

CDPC NM SHARED STRATEGIC PLAN (NMSSP) 2022-2026



CHRONIC DISEASE
PREVENTION COUNCIL

NMSSSP Mission Statement

“To promote wellness and improve the quality and years of life for all New Mexicans through prevention, detection, and management of chronic health conditions.”



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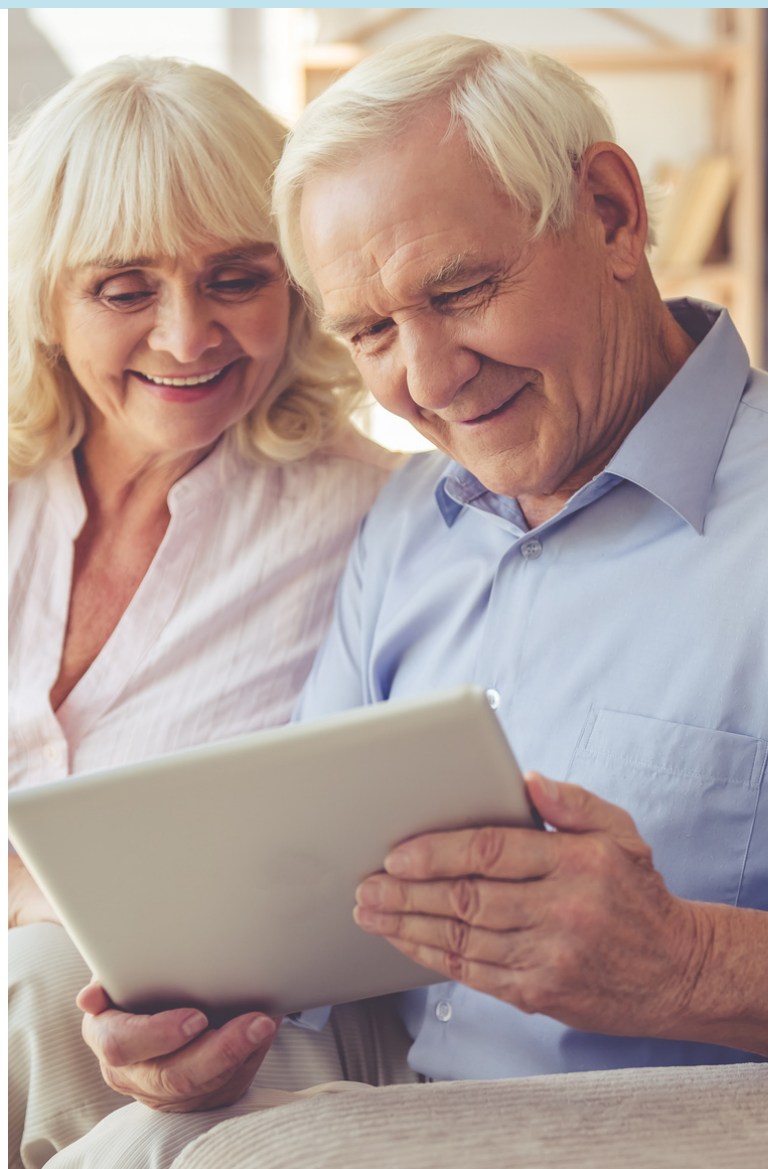
Executive Summary

THE NEW MEXICO SHARED STRATEGIC PLAN (NMSSP) for Prevention and Control of Chronic Disease will empower New Mexicans to make changes that create healthier communities.

The goal is to reduce the burden of chronic disease throughout the state. Previous statewide prevention plans focused on impacting chronic health conditions individually to address arthritis, cancer, diabetes, heart disease, stroke, and diseases related to obesity and tobacco use. A major shift in this new plan is a whole-system approach focusing on risk factors that affect multiple diseases. This plan addresses shared risk factors and the determinants of health across chronic disease rather than addressing specific diseases on their own.

This approach is in alignment with the recent national shifts in public and population health that recognize how to maximize limited resources for a broad impact.

