> <li>▪ Child immunizations are up-to-date or a plan for such is in place.</li> </ul> <p>HV Record documents that Home Visitor has:</p> <ul style="list-style-type: none"> <li>▪ Assisted with arranging health care as needed; and</li> <li>▪ Supported mother/primary care giver to participate in child's healthcare; and</li> <li>▪ Asked about child's health, including issues the parent would like to discuss and support needed to access appropriate services for the child.</li> </ul>
8	<p>Mother and/or primary care giver are supported to assure that the child receives adequate nutrition for optimal physical and mental development.</p>	<p>Records indicate:</p> <ul style="list-style-type: none"> <li>▪ Length of and approaches to breastfeeding (exclusive, supplemented)</li> <li>▪ Information about alternatives to breast feeding was shared as appropriate</li> <li>▪ Discussion of baby's weight gain and growth as measured by healthcare provider</li> <li>▪ Other relevant issues</li> </ul>

**OUTCOME 3: CHILDREN WHO RECEIVE HV SERVICES ARE SAFE.**

The HV Program will be considered effective if:

- The home visitor records indicate that parents are aware of and practice safe care of their children.
- There is a decrease in substantiated reports of child abuse and neglect among families who receive Home Visits.
- Home visitors use the MAD Recommended Anticipatory Guidance document (attached) results in safety issues being adequately addressed.

	<b>PROGRAM ACTIVITIES CONDUCTED BY HOME VISITORS</b>	<b>HV PROGRAMS ARE EXPECTED TO DEMONSTRATE</b>
10	Home Visitors discuss reportable abusive or neglectful behavior in a non-threatening way to ensure parents understand what appropriate and inappropriate behavior is. Also reviews the risks of reportable behavior.	HV record indicates: <ul style="list-style-type: none"> <li>▪ Discussed reportable behavior with parents.</li> <li>▪ Safety plans in place in case of potential DV</li> </ul>

**OUTCOME 4: CHILDREN ARE NURTURED BY THEIR PARENTS AND CAREGIVERS.**

The HV Program will be considered effective if:

- Parents and caregivers demonstrate developmentally appropriate expectations of their children as measured by appropriate evaluation tools.
- Parents and caregivers engage in joyful, interactive play with their child.

	<b>PROGRAM ACTIVITIES CONDUCTED BY HOME VISITORS</b>	<b>HV PROGRAMS ARE EXPECTED TO DEMONSTRATE</b>
12	Home Visitors promote parent child interactions that result in optimal development including healthy, secure and nurturing attachment relationships.	HV record indicates: <ul style="list-style-type: none"> <li>▪ Home Visitor documents observations of progressive parent/caregiver-child interactions; and</li> <li>▪ A developmental curriculum is used to provide developmental guidance and interaction support.</li> <li>▪ Home Visitor records observations about attachment behaviors.</li> </ul>

**OUTCOME 5: THE FAMILY IS CONNECTED TO FORMAL AND INFORMAL SUPPORTS IN THE COMMUNITY**

The HV Program will be considered effective if:

Families know about, seek out and use formal and informal supports within their community.

	<b>PROGRAM ACTIVITIES CONDUCTED BY HOME VISITORS</b>	<b>HV PROGRAMS ARE EXPECTED TO DEMONSTRATE</b>
13	<p>Parents develop a plan that identifies their needs for formal and informal supports for themselves and their child and how to:</p> <ul style="list-style-type: none"> <li>▪ Access needed supports and services; and</li> <li>▪ Find solutions related to any problems making use of informal supports.</li> </ul> <p>Home Visitor provides anticipatory guidance on building a future:</p> <ul style="list-style-type: none"> <li>▪ Parents who have not yet completed high school or a GED are provided with information on their options.</li> <li>▪ Parents who are un/under-employed and seeking to find work are supported to find employment</li> <li>▪ Child care resources are identified and assistance provided for parents who need to work.</li> </ul>	<p>HV records indicate that parents know about, seek out, and use formal and informal supports within their community</p> <p>Lack of community resources are reported to HV agency.</p>
14		<p>HV record indicates when these issues are discussed with parents and any resulting actions:</p> <ul style="list-style-type: none"> <li>▪ Parents sign up for classes or pursue job training;</li> <li>▪ HV actions to support successful education/ employment activities (safe, supportive child care resources discussed, time management planning, etc.)</li> <li>▪ Identify barriers faced in these areas by households and share with supervisor to inform agency advocacy efforts</li> </ul>

## APPENDIX 2

### MINIMUM STANDARDS FOR HOME VISITING PROGRAMS IN NEW MEXICO

#### **Home Visiting Program Design**

Home visiting programs must include within their mission statements that their services are to support families, infants and toddlers by developing mechanisms for family engagement, retention, and satisfaction with services. Home visiting programs **are** family centered and view the family as a whole.

