New Mexico State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Promote high-quality maternal care with a focus on patient-centered and trauma-informed models	Objective 1. Improve awareness among providers and birthing families about Medicaid postpartum benefits extending to 12 months, postpartum Objective 3. Improve Patient-Centered Care Knowledge and Practice with measureable, patient-reported results Objective 2. Increase access to perinatal care for women with the highest social, economic and/or medical need	Strategy 1. Leverage the prenatal High-Risk Fund to address gaps in geographic distribution and service provider type Strategy 2. Enhance uptake of, and increase access to, prenatal and postpartum care navigation Strategy 4. Collaborate to operationalize the extension of Medicaid benefits for a full postpartum year Strategy 5. Elevate community-based organizations and women with lived experience to define and support respectful maternity care in New Mexico Strategy 6. Increase the number and quality of patient-centered and perinatal care metrics in DOH surveillance systems Strategy 3. Evaluate the Medicaid postpartum benefit utilization and cultivate equitable birthing options within the benefit	ESM WWV.1 - Number of NM counties where prenatal HRF services are available ***Inactive -*** *ESM WWV.2 - Percent of expectant families identified and connected to services in key geographic areas.* ESM WWV.3 - Number of prenatal HRF sites where midwifery is a key service offered	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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					NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
Promote high-quality maternal care with a focus on patient-centered and trauma-informed models	Increase awareness and utilization of the 12-month postpartum benefit in New Mexico	Convene a Medicaid policy advisory committee and complete a strategic action plan Pilot use of the DOH telephone line with support to prenatal and postpartum individuals Develop messaging for diverse audiences: patients, providers, health systems to bring awareness to the postpartum Medicaid benefit	ESM PPV.1 - Percent of NM women with live birth having a postpartum visit, reported for Medicaid and non-Medicaid populations.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Grow and sustain an equitable birth and family care workforce	Objective 1. Strengthen community health and a place-based perinatal workforce Objective 2. Improve support system for rural and under-resourced birth settings (hospitals, birth centers, home) Objective 3. Establish a meaningful Birthing Friendly Hospital Designation program in NM	Expand and improve Medicaid reimbursement for doulas, midwives, and community health workers in settings such as home visiting programs Scale curriculum for perinatal training for Community Health Worker (CHW) and health promotions (promotora de salud) certification Integrate the expertise of midwives and doulas providing care in rural settings into statewide quality improvement initiatives (hospital and community settings) Promote state policies to institutionalize universal doula and birth support presence at delivery in NM hospitals and birth centers	ESM RAC.1 - Number or percent of Licensed Midwives (LMs) who are enrolled as Medicaid providers and accept Medicaid reimbursement for community birth services ESM RAC.2 - Number of community health workers, doulas or promotoras de salud certified in perinatal health modules through the NM Department of Health, community organizations or colleges	NPM - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III + Neonatal Intensive Care Unit (NICU) (Risk-Appropriate Perinatal Care, Formerly NPM 3) - RAC	NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related
Build statewide	All birthing hospitals are reporting plans of care to NMDOH and	Evaluate family experiences, receptivity to services, and impact of plans of care on family well-being		SPM 1: Proportion of eligible families receiving	

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capacity to prevent perinatal substance use and advance equitable, culturally-appropriate treatment options.	CYFD by the end of 2023 (NMDOH tracking discontinues in 2024) Ensure that all birthing families receive accurate informed consent about perinatal substance use and if their disclosure would trigger a child protective services (CPS) investigation. Connect birthing families (and when possible, prenatal families) to home visiting, food and nutrition programs, housing support and income support with assessment for substance use, violence and other social determinants of health impacting maternal and infant health status.	Collaborate with reproductive and perinatal justice experts and perinatal service programs to coordinate informed consent awareness for NM birthing families Along with the NM Healthcare Authority (Medicaid) and DOH Public Health Offices, offer support to families requiring social or economic support in the perinatal period		a plan of care for their substance-exposed newborn	
Prevent infant mortality, focusing on safe sleep and reducing sudden unexpected infant deaths (SUID)	Expand birth worker and clinical expertise in safe sleep across the state Improve awareness about safe sleep recommendations and risks associated with sudden unexpected infant death (SUID) in NM	Include more hospitals and birth centers in safe sleep education training Broaden the reach of a multi-media awareness campaign		SPM 3: Proportion of birthing families or infant caregivers receiving safe sleep education	
Child Health					
Expand access to oral healthcare for children and youth, including	Increase the number of children 1-17, who had a preventive dental visit during the past year. Increase the number of children who received at least one dental	Conduct at least one media campaign with statewide Public Service Announcements (PSA) promoting oral health via TV, and other social media avenues, or radio (English/Spanish). Deliver Public Service Announcements via television, radio, Facebook, Twitter promoting the importance of oral health and overall health.	***Inactive -*** *ESM PDV-Child.1 - Percent of Medicaid children who received the recommended schedule of Early and*	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) -	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