This NMSSP will be used to help focus practices, programming, policies, and advocacy connected to chronic disease in New Mexico. The goals and strategies outlined in this document will be implemented between 2022-2026 with progress tracked and evaluated by the Chronic Disease Prevention Council (CDPC) and its broad coalition of partners.



This Plan is a whole-system approach focusing on risk factors that affect multiple diseases

Introduction

HOW THIS PLAN WAS DEVELOPED

There have been two different New Mexico Shared Strategic Plans, from 2012-2016 and from 2017-2022, and both have had a tremendous positive impact on reducing the burden and impact of chronic disease on New Mexicans. For more details and stories on the impact of these plans visit <http://chronicdiseasenm.org>.

This 2022- 2026 NMSSP plan was developed with feedback from a statewide network of partners in the Strategic Plan Working Group, Focus Group participants, the CDPC Steering Committee, and other partner feedback. This collective input resulted in the ability to discuss challenges each disease area is facing and to determine commonalities that required collective statewide planning and action. Effectively addressing chronic disease requires continuing this coordinated effort across a diverse group of partners.

In developing this plan there were many important ideas and things to consider associated with each of the goals. There are numerous organizations in New Mexico doing amazing work to support the health of people across the state.

These entities are in the best position to operationalize focused actions that advance this broad plan and fit their respective missions. CDPC is willing to work collectively with organizations to impact chronic disease statewide.



OUR CHALLENGE AND OUR APPROACH

There is an urgent need to focus efforts nationwide to reduce the burden of chronic disease. Fifty percent of the US population is living with one or more chronic diseases.¹ Seven out of ten deaths among Americans each year are from chronic diseases and 86% of health care costs are due to chronic disease.²

Chronic illness poses a severe threat to the wellbeing of New Mexicans. Heart disease is the leading cause of death and accounts for over 20% of all deaths, and stroke is the fifth leading cause of death in the state.^{3,4} In New Mexico, cancer is the second leading cause of death accounting for 1 in 5 deaths.⁵



Recent New Mexico data shows that 30% of adults have high blood pressure, 12.5% have diabetes and 30.9% are obese.⁹ Many experience complications with multiple chronic diseases, as people living with diabetes are two to four times more likely to develop cardiovascular disease and stroke.⁶

Additionally, some shared risk factors such as tobacco use and physical activity levels impact many people. Over 16% of adults in NM smoke tobacco, 34% of youth use e-cigarettes, and 41.5% of adults report not participating in adequate physical activity in 2019.⁷

Chronic disease prevention and planning will result in a better quality of life for all New Mexicans and create healthcare savings at the same time. A simple one percent drop in preventable health conditions results in saving millions of dollars in health care costs. For every dollar spent on public health interventions, \$14.30 is saved in healthcare costs from treating preventable conditions.⁸

We recognize the limited resources available to address all the challenges chronic disease creates in the lives of New Mexicans. This reality highlights the need to maximize resources by engaging multiple partners in collaborative action. There are multiple factors that impact chronic disease prevention and control including demographics, lifestyle, the built environment, workplaces, community design, and more. This plan will help stakeholders view chronic disease in New Mexico through a wide lens.



A simple one percent drop in preventable health conditions results in saving millions of dollars in health care costs.

PURPOSE OF THE PLAN

This plan addresses factors that contribute to chronic disease and can be used to align actions taken by CDPC member organizations and others statewide. We acknowledge the contributions that can be made by a broad range of non-traditional partners (education, non-governmental organizations, housing, transportation, environmental, businesses) who may not necessarily recognize their work as crucial to improving the social determinants of health. A broad range of partners is critical given that all the places in which people live, work, worship, learn and play impact their health.

As you undertake activities to move this plan forward, please take the following criteria and questions into consideration:

HOW TO USE THIS DOCUMENT

This plan provides broad goals and strategies to address the impact of chronic disease in NM and is carried out by individuals and organizations in communities across New Mexico. Specific activities are not outlined in this document since the communities, groups, and individuals whose work aligns with these broad goals will determine specific actions.



I. INCREASE ACCESS & EQUITY FOR PRIORITY POPULATIONS

Find ways to increase services to the underserved without diminishing or duplicating services already being provided to populations adequately served. Explore actions that support the most impacted and vulnerable populations.

QUESTIONS TO CONSIDER:

- i. How can we best ensure people receive the services they need? Are our activities creating any new barriers or further disparities? Are we using the concept of authentic inclusion to ensure participants are not excluded in any way?***
- ii. Are we engaging those most affected by chronic disease? Are there others doing similar work? How can we build on the work of others or partner with them? How will we measure success?***

II. POLICY

This area includes policies within organizations to policies at the municipal, county, and state levels to support and shape healthy environments.

QUESTIONS TO CONSIDER

i. Who will be affected by our efforts? What are policies that could help shape a healthier environment? How can we support the utilization of best practices? How will we ensure that policies are revisited and improved over time? Where should those policies be instituted? How will we measure success?



III. EDUCATION

Increase awareness and education of factors that influence chronic disease and healthy behaviors for statewide prevention and control partners including individuals, families, employers, educational institutions, all members of a healthcare team, organizations, policy makers, legislators, and communities.

QUESTIONS TO CONSIDER

i. How are we impacting knowledge, awareness and/or practices? What are we doing to ensure that education results in changes in behavior or activity? What are the ultimate outcomes of our activities? How will we measure success?

IV. BUILT ENVIRONMENTS

The availability of sidewalks, lighting, paved roads, parks, open spaces, transportation, or bicycle paths can influence everyone's level of physical activity and health. Look for innovative ways to identify and address gaps in built environments.



According to the Centers for Disease Control & Prevention, “healthy places are those designed and built to improve the quality of life for all people who live, work, worship, learn and play within their borders – where every person is free to make choices amid a variety of healthy, available, accessible, and affordable options.” (Centers for Disease Control and Prevention - CDC, 2017)

QUESTIONS TO CONSIDER

i. How do we capitalize on our strengths to overcome barriers or lack of resources? Are the activities we engage in considering how built environments are part of the solution to chronic disease prevention and control? How will we measure success? Do we have the right partners engaged in this work?

V. EPIDEMIOLOGY AND SURVEILLANCE

The CDC defines epidemiology as “the method used to find the causes of health outcomes and diseases in populations.” In chronic disease management and prevention this involves using research and data to support and improve prevention plans, strategies, and programs. The research helps us know who or how many are affected, the cause of the disease, and understand the most effective ways to prevent or respond to that disease.

We envision New Mexico as a place where all people live, work, worship, learn and play in communities that support optimal health and quality of life.

QUESTIONS TO CONSIDER

i. Are we using the most recent data to drive projects and advocacy efforts? How can we determine the health risk behaviors that lead to health outcomes? Are there specific populations that should be the focus of your efforts? How do we use health information technology?



GOALS AND STRATEGIES OF THE NEW MEXICO SHARED STRATEGIC PLAN

Goal I

Build support for equitable policies that create built environments to promote healthy, safe, and culturally informed physical and behavioral health activities throughout New Mexico and across the lifespan.



STRATEGIES

A. Advocate for and include exercise/physical education, healthy foods topics, and oral health in school curriculum and school-based health centers.

B. Partner with key community stakeholders to identify and build support for safe opportunities for physical activity such as safe and accessible walking and biking trails or opening schoolyards for community use during non-school hours.

C. Support and promote emotional wellness activities using a “health in all policies” approach.

Goal II

Promote and advance policies and practices that provide accessible, healthy, and affordable nutrition opportunities.



STRATEGIES

A. Partner with community stakeholders to increase opportunities for healthy, culturally relevant, affordable food and clean water.

B. Support and expand educational opportunities that increase awareness of healthy eating and its impact on chronic disease.

C. Integrate education in gardening or farming to school curriculum so that young people understand what healthy food is and learn to grow it.

Goal III

Coordinate and collaborate efforts that help people achieve a healthier weight.



STRATEGIES

A. Advocate for health care coverage to support individuals with excess weight that includes individual and group counseling, and workplace wellness program coverage.

B. Partner with and support programs that provide education on healthy lifestyle choices to increase wellbeing and reduce health insurance costs.

C. Advocate for proper food labeling and a state tax on sugar-sweetened beverages and increase the state tax on junk and processed foods.

D. Promote health education in topics such as healthy eating to reduce obesity and oral diseases.

Goal IV

Ensure the genuine collaboration of priority populations in the goals contained in this plan.



STRATEGIES

A. Provide relevant data to priority populations so they can identify and address disparities.

B. Provide for genuine collaboration in the policy development and advisement processes with groups experiencing disparities.

C. Support community identified research priorities and engage community members in the process and the sharing of results.

D. Increase access to and use of existing community informed data while maintaining research integrity.

Goal V

Increase access to chronic disease prevention and self-management opportunities for people within their communities.

STRATEGIES

A. Expand the availability of prevention and self-management opportunities and resources.

B. Support the education and training of all members of the health care team to provide prevention and self-management education.



C. Advocate for increased access to clean water to decrease disease transmission and support hygiene.

D. Promote oral health and wellness through fluoridated water policies.

E. Practice health literacy by providing information that empowers and equips individuals to understand and effectively manage their health and healthcare.

Goal VI

Increase use of proper guidelines by healthcare teams for prevention, screening, diagnosis, treatment, and referral to chronic disease prevention and self-management programs.

STRATEGIES

A. Promote guidelines for practices that have been proven to work including evidence based prevention, medicine and health practices.

B. Advocate for the improved exchange of health information.



C. Support use of health information technology for patient and population health management.

D. Integrate screening practices for individuals with chronic disease conditions that address behavioral health.

Goal VII

Identify, develop, and use technology for chronic disease education, prevention, and treatment.

STRATEGIES

A. Advocate for increased access and use of the internet, social media, and phone-based strategies and systems to improve health.

B. Expand the telehealth infrastructure to support health promotion and affordable access to quality care.



C. Ensure sufficient billing codes for health professionals and training for telehealth providers to support reimbursement and sustainability.

Goal VIII

Promote optimal behavioral health for all New Mexicans living with chronic disease.

STRATEGIES

A. Identify and collect data to identify and address disparities and the root causes of behavioral health issues.

B. Rebuild and support the capacity of a viable Behavioral Health System especially in rural and frontier communities.

C. Develop and advance policy efforts to address behavioral health.



D. Increase recruitment, education, and retention of behavioral health providers, including Peer Support Workers and CHWs, with a focus on workforce development.

E. Expand the integration of behavioral health into all forms of healthcare including telehealth.

F. Engage in efforts to reduce the burden of substance-use disorders through advocacy, partnership development, and program implementation.

Goal IX

Prioritize health equity by actively improving the conditions in which people live, work, learn, and play.

STRATEGIES

A. Increase educational attainment and the quality of public education.

B. Educate decision makers and advance policies that advance equity and healthy environments for all New Mexicans.

C. Address health equity using a holistic approach accounting for social, behavioral, cultural, political determinants, systemic oppression and other inequities such as in health insurance coverage, access to care, housing, transportation, employment, and more.



***For updates on activities advancing this living document please visit:
www.ChronicdiseaseNM.org***

V. CONCLUSION

The NM Chronic Disease Prevention Council provides a forum for collaboration and communication to focus on the commonalities across chronic disease prevention and control.

This Shared Strategic Plan helps to coordinate efforts that tap into the skills, talents, and experience across the state to strengthen efficiencies and synergy. We will identify and work with partners across New Mexico to prevent and manage chronic disease by addressing gaps, such as safe sidewalks, access to healthy foods and activities, and improving affordable access to care.

The Council will ensure this plan continues to be relevant and useful with a yearly Operational Plan that will include annual priorities and actions. We invite our partners to share the activities and outcomes that support this NMSSP for inclusion in each year's Operational Plan.

CDPC Quarterly meetings and communication tools, including a website (www.chronicdiseasenm.org), to highlight and organize activities supporting this plan as we work together to improve the health and quality of life of all New Mexicans.

ACKNOWLEDGEMENTS

Thank you to the CDPC Working Group and the CDPC Steering Committee for their efforts to thoughtfully develop this plan. The NMSSP was developed with facilitation and writing support from John Linney of Impact Associates (www.impact-associates.org).

References and Resources

[Epidemiology, Surveillance and Response at the NM Department of Health](https://www.nmhealth.org/about/erd/) -

<https://www.nmhealth.org/about/erd/>

[Further information on epidemiology and surveillance from the CDC](https://www.cdc.gov/chronicdisease/center/nccdphp/how.htm) -

<https://www.cdc.gov/chronicdisease/center/nccdphp/how.htm>

[Military members and families resources on chronic disease prevention and military liaisons](https://www.thecommunityguide.org/content/us-armed-forces-and-community-guide)-

<https://www.thecommunityguide.org/content/us-armed-forces-and-community-guide>

[Community Guide of Preventive Services with evidence-based resources for population health](https://www.thecommunityguide.org/content/us-armed-forces-and-community-guide)-

<https://www.thecommunityguide.org/content/us-armed-forces-and-community-guide>

[New Mexico Chronic Disease Prevention Council](https://chronicdiseasenm.org/) -

<https://chronicdiseasenm.org/>

[New Mexico Department of Health Data & Resources](https://www.nmhealth.org/data/) -

<https://www.nmhealth.org/data/>

[New Mexico's Indicator Based Information System \(NM-IBIS\)](https://ibis.doh.nm.gov/) -

<https://ibis.doh.nm.gov/>

Scan for Links-



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Glossary

Authentic Inclusion: Full engagement and participation of members of a priority population within a group or effort where meaning and purpose are experienced by the members without limitation. (TUPAC, 2015)

Behavioral health: encompasses a broader range of physical, psychological, and lifestyle factors that, when taken together, speak to an individual's overall sense of wellness. This can include behaviors related to mental health, as well as those related to relationships, substance use and abuse, and general health.

<https://synergyhealthprograms.com/behavioral-health-services/>

Built Environments: The built environment includes all of the physical parts of where we live and work, which influence a person's level of physical activity. Built environments which discourage activity lead to habits linked with poor health outcomes such as obesity, cardiovascular disease, diabetes, and some types of cancer.

https://www.cdc.gov/nceh/information/built_environment.htm

Chronic Disease: Chronic disease is a long-lasting condition that can be controlled but not cured. Chronic illness affects the population worldwide. As described by the Centers for Disease Control, chronic disease is the leading cause of death and disability in the United States. It accounts for 70% of all deaths in the U.S., which is 1.7 million each year. Data from the World Health Organization show that chronic disease is also the major cause of premature death around the world even in places where infectious disease is rampant. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable and most can be effectively controlled.

<http://cmcd.sph.umich.edu/what-is-chronic-disease.html>

Community: Usually refers to a group of people who share a common location, common interests, common characteristics, or common need. A community encompasses a diverse set of entities, including voluntary health agencies; civic, social, and recreational organizations; labor groups; health care systems and providers; professional societies; schools and universities; faith communities; and different socioeconomic classes and organizations for racial and ethnic groups.

Comorbidity: The condition of having two or more diseases at the same time.

www.cancer.gov

Culturally Relevant Healthcare: Cultural competence in healthcare means delivering effective, relevant, understandable, quality care to patients who have diverse beliefs, abilities, attitudes, backgrounds, values, and behaviors. This practice requires systems that can personalize health care according to cultural and linguistic differences (Tulane University School of Public Health).

Emotional Wellness: Refers to an awareness, understanding and acceptance of our feelings, and our ability to manage effectively through challenges and change.

<https://www.nationalcenterforemotionalwellness.org>

Epidemiology: The method used to find the causes of health outcomes and diseases in populations (Centers for Disease Control and Prevention).

Equitable Health Policies: See “health in all policies” below.

Health Care Team / Health Professionals: A group of health care workers from various disciplines (includes: primary care providers, nurses, social workers, promotores, community health workers, peer support workers, curandera, etc.) that provide specific services in a cooperative, collaborative, integrated manner that ensures continuity of care.

Health Disparities: Differences in health status among population groups or communities that can be shown with statistics (e.g. death rates, rates of occurrence of disease). To have disparities, one group must have lower rates or risk and another group must have higher rates or risk.

Health Equity: Fair access to the conditions for good health, such as healthy food, good housing, good education, safe neighborhoods and freedom from racism and other forms of discrimination, resulting in the distribution of disease, disability, and death that does not more severely burden a particular population.

Health in All Policies: An approach to public policies across sectors that systematically considers the health implications of decisions across sectors and policy areas, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity in areas such as housing, transportation, education, air quality, parks, criminal justice, energy production, and economic and workforce development (World Health Organization).

Priority Population: Any group or population that has been shown to experience health disparities including higher rates of disease or risk behaviors, inadequate access to resources, and poor health outcomes. Examples include African American, Native American, Asian/Pacific Islanders, Lesbian- Gay-Bisexual-Transgender- Queer/Questioning- Intersex (LGBTQI), people whose primary language is not English, people living with disabilities, people experiencing poverty, people living with behavioral health and or substance abuse issues, etc. It may also be important to look at certain professions, such as first responders or military members, that may experience significant health disparities and unique health risks.

Social Determinants of Health: The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

http://www.who.int/social_determinants/sdh_definition/en/

Substance Use Disorder: A substance use disorder (SUD) is a mental disorder that affects a person’s brain and behavior, leading to a person’s inability to control their use of substances such as legal or illegal drugs, alcohol, or medications. Symptoms can range from moderate to severe, with addiction being the most severe form of SUDs. Patients with SUDs had higher prevalence of major health problems (National Institute of Mental Health).



2022 - 2026 NMSSP Development Contributors

Ashley Avila
Baudelia Salgado
Bonnie Vallo
Britt Levine
Christine Brown
Devona Quam
Devona Valdez
Dr. Ifeoma Achusim, RN, PharmD, MPH
Francisco J. Ronquillo, PA
Fred Sandoval
Gail Crane
Gary Williams
Jessica Spittler BSN RN
John Linney
Kenneth Reid
Kenneth Winfrey, LCSW
Laurel McCloskey, MPH, CPH
Liz Chavez
Norma Vazquez de Houdek
Porfirio Bueno
Rachelle Karman
Raymond Sanchez
Renaldo Wilson
Renee Volker-Rector
Sarah Ijadi
Sheryl Wilkeson
Sonia Garcia Lopez
Sophie Rouge, MPH
Theresa Clay
Troy Jones
Valentina Livingston
Valerie Quintana
Winona Gishal

AARP NM
Asthma Control Program, NM DOH
Blue Cross Blue Shield
Building Health Military Communities NM
Community and Clinical Linkages
Community Impact, American Heart Association
Comprehensive Cancer Program, NM DOH
FORWARD Area Health Education Center
Health & Wellness Program, City of Albuquerque
Impact Associates
Indian Health Services
Mid-Region Council of Governments
Montas del Norte Health Education Center
National Latino Behavioral Health Association
NM Chronic Disease Prevention Council
NM Chronic Disease Prevention Council
NM Department of Health Bureau Chief
NM DOH Comprehensive Cancer Program
NM DOH Nicotine Use Prevention & Control
NM Primary Care Association
Office of Community Health Workers, NM DOH
Office of Community Health, University of NM
Office of Oral Health, NM DOH
Population and Community Health Bureau, NM DOH
Presbyterian Health Plan
Presbyterian Healthcare Services
Public Health Pharmacist Clinic
San Juan Collaborative 16
The Solutions Group
Umoja Behavioral Health PC
United Healthcare Community Plan
Western Sky Community Care

Citations

1. The Relation of the Chronic Disease Epidemic to the Health Care Crisis

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7077778/>

2. National Vital Statistics Reports

http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf

3. New Mexico Indicator Based Information System

<https://ibis.doh.nm.gov/>

4. Health Behaviors and Conditions of Adult New Mexicans

<https://www.nmhealth.org/data/view/behavior/2365/>

Scan for Links-



For more information or to connect with the NM Chronic Disease Prevention Council:

Laurel McCloskey, MPH, CPH Executive Director

Chronic Disease Prevention Council

P.O. Box 3511 Albuquerque, NM 87190

laurel@chronicdiseasenm.org (505) 463-5300

www.chronicdiseasenm.org