As a priority, programs should emphasize the enhancement of nurturing, joyful parent-child interactions and relationships as the organizer for all areas of health and development for young children. Enhanced parent-child interactions (which lead to positive health outcomes for the child) can best be supported through the development of a parallel nurturing relationship between the home visitor and the family that supports each parent to focus on their interactions with their baby. The visit should be more than checklists and structured teaching.

Home visiting programs are designed to deliver, at a minimum, the Outcomes designed by the state of New Mexico. Programs must meet the needs of individual families and support the strengths and resiliency of families. At a minimum, Home Visiting services should include: developmental guidance, interaction support, educational and local community resource information, identification of social supports, referral of families to community resources, and services offered prenatally and during the first three (3) years of the child's life.

Home visiting programs must partner and collaborate with other agencies and providers in their community to enhance the safety and well-being of the families served.

Home visiting programs are inclusive of, and responsive to, the ethnic, cultural, racial and socioeconomic diversity of the community. Home visitors are able to work effectively with the diverse cultures in their community.

Home visiting programs must have a continuous quality improvement process, evaluate their services and report on the outcomes achieved for individual families and the program.

#### **Schedule of Visits**

Home visiting programs must design a level of intensity of delivery of services that determines the duration and frequency to develop a trusting relationship between the home visitor and the parents, and at a minimum should include the following:

1. The home visitor should meet with a new family to develop a schedule of home visiting that meet the needs of the family with the goal of weekly meetings in the first six months of the program, depending on family needs. These home visiting plans must be reviewed every three (3) months for the first six months and updated every six (6) months;
2. The agreed upon services should be delivered based on family needs including visits during non-traditional working hours;
3. Services should normally be scheduled in the family's home, with alternative locations allowed when appropriate to address the family's needs.

### **Home Visiting Curriculum**

Home visiting programs have a core curriculum designed to achieve program outcomes. The curriculum must be interactive, flexible and have key messages and specific achievements for the families and their home visitor. The curriculum must be culturally competent, including translation appropriate to the culture being served. Activities covered in the curriculum must include at a minimum the following components:

1. During the prenatal home period:
  - Assistance to families in establishing a primary health care home for mother and child, and planning when hospital emergency care/urgent care visits are needed in addition to primary health care visits;
  - Assistance to families in identifying informal and formal support networks and referrals to community resources as necessary;
  - Provision of information on prenatal health, newborn care, and child development, including developmental guidance;
  - Determination if families have been referred and referral to Medicaid on Site; Assistance/Presumptive Eligibility (PE/MOSAA), Women, Infants and Children (WIC) services, when appropriate;
  - Impact of alcohol, tobacco or drug use, either active use or passive exposure to the unborn child;
  - Use of seatbelt during pregnancy
  - Attachment relationships
  - Breastfeeding supports
  - Early labor warning signs and interventions
  - Oral health care of the mother during pregnancy;
  - Mental health of mother and individuals living-with or significantly-involved with the mother and effects of prenatal depression and exposure to or direct involvement of domestic violence

- Safe sleep positions and injury prevention through home safety and selection of play areas and toys.
2. During the Post-Partum and infancy period:
- Assessing the mother's wellbeing including physical, emotional and social supports.
  - Discussion of what are reportable abusive or neglectful behaviors compared to appropriate responsive behaviors toward child
  - Safe sleep positions and injury prevention through home safety and selection of play areas and toys.
  - Parental recognition of poison hazards.
  - Parents recognize early signs of illness and know how to seek appropriate levels of medical care or emergency help as needed;
  - Parents understand and practice prevention of accidental injuries in the home (falls, burns, drowning).
  - Other needs as identified by the parents.
  - Anticipatory guidance regarding future pregnancies.
  - Maternal nutrition and impact on nursing child.
  - Mental health of mother and individuals living-with or significantly-involved with the mother and effects to a child exposed to domestic violence in their development and growth.
3. Future Planning/Transition period:
- Provision of referrals to community resources, as necessary, including Part C and Part B providers for concerns about child development after home visiting services end;
  - Provision of developmental guidance and interaction support to families and caregivers including adoptive parents;
  - Anticipatory guidance to parents who have not yet completed high school or a GED is provided with information on their options;
  - Anticipatory guidance to parents who are un/under-employed and seeking to find work are supported to find employment;
  - Child care resources are identified and assistance provided for parents who need to work; and
  - Injury prevention through home safety and selection of play areas and toys including recognition of poison hazards and injury prevention as stated above.
4. Voluntary home visits available for the first three years of the child's life that include the following components:
- Guidance to families through developmental curricula that support nurturing, responsive parent-child interactions;
  - Assistance to families in establishing a primarily health care home including identification of insurance or benefits to which the family is entitled;

- Assistance to families in identifying informal support networks;
- Provision of developmental guidance and interaction support to families and caregivers including adoptive parents.

Home visiting programs must maintain appropriate records and ongoing review of home visitor activities. The programs must provide funders with regular and comprehensive reports on outcomes influenced by home visiting services. Funders will provide home visiting services programs with the reporting requirements.

### **Home Visiting Family Recruitment/Selection/Enrollment**

Home visiting programs must develop and implement a system that describes specifically how those most in need of these services are recruited, selected and enrolled. "Need of service" must be defined based on the needs in the community the family resides in and the resources available for the family's support.

Home Visiting programs must establish and maintain referral procedures with Families FIRST providers, Maternal and Child Health providers, WIC Programs and any other medical or service providers who provide service to pregnant and new families.

Family involvement in the home visiting services must be voluntary and a family may terminate enrollment at any point in the service delivery.

Home visiting programs must develop and implement strategies that recruit, select, enroll and retain teen-parents in home visiting services.

In most cases, a family receives home visiting for one child. Re-enrollment of families for subsequent children, once a family has fully participated in the home visiting program, is discouraged and allowable only with special family circumstances. The premise is families will develop the networks and systems to provide the family support with the arrival of additional children.

A family is eligible to begin services during the pregnancy of the mother. The family may choose to continue services up to that child's third birthday. Priority must be given to those families wanting prenatal services. The second priority is families who enroll before the mother's hospital discharge after the birth of the child. Families are eligible for enrollment after these life events up to the child's second birthday. The home visiting program may not enroll a child over the age of 24 months. Once a child/family is enrolled, they may continue to receive services up to that child's third birthday.

### **Home Visiting Staff**

A home visitor's caseload must not exceed 25 families. Home visiting programs must adjust the caseload of those home visitors who serve families actively engaged with Children, Youth and Families Department (CYFD) Child Protective Services or the Department of Corrections (DoC) or otherwise present complex issues and demands.

Home Visitors are composed of degreed professionals and non-degreed professionals with knowledge and skills in early childhood development or early childhood behavioral health. The visitor may be a nurse, social worker, psychologist, early childhood educators, promotoras, or have experience in another related field.

Home visiting programs must have a working relationship with licensed, clinical professional(s) who is/are knowledgeable in maternal and child health issues.

Home visitors must either be bi-lingual in the language of the family served or must include as part of the team an individual that is bi-lingual in the language of the family served.

All home visiting program staff that have direct contact with families must undergo a criminal record check through CYFD.

Home visiting programs must have a staff training plan in place that supports home visitors develop the competencies needed for effective home visiting. Pre-Service training and continuing education is provided to home visitors at the level appropriate to achieve outcomes specified in this document. Required topics include those that will facilitate successful home visiting State outcomes.

Home visiting programs must provide reflective supervision at least twice a month, with at least one individual session to staff delivering home visiting services. Supervision is provided individually and enhanced through group sessions. A practitioner who is trained and knowledgeable in early childhood development or early childhood mental health and utilizes reflective practice must conduct the supervision. Supervision must be documented by a sign-in sheet to include a short summary.

Home visiting supervisors must:

1. Review the screening results for child development milestones and referrals for service, if appropriate. All screening tools must be normed and validated, as appropriate.
2. Review family records for observations by home visitor and/or family about attachment behaviors.
3. Ensure that all evaluation materials are completed and entered into the database in a timely manner;

4. Ensure that home visitors utilize the child development curriculum information with families on a regular basis;
5. Accompany newly employed Home Visitors at least twice in their first year and at least once a year in subsequent years.
6. Review status regarding use of consistent health care provider (s).
7. Other duties as identified throughout the Service Definition Manual and contract Scope of Work.

### **Home Visiting Program Records**

Home visiting programs records for families at a minimum must contain:

1. Complete intake form
2. Complete additional required forms
  - a. Family rights, responsibilities and grievance procedures;
  - b. Family release of information (confidentiality statement);
  - c. Consent form (documentation of consent or attempt to obtain consent) of the family for admission, treatment, evaluation, aftercare or research;
3. All forms must be signed and dated by the family or legal guardian, and the staff.
4. A separate release of information must be used for each request;
5. Family must also be informed of data collection methods utilized by the and to whom information will be reported including file reviewers;
6. An evaluation consent form must be signed and dated by the family or legal guardian.

Reports, as appropriate from mother's and child's primary health care practitioner(s) that document:

- Mother has pre-natal provider and has consistently attended scheduled prenatal appointments;
- Family has made arrangements for delivery, including a plan for early labor
- Mother attended post-partum appointments;
- Mother and child have a consistent health care provider established;
- Family discussion of mother's nutritional health and future pregnancies;
- Recommended well-child visits have occurred;
- Child immunizations are up-to-date or a plan for such is in place;

Documentation that the Home Visitor has:

- Assisted with arranging prenatal and post partum health care, as needed;
- Supported the mother's regular participation in arranging and receiving health care, as needed;
- Supported mother/primary caregiver to participate in child's health care;
- Asked regularly about the prenatal visits, including issues the mother and family would like to discuss and plans being made for delivery and discharge home;

- Supported the mother and family with education about the availability of prenatal classes, early childhood development, attachment issues and other nurturing behaviors;
- Asked about child's health, including issues the parent would like to discuss and support needed to access appropriate services for the child.
- Assisted with arranging post partum care as needed and supported mother/primary caregiver to participate in health care;
- Asked as appropriate about mother/primary caregiver's health, including issues the parent would like to discuss and support needed to access appropriate services;
- Lack of appropriate resources are documented and reported to supervisors

Records indicate:

- Length of and approaches to breastfeeding (exclusive, supplemented);
- Information about alternatives to breastfeeding shared as appropriate;
- Discussion of baby's weight gain and growth as measured by health care practitioner
- Appropriate-for –age and service setting child development screening tools that are standardized, normed and validated, such as ASQ and ASQ:SE or other assessments, were administered, scored, and discussed with the family;
- Referrals made by home visitor and follow-up on referrals
- Home visitors discussed with families reportable behavior to CYFD with family;
- Discussion and if requested by family, development of a safety plan for family;
- Parents/family reported they are positioning infants to sleep on their back;
- Parents reported they have a safe sleeping arrangement for infant.
- Parents have a smoke-free home (infant is not exposed to cigarette smoke);
- Parent report using an age/size-appropriate child safety restraint in the vehicle
- Parents recognize poison hazards and safe-guard their child;
- Parents recognize early signs of illness and know how to seek appropriate levels of medical care or emergency help as needed;
- Parents understand and practice prevention of accidental injuries in the home (falls, burns, drowning)

Transition Records include at a minimum:

- Parents know about, seek out, and use formal and informal supports within their community;
- Lack of community resources are reported;
- Discussion with parents who have not yet completed high school or a GED are provided with information on their options;
- Discussion with parents who are un/under-employed and seeking to find work are supported to find employment;
- Discussion with parents who will be seeking/needing child care resources identified and assistance provided for parents who need to work.

- Discussion with parents to identify barriers faced by family and this information is reported back to home visiting agencies for use in advocacy efforts.

### **Evaluation**

- Home Visiting programs survey their clients at least each six months and maintain records on the results of these surveys to determine how the family views their home visitor and the services offered.
- Home Visiting programs have a system to measure the achievement of the state outcomes and report on these outcomes at least every six months.
- Home Visiting programs may evaluate other outcomes as well and report to other funders and the state on the achievement of these outcomes.

**APPENDIX 3****TOP TEN RANKINGS BY VOLUME AND RANK ORDER of KEY BIRTH CHARACTERISTICS BY COUNTY**

The following Tables provide volume and rank information about five key characteristics that are relevant for Home Visiting Programs. Two Tables are provided on each issue. The first rank shows volumes in rank order in each county, while the second ranks the proportion that those volumes represent of live births in each county. Note that Vital Records deems observations of <20 as being statistically unreliable. The five tables are:

1. Teen Births
2. Low Birth Weight
3. Low or No Prenatal Care
4. Mothers on WIC who Delivered and Did Not Deliver in 2006
5. Mothers on WIC who delivered in 2006.

**TRIBAL WIC**

The tables below do not include New Mexico women who participate in the WIC program administered by tribal governments. An average of 284 pregnant women and 172 post partum women per month received WIC through the pueblos in 2006. The Navajo Nation also operates a WIC program but does not separate out recipients by state of residence so that numbers of Navajo women in New Mexico on the program are not available.

Source for Tribal WIC data: <http://www.fns.usda.gov/pd/WICAgencies2008ytd.xls>.

1. TEEN BIRTHS

Teen Births by County (Volumes)				Teen Births ordered by % of Births in their County							
Region	County of Residence	Live Births 2006	School Age Teen Births 2006: 15-18	Monthly Est of School Age Teen Births	Teen births as % of total births in county	Region	County of Residence	Live Births 2006	Monthly Est of School Age Teen Births 2006: 15-18	Est School Age Teen Births by month	Teen births as % of total births in county
3	Bernalillo	9,633	746	62	8%	4	Harding	6	2	0	33%
5	Doña Ana	3,385	399	33	12%	5	Luna	404	59	5	15%
1	San Juan	2,188	194	16	9%	4	Roosevelt	333	47	4	14%
1	McKinley	1,415	153	13	11%	5	Sierra	97	13	1	13%
2	Santa Fe	1,688	135	11	8%	4	Eddy	763	100	8	13%
4	Lea	1,126	133	11	12%	4	Chaves	1,015	132	11	13%
4	Chaves	1,015	132	11	13%	4	Quay	121	15	1	12%
1	Valencia	971	106	9	11%	1	Cibola	439	54	5	12%
4	Eddy	763	100	8	13%	5	Hidalgo	57	7	1	12%
1	Sandoval	1,446	97	8	7%	4	<b>Lea</b>	1,126	133	11	12%
<b>Subtotals Top 10 by volume</b>		<b>23,630</b>	<b>2,195</b>	<b>183</b>	<b>9%</b>	<b>Subtotals Top 10 by %</b>		<b>4,361</b>	<b>562</b>	<b>47</b>	<b>13%</b>
<i>As % of NM totals</i>		<i>79%</i>	<i>78%</i>			<i>As % of NM totals</i>		<i>15%</i>	<i>20%</i>		

Source: Live Births and Teen Birth Data from New Mexico Vital Records and Health Statistics

**2. LOW BIRTH WEIGHT**

**LOW BIRTH WEIGHT BY VOLUME**

Region	County of Residence	Live Births 2006	Low Birth Weight	%Low Birth Weight
3	Bernalillo	9,633	893	9%
5	Dona Ana	3,385	275	8%
2	Santa Fe	1,688	164	10%
1	San Juan	2,188	156	7%
1	McKinley	1,415	133	9%
1	Sandoval	1,446	116	8%
4	Lea	1,126	104	9%
4	Chaves	1,015	85	8%
2	Rio Arriba	744	79	11%
4	Curry	897	79	9%
<b>Sub Totals for Low BWT by Vol</b>		23,537	2,084	9%
<b>Top 10 as % of NM totals</b>		79%	78%	
<b>Totals New Mexico</b>		<b>29,918</b>	<b>2,669</b>	

**% OF LOW BIRTH WEIGHT OF ALL BIRTHS IN COUNTY**

Region	County of Residence	Live Births 2006	Low Birth Weight	%Low Birth Weight
2	San Miguel	382	53	14%
5	Luna	404	46	11%
5	Grant	405	46	11%
2	Taos	370	42	11%
2	Colfax	151	17	11%
5	Lincoln	213	23	11%
2	Los Alamos	178	19	11%
2	Rio Arriba	744	79	11%
2	Guadalupe	<b>48</b>	5	10%
2	Santa Fe	1,688	164	10%
<b>Sub Tot : % of Low BWT by %</b>		4,583	494	11%
<b>Top 10 as % of NM totals</b>		15%	19%	
<b>Totals New Mexico</b>		<b>29,918</b>	<b>2,669</b>	

- Birth Characteristics (Live Births, Low Birth weight, Low or No Prenatal Care) from: <http://www.health.state.nm.us/pdf/2006%20Vital%20Statistics%20Natal%20Summary.pdf>
- Low birth weight is defined as a birth of an infant weighing less than 2,500 grams.

**3. LOW OR NO PRENATAL CARE**

**Low or No PNC by Volume of live Births**

Region	County of Residence	Live Births 2006	# Low or No Prenatal Care	% with Low or No Prenatal Care
3	Bernalillo	9,633	846	9%
5	<i>Dona Ana</i>	3,385	577	17%
1	San Juan	2,188	389	18%
1	<i>McKinley</i>	1,415	226	16%
4	Lea	1,126	155	14%
1	Sandoval	1,446	136	9%
4	Chaves	1,015	132	13%
2	<i>Rio Arriba</i>	744	109	15%
5	<i>Luna</i>	404	95	24%
4	Curry	897	90	10%
<b>Subtotals Top 10 by volume</b>		<b>22,253</b>	<b>2,755</b>	
<b>As % of NM totals</b>		<b>74%</b>	<b>80%</b>	
<b>Totals New Mexico</b>		<b>29,918</b>	<b>3,431</b>	

**Low or No PNC by % of Births**

Region	County of Residence	Live Births 2006	# Low or No Prenatal Care	% with Low or No Prenatal Care
5	<i>Luna</i>	404	95	24%
2	Colfax	151	28	19%
1	San Juan	2,188	389	18%
5	Sierra	97	17	18%
5	<i>Dona Ana</i>	3,385	577	17%
4	Harding	6	1	17%
1	<i>McKinley</i>	1,415	226	16%
2	<i>Rio Arriba</i>	744	109	15%
5	Lincoln	213	30	14%
5	Hidalgo	57	8	14%
<b>Subtotals Top 10 by %</b>		<b>8,660</b>	<b>1,480</b>	
<b>As % of NM totals</b>		<b>29%</b>	<b>43%</b>	
<b>Totals New Mexico</b>		<b>29,918</b>	<b>3,431</b>	

- Birth Characteristics (Live Births, Low Birth weight, Low or No Prenatal Care) from: <http://www.health.state.nm.us/pdf/2006%20Vital%20Statistics%20Natal%20Summary.pdf>
- Low or no prenatal care is defined as beginning care in the last trimester of pregnancy or having fewer than 5 prenatal visits.

**4. MOTHERS ON WOMEN INFANTS AND CHILDREN PROGRAM WHO DELIVERED AND DID NOT DELIVER IN 2006**

WIC Mothers – Delivered and Not Delivered in 2006 by Volume		% of WIC Mothers Delivered and Not Delivered – as % Of Live Births							
Region	County of Residence	Live Births 2006	Teen Births 2006: 15-18	# of All Preg W on WIC Deliv & Not Deliv 2006	% of Preg W on WIC D & Not D as % of 2006 births	Live Births 2006	Teen Births 2006: 15-18	# of All Preg W on WIC Deliv & Not Deliv 2006	% WIC D and Not D as % of live births
3	Bernalillo	9,633	746	5423	56%	48	2	53	110%
5	Doña Ana	3,385	399	2848	84%	857	55	931	109%
2	Santa Fe	1,688	135	1063	63%	121	15	118	98%
4	Chaves	1,015	132	971	96%	404	59	389	96%
4	Lea	1,126	133	948	84%	1,015	132	971	96%
5	Otero	857	55	931	109%	275	26	252	92%
1	Valencia	971	106	780	80%	382	31	345	90%
4	Curry	897	87	745	83%	333	47	298	89%
4	Eddy	763	100	649	85%	18	2	16	89%
1	Sandoval	1,446	97	556	38%	97	13	85	88%
<b>Subtotals for Top 10</b>		<b>21,781</b>	<b>1,990</b>	<b>14914</b>	<b>68%</b>	<b>3,550</b>	<b>382</b>	<b>3458</b>	<b>97%</b>
<b>As % of NM Totals</b>		<b>73%</b>	<b>71%</b>	<b>79%</b>		<b>12%</b>	<b>14%</b>	<b>18%</b>	
<b>Totals New Mexico</b>		<b>29,918</b>	<b>2814</b>	<b>18821</b>	<b>63%</b>	<b>29,918</b>	<b>2814</b>	<b>18,821</b>	

Source: NM WIC Data from NM WIC Program Director  
 Live Births Data from New Mexico Vital Records and Health Statistics

**5. MOTHERS ON WOMEN INFANTS AND CHILDREN PROGRAM WHO DELIVERED IN 2006**

WIC Deliveries in 2006 As % Of Live Births In 2006- Volume					WIC Deliveries in 2006 - % Of Live Births				
Region	County of Residence	Live Births 2006	# of Preg W on WIC Deliv in 2006	% of WIC Deliv in 2006	Region	County of Residence	Live Births 2006	# of Preg W on WIC Deliv in 2006	% of WIC Deliv in 2006
3	Bernalillo	9,633	3901	40%	2	Guadalupe	48	42	88%
5	Doña Ana	3,385	2138	63%	5	Otero	857	662	77%
2	Santa Fe	1,688	770	46%	4	Quay	121	93	77%
4	Chaves	1,015	737	73%	4	Chaves	1,015	737	73%
4	Lea	1,126	706	63%	5	Luna	404	282	70%
5	Otero	857	662	77%	4	Roosevelt	333	231	69%
1	Valencia	971	580	60%	2	San Miguel	382	253	66%
4	Curry	897	570	64%	5	Socorro	275	179	65%
4	Eddy	763	485	64%	4	Eddy	763	485	64%
1	Sandoval	1,446	403	28%	4	Curry	897	570	64%
<b>Sub Totals for Top 10</b>		<b>21,781</b>	<b>10952</b>	<b>50%</b>	<b>Sub Totals for Top 10</b>		<b>5,095</b>	<b>3534</b>	<b>69%</b>
<b>As % of NM Totals</b>		<b>73%</b>	<b>80%</b>		<b>As % of NM Totals</b>		<b>17%</b>	<b>26%</b>	
<b>Totals New Mexico</b>		<b>29,918</b>	<b>13733</b>	<b>46%</b>	<b>Totals New Mexico</b>		<b>29,918</b>	<b>13733</b>	<b>46%</b>

Source: NM WIC Data from NM WIC Program Director  
Live Births Data from New Mexico Vital Records and Health Statistics

**6. ESTIMATED MOTHERS ON MEDICAID WHO DELIVERED IN 2006**

Number of Deliveries where Medicaid was Payer of Delivery				
Region	County of Residence	Live Births 2006	% *MCaid - PRAMS data - Payer of Delivery 1998-2005	Estimated # Deliveries on Medicaid
3	Bernalillo	9,633	44.5%	4289
5	Doña Ana	3,385	58.6%	1984
1	San Juan	2,188	41.5%	907
4	Lea	1,126	68.7%	774
4	Chaves	1,015	74.0%	751
2	Santa Fe	1,688	42.9%	723
1	Sandoval	1,446	44.5%	643
1	Valencia	971	62.0%	602
1	McKinley	1,415	39.4%	558
4	Eddy	763	68.9%	525
<b>Sub Totals for Top 10</b>		<b>23,630</b>	<b>50%</b>	<b>11,757</b>
<b>As % of NM Totals</b>		<b>79%</b>	<b>95%</b>	<b>75%</b>
<b>Totals for New Mexico</b>		<b>29,918</b>	<b>52.5%</b>	<b>15698</b>

% of Live births Where Medicaid was Payer of Delivery				
Reg ion	County of Residence	Live Births 2006	% *MCaid - PRAMS data - Payer of Delivery 1998-2005	Estimated # Deliveries on Medicaid
4	Harding	6	N/A	N/A
5	Catron	27	100.0%	27
2	Guadalupe	48	88.7%	43
2	Union	39	81.8%	32
5	Lincoln	213	80.1%	171
2	Mora	49	78.8%	39
5	Sierra	97	76.0%	74
4	Chaves	1,015	74.0%	751
2	Taos	370	73.5%	272
2	San Miguel	382	72.5%	277
<b>Sub Totals for Top 10</b>		<b>2,246</b>	<b>75%</b>	<b>1,685</b>
<b>As % of NM Totals</b>		<b>8%</b>	<b>21%</b>	<b>11%</b>
<b>Totals for New Mexico</b>		<b>29,918</b>	<b>52.5%</b>	<b>15698</b>

Note: Deliveries on Medicaid was estimated using the PRAMS report, Table 6: Payer of Delivery by County (1998-2005) and applied to 2006 Live Births

## APPENDIX 4

### THREE SUCCESSFUL HOME VISITING SERVICES IN NEW MEXICO

#### I. First Born Program – Grant County, New Mexico

First Born was established in Silver City and Grant County in 1997 as a result of a comprehensive community-based collaborative planning process. Vicki Johnson, a clinical counselor, led the development and implementation of the program which is housed at the Gila Regional Medical Center. The program offers home visits to all women pregnant for the first time and to first-time families, including adoptive families in Grant County.

Services may begin anytime during pregnancy or immediately following the birth of the baby and may continue until the child is three years old. Services are free, voluntary, provided in the home and occur weekly, according to the needs of the family. All first-time families are offered a First Born Postpartum Home Visit by a nurse that includes a clinical assessment of both mother and newborn. The First Born program likes to begin services before the baby is two months old.

First Born's mission is to improve the health and wellness of all first-time families by recognizing and building family strengths and competencies through relationships, support, education and referrals. At the core of the program is the conviction that healthy pregnancies and healthy families are basic to the long-term health and success of the community. First Born was named one of the nation's ten most innovative and exemplary prevention programs by the Center for Substance Abuse Prevention (CSAP) in 2002. The First Born model is being replicated in Rio Arriba, Taos and Los Alamos Counties by the LANL (Los Alamos National Laboratory) Foundation. A program is planned in Santa Fe as well.

The First Born staff is a culturally sensitive combination of degreed and non-degreed professionals who have been trained using First Born Training modules. Staff receives weekly supervision. Staff uses the First Born Core Curricula, written specifically for the First Born Program, containing activities tailored to the developmental needs of the child and family.

The First Born program strives to increase resiliency of participating infants and parents as well as the resiliency and strength of the community.

#### 2. Promotoras at La Clinica de la Familia in Anthony, New Mexico

The Promotora program began in Anthony, New Mexico along the border with Texas, New Mexico and Mexico in 1993 as a Maternal and Child Health project to link pregnant women in rural Dona Ana County to the prenatal services they needed to have healthier babies. Sylvia Sapien, a social worker, created the program and has

directed it since the beginning. She studied community lay health workers in Houston, Texas and in Juarez, Mexico and participated in the development of the curriculum for community health workers used throughout the New Mexico.

The *Promotora* program has grown from providing prenatal information and social work services for high-risk patients to focusing on broader health areas that meet the needs of the entire family. *Promotoras* deal with issues that address community concerns such as family planning, parenting classes, clean water education, insurance programs, farm health worker surveys, diabetes education and other border health issues. The program is an integral part of the clinic system and is the social services component of La Clinica de la Familia.

*Promotoras* live in the community that they serve and know the services needed in that community. *Promotoras* receive extensive and intensive training on how to be the catalytic agents to help residents take advantage of the health care services of local providers. The *Promotora* helps families access services and brings families closer to the community.

Initial assessments may occur in the office, clinic or hospital maternity floor. This first contact is crucial because the bonding and trust between *Promotora* and client begins. Home Visits are essential because it is in the home where clients are more apt to open up with “real health concerns” and the *Promotora* can best offer her resources.

With the creation of additional funds for home visiting for new families, the *Promotora* program added a *Welcome Baby* component for first time families expecting a baby. Referrals come from the Public Health office when women discover they are pregnant. A *Promotora* also visits families delivering babies at Memorial Hospital in Las Cruces to offer services at that time. *Welcome Baby promotoras* can work with a family, depending on individual family needs, until the child is three years of age. *Promotora*'s often use videos to start the conversation about issues that are important to the family. In addition, *promotoras* offer printed information and referrals to community providers according to the family's needs. Families who are having second or more children are assisted through the MCH – Maternal and Child Health – Home Visiting program which is a shorter term case management approach.

### **3. Healthy Families First – Primeros Pasos – Santa Fe, NM**

*Primeros Pasos* uses the Healthy Families America model of home visiting which is designed to reduce child abuse and neglect by supporting new parents in positive parenting practices. As with the programs described above, *Primeros Pasos* staff work to become “an understanding friend – someone to talk to confidentially, someone to count on when you feel you need answers to be a confident parent.” (Program brochure).

*Primeros Pasos* began in 1992 as a project of the City of Santa Fe and the District 2 Public Health Office. The program continues to be housed in the Public Health office and is funded by the Department of Health. *Primeros Pasos* staff include social workers, social work interns and volunteers. The program serves 50 families at any given time and is always full.

*Primeros Pasos* targets its services to families who are judged to be “at risk” on the basis of a standardized assessment administered during pregnancy or the first two weeks of the child’s life. Families who have a high score on the risk assessment are then invited to join the program which is strictly voluntary. Teenage parents are always invited to participate. Families may remain in the program until their child reaches age three.

*Primeros Pasos* relies on referrals from the Families First program, WIC and the teen parent center. Half of the families enter the program during pregnancy. During the first six months on the program, families are visited every week. Visits then occur every other week or according to family needs. The program uses *Babies First Wish*, a curriculum disseminated by the New Mexico Cooperative Extension service at New Mexico State University which is now available on the Internet.

## APPENDIX 5

### TOOLS FOR HOME VISITORS

The work-group recommended that to assure consistency and continuity across State funded Home Visiting Programs, all programs should use only normed and validated screening instruments.

The following instruments are currently used by a number of Home Visiting Programs in New Mexico:

- The **Edinburgh Postnatal Depression Scale**
- The **Partner Violence Scale**
- The **Ages and Stages Questionnaires (ASQ)**
- The **Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)**
- The **Knowledge of Infant/Child Development Inventories (KIDI)**, MacPhee, 1981; and
- The **Social Support Index** (McCubbin, H. I., Patterson, J., and Glynn, T. Social Support Index (SSI). In H. I. McCubbin, A. I. Thompson, and M. A. McCubbin (1996). Family Assessment Resiliency, Coping and Adaptation. Inventories for Research and Practice. Madison University of Wisconsin, 357-389).
- Medical Assistance Division (MAD) **Recommended Anticipatory Guidance**  
[HTTP://WWW.HSD.STATE.NM.US/MAD/PDF\\_FILES/EPSDTANTICGUIDTBL.PDF](http://www.hsd.state.nm.us/mad/pdf_files/epsdtanticguidtbl.pdf)

In addition, the following link is provided to the website of the American Academy of Pediatrics which provides a number of additional screening tools which sites might review and evaluate to ensure that they are valid for their specific communities and the families they serve.

<http://www.medicalhomeinfo.org/screening/DPIP/screeningtoolgrid.pdf>