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those with special healthcare needs	sealant in a permanent tooth through the Office of Oral Health (OOH).	Partner with Early Head Start, Head Start and Pre-K programs, and K-12 programs to deliver sealants, varnishes and dental health education	*Periodic Screening Diagnostic and Treatment (EPSDT).* ESM PDV-Child.2 - Number of media campaigns promoting the importance of children's oral health ESM PDV-Child.3 - Percent of special needs children who had at least one preventive dental visit during the last year.	PDV-Child	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Support capacity of early childhood workforce to incorporate trauma-informed practice in all program areas	Increase the number of early childhood professionals trained in trauma-informed screening and care of families impacted by Adverse Child Experiences (ACE) Increase ability to analyze and improve early childhood services, including mental health and substance use referrals, through inter-agency coordination	Partner with the Early Childhood Education and Care Department (ECECD) and the Children, Youth and Families Department (CYFD) to institute trauma-informed training for early childhood staff Improve data sharing and data linkages to improve mental health access and referrals		SPM 2: Number of early childhood professionals trained in in trauma-informed screening and care of families impacted by Adverse Child Experiences (ACE).	
Grow and sustain an equitable birth and family care workforce	Improve family navigation for medical home under the Community Health Worker Program Improve family navigation for medical home under the Community Health Representative (CHR) tribal programs	Expand CHW and CHR curriculum and continuing education to support families to establish and maintain a medical home.	ESM MH.1 - Number of family trainings completed by partnering organizations that promote parent/professional partnerships ESM MH.2 - Number of trainings for	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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			parents and professionals around care coordination and family-centered practice based on the National Framework for Systems of Care.		(Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Support the breadth of programs and services that address behavioral health conditions in the adolescent population	Increase suicide prevention knowledge and awareness among adolescents ages 12 through 18, within the NM Youth Peer-to-Peer Helper (NM YP2PH) program Support youth resiliency strategies among adolescents ages 12 through 18 through participation in the NM YP2PH program Increase prevalence of intended pregnancy among birthing people 15-19 years of age	Increase knowledge and awareness of youth suicide and prevention through the Annual Youth Peer to Peer Helper Trainings for NM youth Increase youth resiliency through program activities using the 6 Step Helping Skills" to assist peers Continue to update, refine and develop other evaluation tools for the PYD guiding principles, 40 developmental assets Ensure teens receive confidential services including access to a broad range of methods	ESM IH-Adolescent.1 - Number of students trained in the YP2PH program who have increased health literacy in topic areas (suicide prevention, substance use, healthy relationships). ESM IH-Adolescent.2 - Percent of youth participating in YP2PH program with increased assets contributing to resiliency	NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization - Adolescent, Formerly NPM 7.2) - IH-Adolescent	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Children with Special Health Care Needs					
Increase	Expand access to specialty	Improve access to a family-centered medical home for all CYSHCN by	ESM MH.1 - Number	NPM - Percent of children	NOM - Percent of children with

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access to specialty medical care for children and youth with special healthcare needs	medical care for children and youth with special health care needs Improve the system of care coordination for children and youth with special health care needs across key agencies, statewide.	partnering with family advocacy organizations that provide parent trainings and promote parent/professional partnerships Explore alternative methods to provide specialty care to CYSHCN in underserved regions of the State Promote the use of high quality care coordination for CYSHCN utilizing the standards developed by the National Consensus Framework for Systems of Care for CYSCHN Improve collaboration between the Title V CYSHCN program, Medicaid and the Managed Care Organizations	of family trainings completed by partnering organizations that promote parent/professional partnerships ESM MH.2 - Number of trainings for parents and professionals around care coordination and family-centered practice based on the National Framework for Systems of Care.	with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Increase access to specialty medical care for children and youth with special healthcare needs	Increase access to specialty medical care for children and youth with special health care needs. Improve the system of care coordination for children and youth with special health care needs provided by different agencies across the State.	Improve access to a family-centered medical home for all CYSHCN by partnering with family organizations that provide parent training and advocacy efforts to promote parent/professional partnerships Promote the use of high-quality care coordination for CYSHCN utilizing the standards developed by the National Consensus Framework for Systems of Care for CYSCHN.	ESM MH.1 - Number of family trainings completed by partnering organizations that promote parent/professional partnerships ESM MH.2 - Number of trainings for parents and professionals around care coordination and family-centered	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0

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			practice based on the National Framework for Systems of Care.		through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC