PRESBYTERIAN HEALTHCARE SERVICES COMMUNITY HEALTH ASSESSMENT

Presbyterian Northern New Mexico -

Presbyterian Santa Fe Medical Center and

Presbyterian Española Hospital

2026-2028

PRESBYTERIAN

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DEAR COMMUNITY

Dear Community,

At Presbyterian, we remain determined to improve the health of the patients, members, and communities we serve. Our focus continues to be on ensuring that every New Mexican has an opportunity to be healthy—regardless of their background, income, or zip code.

Health is shaped by so much that occurs *outside* of the four walls of a clinical setting. Challenges look different for every individual, family, neighborhood and community and are profoundly affected by where we live, social and political norms, and by what resources we each have access to. That's why Community Health must focus on New Mexico's abundant strengths, maintain the gains we've made together, and stay rooted in the lived experiences of those we serve.

Every three years, Presbyterian conducts a community health assessment and implementation planning process. For this cycle we are grateful to have collaborated with NMHealth - the state's department of health, and many others to better share information, leverage our resources, collaborate on meaningful initiatives, and work together to address our communities' most pressing health needs.

Our approach centers on partnership with our community. Through community conversations we gather insights that guide our priorities and shape our strategies. Our communities identified three major areas of concern:

- **Connections to Care –** helping people navigate and better access healthcare and social services. This includes guiding individuals to behavioral health and substance use treatment, supporting them in overcoming barriers like transportation, housing, and insurance, and connecting them with specialty care and addressing health-related social needs.
- **Healthy Lifestyle –** communities want to continue to focus on empowering changes that individuals and families can make to prevent and manage communicable and chronic conditions.
- **Healthy Communities –** conditions like safe drinking water, breathable air, a strong economy and opportunities to earn better wages, as well as strong connections to each other, are essential for health.

Providing safe, compassionate, equitable care - rooted in earning and maintaining trust - remain guiding principles for our community health programs, partnerships, and investment plans for 2026-2028.

We invite you to explore updates to our work at *www.phs.org/community/committed-to-community-health*.

Thank you for your continued partnership and support,

Leigh Caswell, MPH
VP, Community Health and Equity

EXECUTIVE SUMMARY

Presbyterian Healthcare Services (Presbyterian) envisions a healthy New Mexico, and we exist to improve the health of the patients, members, and communities we serve. We are committed to addressing health equity in our communities by creating opportunities for good health and well-being for all New Mexicans. This means improving access to healthcare, behavioral health, health insurance benefits and financial assistance, community supports, healthy food, and opportunities for exercise. We recognize none of this is possible without working to eliminate barriers such as poverty, discrimination, and systems of oppression that contribute to health inequity.

To fulfill that commitment, every three years, Presbyterian Community Health completes a Community Health Assessment (CHA) and Implementation Plan process that informs the identified health priorities in the communities we serve and Presbyterian's systemwide community health strategy. The 2026-2028 assessment process focused on elevating our community voices through meaningful statewide partnerships. During the last cycle, we heard community concerns around over-assessment. This cycle, we intentionally worked with organizations who had recently completed assessment activities around community health priorities to reduce that over-assessment. In partnership with the New Mexico Department of Health (NMHealth), we created the Community Health Implementation Plans and Systems Alignment for Sustainable Action (CHIPs & SALSA) Collaborative with the express purpose of increasing collaboration and decreasing community burden. Additionally, in recognition of the expansive reach of Presbyterian Healthcare Services, Presbyterian Community Health, and the Presbyterian Health Plan, we have expanded the geography covered in our assessments to include counties surrounding each of our hospitals, resulting in a new regional assessment model.

The following CHA provides an in-depth look at the communities within Northern New Mexico, which is served by two of Presbyterian's not-for-profit hospitals: Presbyterian Española Hospital (PEH) in Española (Rio Arriba County) and Presbyterian Santa Fe Medical Center (SFMC) in the city of Santa Fe in Santa Fe County. This area is also served by Presbyterian Medical Group clinical services, the Presbyterian Health Plan, and the Community Health Team. We describe the process and methods used in conducting the assessment, share our findings, and outline our priorities for 2026-2028, which will inform the Northern New Mexico Community Health Implementation Plan (CHIP).

Our Priorities

Presbyterian Community Health's 2023-2025 CHIPs addressed three priorities: Behavioral Health, Social Health, and Physical Health with the lenses of Access and Equity. Informed by the gathering of data and feedback from our community partners, community-based organizations and collaborators, our priorities for 2026-2028 are as follows:

1. Connections to Care
2. Healthy Lifestyle
3. Healthy Communities

Northern New Mexico – Key Findings

This region of the state is composed of thirteen counties: Cibola, Colfax, Guadalupe, Harding, Los Alamos, McKinley, Mora, Rio Arriba, San Juan, San Miguel, Santa Fe, Taos, and Union. This region is also characterized by the following tribal communities: Acoma Pueblo, Nambe Pueblo, Navajo Nation, Picuris Pueblo, San Ildefonso Pueblo, Santa Clara Pueblo, Taos Pueblo, Tesuque Pueblo, and Ohkay Owingeh. We recognize that while we've grouped these communities into one report, there are geographical and cultural differences we must consider, especially when identifying community health improvement strategies in partnership with each of our communities. This region is a combination of rural, frontier, and urban, plains, basins, and mountainous. The region spans the northern section of the state, bordering Texas, Oklahoma, Colorado, Utah, and Arizona. They are diverse with unique needs, assets, and gaps that we summarize in this report.

This cycle, when looking at the landscape assessment of priorities, we consistently saw Access to Care and Services and Health Equity as rising to the top of the priority lists for most communities followed closely by Behavioral Health.

These priorities were confirmed during the three Community Conversations in this region. Many of the access to care and services topics in the community conversations centered around equity, justice, and collaborations. Our communities stressed the importance of addressing underlying racial and ethnic tensions, systems of oppression, and stigma around various topics as a method of addressing underlying barriers to poor health. Conversations involved the distinction between systems of oppression as a barrier to better health and as a cause of poor health, which should be addressed in tandem with addressing other causal factors and barriers to health.

Access to care and services is complicated in this region by a variety of factors including lack of adequate transportation, internet access for virtual care, stigma around seeking care, lack of trauma-informed care, insurance barriers, and a disconnected social needs system with low utilization of closed-loop referral systems A significant theme in these conversations was a disconnect between organizations who address social needs and those working to improve health – stronger and more consistent coordination between agencies and organizations is needed to increase efficiency and prevent people from falling through the cracks.

Participants also brought awareness to the structural drivers of health in their communities including safe sidewalks/walking paths/hiking trails, and infrastructure including food and water systems. Water access arose as a concern for many communities, especially some tribal communities where water is difficult to access. Water cleanliness was another concern that arose – there are communities in Northern New Mexico without potable water (i.e. Madrid, NM).

Building community was a prevailing theme in all three Community Conversations. This manifested in several key tactics: increasing general community interactions, increasing elder and youth interactions, and building meaningful youth engagement programs. These conversations brought meaningful nuance to this topic and importantly highlighted the importance of youth engagement to prevent poor health outcomes (i.e. substance use) and increase community and civic involvement but also to change perceptions of youth as not having a place in any of these spaces. Some community members noted that the current systems sometimes treat youth, especially teenagers, as a burden in community, a perception that needs to change.

Despite limitations, the community identified many assets and methods of addressing gaps. They were able to identify many organizations working on this work already as well as general assets that can be supported and coordinated. Some general resources the community noted as being available include crisis hotlines, Peer Support Specialists, Community Health Workers (CHWs), mobile crisis and outreach efforts, behavioral health services in a variety of contexts and communities, drug court, senior centers, food banks, food distribution programs. The community noted multiple times in all conversations the importance of the CHW workforce as a bridge between health care institutions, social needs resources, and the community and their role in improving health from a community perspective.

This CHA is followed by the development of a comprehensive CHIP – or Community Health Implementation Plan - developed by Presbyterian Community Health in alignment with the hospital and larger health system to address the health needs prioritized in this assessment. Please visit www.phs.org/community for intervention strategies, prioritized partnerships, detailed goals, and resources Presbyterian Healthcare Services has committed for 2026-2028 to improve the health of Northern New Mexico.

ACKNOWLEDGEMENTS

The 2026-2028 Community Health Assessment and Implementation Planning process could not have been completed without the dedication of the following partners: New Mexico Department of Health, County and Tribal Health Councils, the New Mexico Alliance of Health Councils, the Early Childhood Education and Care Department, the volunteer community leaders that make up each of Presbyterian's hospital Board of Directors, Presbyterian Health Plan, community organizations, numerous coalitions, and community members. In addition, Presbyterian would like to thank the many individuals and organizations who participated in surveys and focus groups, and provided key informant interviews, document reviews, and verbal and written comments.

Special thanks to the volunteer public health and business leaders that make up the Community Health Advisory Board, for their valuable input and stewardship of this process.

Presbyterian is grateful for the support of The New Mexico Alliance of Health Councils and tribal and county health councils and their willingness to partner with the Community Health Implementation Plans and Systems Alignment for Sustainable Action (CHIPs & SALSA) Collaborative.

We would like to specifically thank and acknowledge our partners at New Mexico Department of Health, the New Mexico Hospital Association, and the New Mexico Early Childhood coalition for their increased collaboration on community assessment planning and data sharing, counsel and communication on methods and priorities, and commitment to serving our shared communities with increased alignment. We are thrilled to be much closer to the goal of shared assessments, plans, and implementation to address our communities' health priorities.

Presbyterian, in close collaboration with community partners, hopes to continue sharing information like this for the purpose of solving complex problems so we can each be accountable in our roles for improving health and equity in New Mexico.

Report compiled by:

Sharz Weeks, MPH
Community Health Epidemiologist

Meredith Root-Bowman, MPH, MPA
Director of Community Health Improvement

Andrea Botero, MHA, CAGS, CD
Manager, Population Health Integration

Toni Grinstead, MPA
Health Equity Consultant

Natahlia Enoah, MS
Community Health Evaluator

Danielle Lucero, MSW, MPH
Senior Program Manager

Special thanks to the following people for their many contributions:

Barbara Arnold
Kim Horan
Valentina White
Lillian Walker
Liam Westgate
Tracy Jaramillo
Cheynna Lapahie
Roberto Martinez
Rach Ralya
Jasmine Meyer
Adrian Ortiz
Kyaolin Rajbhandary
Elizabeth Tafoya
LaKiesha Cotton
Lilan Lawrence Metzler
Rachelle (Shelly) Simpson
Marie Velasco
Liesl Gonzales
Ryan Edgington
Tatiana Falcon Rodriguez
Sarah Zalud Cerrato
Rebekah West
Jeremy Espinoza
Camie Willetto
Ophelia Hudson
Annaliese Mayette
Evan Hall

ABOUT PRESBYTERIAN HEALTHCARE SERVICES

Presbyterian Healthcare Services (Presbyterian) exists to improve the health of the patients, members, and communities we serve. We are a locally owned and operated not-for-profit healthcare system known nationally for our extensive experience in integrating healthcare financing and delivery.

We've grown from a small tuberculosis sanatorium founded in 1908, to a system of nine hospitals, a multi-specialty medical group with more than 1,300 employed clinicians and a statewide health plan. We serve one in three New Mexicans with healthcare or coverage.

Our regional hospitals provide both acute and preventive care: from surgical, ambulatory, and emergency services to health fairs, fun runs, and prevention and screening programs. Our nearly 14,000 employees are not only dedicated to the communities we serve but are also a part of the communities we serve.

We are governed by a volunteer Board of Trustees comprised of community leaders. These individuals have included members of the Navajo Nation, theologians, business leaders, educators, medical administrators, and others. They donate their time and energy to ensure that we maintain superior caregiving, deliver high-quality healthcare and work tirelessly to create a healthy New Mexico, now and for years to come.

We are committed to caring for our community -- and have been for more than 115 years. Learn more in the *PHS Report to the Community*.

ABOUT PRESBYTERIAN COMMUNITY HEALTH

As part of Presbyterian's commitment to our charitable purpose and to our communities, Presbyterian Community Health oversees the Community Health Assessment and Implementation Plan process every three years, implements community health programming, and helps inform systemwide strategy in alignment with identified priorities.

Since its founding in 2013, Presbyterian Community Health has invested more than $15 million in operational funds and leveraged $34.6 million in federal and local grants, foundation funds, contracts, and awards.

Through the extensive community assessment process detailed here, Presbyterian Community Health focused on the following priorities from 2023-2025: behavioral health, social health, and physical health. For reports on the progress made and additional information on past priorities, assessments, plans, please visit phs.org/community.

New Mexico Shared Community Health Assessment Collaborative: Presbyterian is proud to participate as a backbone agency in the novel New Mexico Community Health Improvement Plan and System Alignment for Sustainable Action (NM CHIPS & SALSA) in close partnership with the New Mexico Department of Health (NMHEALTH). A key function of this collaboration is the New Mexico Shared Community Health Needs Assessment Collaborative which is a dynamic public-private partnership that creates shared community health needs assessment processes to reduce the burden of assessment fatigue on our communities and increase efficiency and alignment in our efforts to improve the health of New Mexicans. This partnership focuses on engaging and activating communities in intentional, aligned, non-duplicative ways, supporting data-driven health improvements, and alignment in those health improvement efforts to maximize impact and reduce duplication. Join the collaborative at *www.chipsandsalsanm.com*.

A Focus on Health Equity

In 2019, Presbyterian embarked on a formalized journey to address health equity in our communities and for our patients and members. We adopted a framework developed by the Institute for Healthcare Improvement for healthcare organizations to achieve health equity, which identifies five core practices:

- Make health equity a strategic priority.
- Develop structures and processes to support equity-focused work.

- Deploy targeted strategies to address the multiple drivers of health.
- Eliminate racism and other forms of oppression.
- Build and sustain partnerships with community organizations.

According to the Robert Wood Johnson Foundation, health Equity means that "everyone has a fair and just opportunity to be as healthy as possible." This means removing obstacles that contribute to health inequity such as poverty and discrimination and their consequences, including powerlessness, and a lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare. To achieve health equity, we strive to understand how our patients experience inequities rooted in structural and social drivers of health (SDOH), and to remove individual barriers while advancing systemic change.

In 2021 Presbyterian implemented a systemwide Social Drivers of Health (SDOH) screening tool embedded in our electronic health record (EHR). Health related social need screening is routinely done twice a year in all settings including primary care, specialty care, when a patient is admitted, emergency department, and urgent care. Fifty-six percent (56%) of all patients have been asked if they need help with food, housing, utilities or other social needs that help keep them and their families heathy since screenings started in 2021. Over 229,000 personalized resource lists were automatically created in response to Presbyterian patients' identified needs in 2024 alone.

Given our continued recognition that food insecurity as a key barrier to health, Presbyterian has expanded its Food Farmacy and Produce Prescription programs across the state each year.

To ensure ongoing accountability and progress, Presbyterian embedded health equity into our system's quality improvement infrastructure. Our Health Equity and Cultural Competency Committee, in collaboration with operational leaders, established equity dashboards to stratify quality and utilization data by race, ethnicity, preferred language, and geography—helping drive targeted interventions and address disparities in real time.

Presbyterian is proud that all nine Presbyterian hospitals across New Mexico are recognized as LGBTQ+ Healthcare Equality High Performers by the Human Right's Campaign Foundation's Healthcare Equality Index (HEI) in 2024. HEI is a national benchmark survey that evaluates healthcare facilities on policies and procedures related to equity and inclusion of LGBTQ patients, visitors and employees. Presbyterian received the highest score in New Mexico and is the first healthcare system in the state with more than one hospital recognized.

Together, these strategies reflect our commitment to building a healthcare system where everyone—regardless of race, income, geography, gender identity, or language—has a fair and just opportunity to achieve their best health.

Learn more about Health Equity and read full reports at *phs.org/community/committed-to-community-health/health-equity*

Understanding and Addressing Health-Related Social Needs: A foundational element of health equity work at Presbyterian is identifying and addressing health-related social needs (HRSN) through universal screening. This process, overseen and managed by the Community and Clinical Linkages division (CCL), ensures that all patients can be screened at least twice a year for key needs—including food insecurity, housing instability, transportation access, utilities support, and experiences of violence or abuse—and that those with identified needs automatically receive information about relevant community resources. By integrating a resource directory and closed-loop referral platform

(Unite Us) directly into Presbyterian's electronic medical record system (Epic), this work ensures that every patient is offered meaningful support at the point of care, without adding extra burden to providers.

This standardized approach enables Presbyterian to identify HRSNs consistently and at scale, reduce variability and bias in how patients access social care, normalize conversations with patients about HRSNs within clinical workflows, align medical and community-based interventions, and generate data that can inform equity-focused quality improvement across the system.

Community & Clinical Linkages Workforce: The Community & Clinical Linkages (CCL) division of Community Health bridges healthcare, behavioral health, and social care, helping providers, care teams, and community partners work together to connect patients to the support they need beyond the clinical setting, as well as driving change at the individual and community levels.

CHWs and Peers form a social care team that brings lived experience, cultural insight, and trusted relationships into the care setting. Often members of the communities they serve, Presbyterian's CHWs and Peers work across healthcare settings to support patients in-person, by phone, or virtually. They offer patients accessible, relationship-centered care with a focus on connecting individuals to the community-based resources and support needed to improve their health and well-being.

While CHWs focus on addressing health-related social needs (HRSNs) such as food, housing, transportation, and utilities—Peers provide mentorship, recovery support, and guidance for those navigating behavioral health and substance use challenges. Together, they reduce barriers to care, improve engagement, and strengthen the link between healthcare, social services, and community life. Their work supports patients directly while also equipping care teams with the insight and tools to provide more holistic, person-centered care.

CHWs and Peer Support Specialists are essential connectors between healthcare, patients, and community-based services. They enhance whole-person care by addressing patients' social, behavioral and physical health needs while improving patient experience and engagement. CHW and Peer models strengthen care teams and provider capacity by reducing workload and improving care coordination, while also contributing to high levels of satisfaction among care team members, who recognize CHWs and Peers as invaluable partners in delivering equitable, patient-centered care. Community Health Workers and Peer Support Specialists are some of the best sources of information about the needs of our communities, because they work to assess assets and gaps in their day-to-day work with individuals, families, institutions, and greater networks within the community.

ABOUT PRESBYTERIAN NORTHERN NEW MEXICO

Northern New Mexico is part of the Regional Delivery System at Presbyterian Healthcare Services and includes the following hospitals: Presbyterian Española Hospital and Presbyterian Santa Fe Medical Center.

Presbyterian Española Hospital

Presbyterian Española Hospital is an acute care hospital located in Española, New Mexico. As a not-for-profit hospital with 80 licensed beds, Presbyterian Española Hospital exists to improve the health of the patients, members, and communities we serve in northern New Mexico.

At Presbyterian Española Hospital, our highly skilled doctors, nurses, and healthcare providers provide a wide range of services for our patient's healthcare needs, including emergency medicine and sleep disorders, as well as primary care and specialty services.

Small Town Hospital. Big City Services.

The people of Presbyterian Española Hospital -- physicians, nurses, volunteers and support staff -- take great pride in a long tradition of delivering compassionate patient care, a wide range of general acute care and specialty services to residents and visitors of northern New Mexico. Presbyterian Española Hospital's high quality and values are made possible through a unique partnership between the County of Rio Arriba, a local Board of Trustees, and Presbyterian Healthcare Services, which has owned and managed hospital operations since 1977.

Our goal has been to provide the finest care and service possible since we first opened in 1948. Over the years, we have expanded to meet the growing needs of the Española Valley, Rio Arriba County, and northern New Mexico. We continue to add new services to provide state-of-the art treatment and technology for our patients.

Presbyterian Santa Fe Medical Center

Presbyterian Santa Fe Medical Center and Physician Office Building provides a range of healthcare services in one convenient location. Our services and features include:

- 30 private inpatient beds
- A family birthing unit designed to provide the best start to life for babies, their moms and families
- Surgery and procedure suites for outpatient and short stay surgeries, including orthopedic surgery
- Adult intensive care unit (ICU)
- Lab and imaging services, including CT and MRI
- Specialty medical services
- Inpatient and outpatient rehabilitation services
- Outpatient primary and specialty care
- Emergency department
- Ground and helicopter ambulances
- Nearby walking and biking trails, a rooftop healing terrace and green building practices

We have additional services available at our Presbyterian Medical Group clinic, including:

- An urgent care
- Primary and specialty care
- Lab and radiology

As part of the Presbyterian Healthcare Services system, we are dedicated to the health of our patients, members, and community.

OUR COMMUNITY

For the purposes of the Community Health Assessment and the Implementation Plan, Presbyterian Healthcare Services (Presbyterian) defines the "community" of the Northern New Mexico Delivery System as the counties which these facilities serve including the following counties: Santa Fe, Rio Arriba, Los Alamos, Taos, Colfax, Mora, San Miguel, Guadalupe, Harding, Union, San Juan, Cibola, and McKinley. The northern region is also home to many tribal and

indigenous lands and nations these include: Acoma Pueblo, Nambe Pueblo, Picuris Pueblo, San Ildefonso Pueblo, Santa Clara Pueblo, Tesuque Pueblo, Taos Pueblo, Ohkay Owingeh, Jicarilla Apache Nation, Pojoaque Pueblo, Laguna Pueblo, Zuni Pueblo, and the Navajo Nation. To align community health assessment and implementation work both internally and with community partners, in response to the ongoing recognition that accessing health care and social services often crosses borders, and in recognition of the reach of the Presbyterian Healthcare Services system, we have elected to combine the counties within the NMHealth Northeast and Northwest regions and conceptualize those as the "Northern region".

It is important to understand the characteristics of our communities to begin to understand how people are affected by health and social structures differently, which leads to differences in health outcomes. By understanding the makeup of our communities, we can begin to develop interventions driven by community needs and desires, tailor interventions in partnership with our communities, and ensure culturally and linguistically relevant support.

Data for this section were abstracted from the New Mexico Indicator-Based Information System in August 2025. Population estimates are available for 2023 based on a combination of census data and data collected and processed by the University of New Mexico Geospatial and Population Sciences Studies (GPS) Program.

Race and Ethnicity are presented as joint social and cultural constructs according to the NM Department of Health (NMHealth) guidelines as follows:

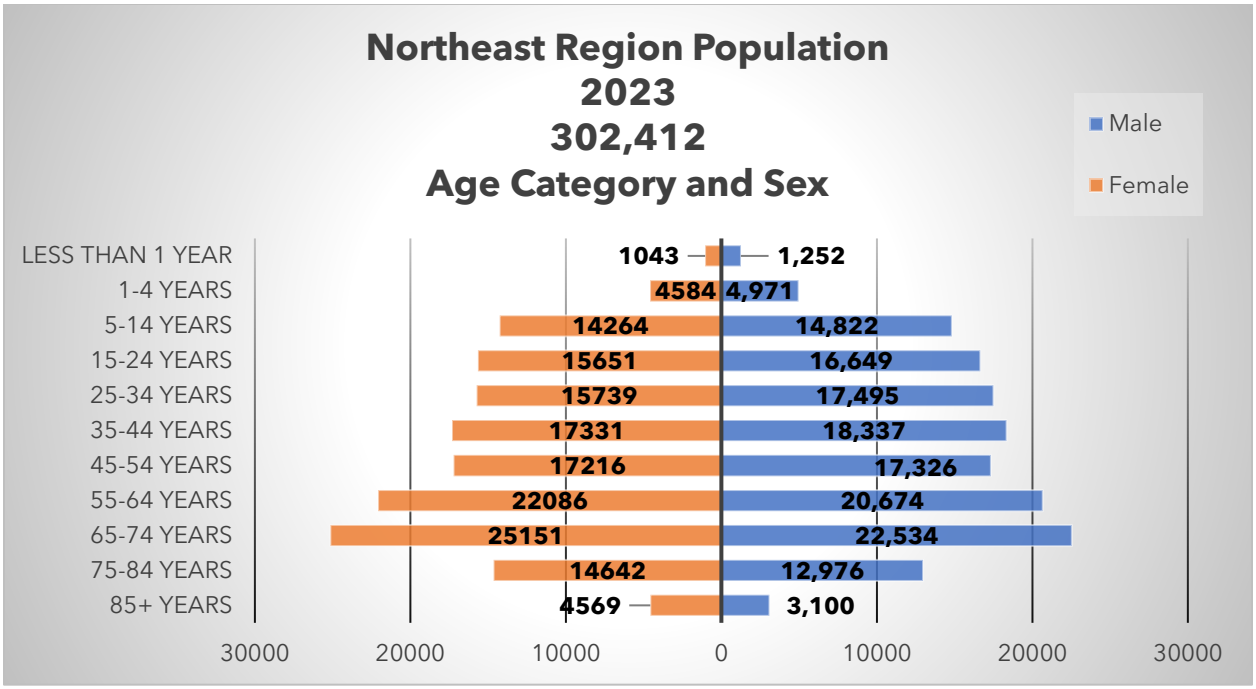
"The New Mexico presentation standard uses the estimates by bridged race and Hispanic ethnicity. Presentation of race and ethnicity will be done together in the same table. Race/ethnicity will be presented as a single social and cultural construct. Persons designated as Hispanic ethnicity, regardless of race, will be categorized as 'Hispanic.' Persons not designated as Hispanic will be categorized by their single race ('Black or African American,' 'American Indian or Alaska native,' 'Asian or Pacific Islander,' 'White,' or 'Other'). For more information, please see the *NMHEALTH Race and Ethnicity Presentation Standards*."

Language and Disability data come from the American Community Survey 2023 5-year estimates (US Census Bureau). Because these data are 5-year moving averages, we should not compare these metrics to prior health assessments to identify changes over time from one report to the other without understanding these caveats. The American Community Survey is an annual survey conducted among people living within the US regardless of their immigration or citizenship status and excludes people who live in institutional settings (nursing homes, long-term care facilities, prisons).

Demographics

Northeast

The Northeast Region of NM is characterized by larger proportions of people between the ages of 55 and 74 years old, indicating a slightly older population. These two age groups make up nearly 30% of the region's population. Understanding the limitation of availability of population data on the gender binary, we see that there is very little difference in the proportion of men and women in this region (49.6% are identified as male while 50.4% are female). While the racial/ethnic makeup of the region varies by county, overall we see that over half of the population identifies as Hispanic while 39.9% identifies as White and 5.1% identifies as Native American. Rio Arriba has the highest proportion of their population identifying as Native American compared to other counties in the region, with 16.8% of the population identifying as such. San Miguel County has the highest proportion of the population identifying as Hispanic – 75% of the population.



Northeast New Mexico						
	Colfax		Guadalupe		Harding	
American Indian or Alaska Native	323	2.7%	92	2.1%	8	1.2%
Asian or Pacific Islander	124	1.0%	58	1.3%	2	0.3%
Black or African American	139	1.1%	103	2.4%	18	2.8%
Hispanic	5,719	47.2%	3,321	77.2%	267	41.3%
White	5,813	48.0%	726	16.9%	352	54.4%
Total	12,118	100.0%	4,300	100.0%	647	100.0%

	Los Alamos		**Mora**		**Rio Arriba**	
American Indian or Alaska Native	341	1.8%	39	0.9%	6,562	16.8%
Asian or Pacific Islander	1,567	8.1%	24	0.6%	321	0.8%
Black or African American	345	1.8%	24	0.6%	332	0.8%
Hispanic	3,509	18.1%	3,273	78.7%	26,237	67.0%
White	13,574	70.2%	797	19.2%	5,723	14.6%
Total	19,336	100.0%	4,157	100.0%	39,175	100.0%

	San Miguel		**Santa Fe**		**Taos**	
American Indian or Alaska Native	492	1.8%	5,275	3.4%	2,324	6.7%
Asian or Pacific Islander	355	1.3%	3,146	2.0%	353	1.0%
Black or African American	515	1.9%	1,915	1.2%	273	0.8%
Hispanic	20,165	75.0%	74,933	47.6%	17,453	50.5%
White	5,342	19.9%	72,030	45.8%	14,158	41.0%
Total	26,869	100.0%	157,299	100.0%	34,561	100.0%

	Union		Northeast Total	
American Indian or Alaska Native	92	2.3%	15,548	5.1%
Asian or Pacific Islander	44	1.1%	5,994	2.0%
Black or African American	109	2.8%	3,773	1.2%
Hispanic	1,605	40.6%	156,482	51.7%
White	2,103	53.2%	120,618	39.9%
Total	3,953	100.0%	302,415	100.0%

Language and Disability

Rio Arriba County has the lowest proportion of the county's population who speak only English, with only 46.2% of people reporting so while 53.8% report speaking a language other than English. About 45% of the population of Rio Arriba County speak Spanish, consistent with other counties including Guadalupe, Mora, and San Miguel counties. Los Alamos, Colfax, and Union counties have the highest proportion of their populations who only speak English compared to other counties in this region. Overall, the region has a slightly higher proportion of the population who speak Spanish compared to the state overall, but a slightly lower proportion who only speak English.

	Colfax County	Guadalupe County	Harding County	Los Alamos County	Mora County
Speak only English	82.10%	51.30%	77.90%	83.40%	54.90%
Speak a language other than English	17.90%	48.70%	22.10%	16.60%	45.10%
SPEAK A LANGUAGE OTHER THAN ENGLISH					
Spanish	16.10%	46.10%	22.00%	7.40%	43.50%
Other Indo-European languages	0.50%	0.10%	0.10%	3.80%	1.50%
Asian and Pacific Island languages	0.00%	0.00%	0.00%	4.90%	0.00%
Other languages	1.30%	2.50%	0.00%	0.60%	0.10%

	Rio Arriba County	San Miguel County	Santa Fe County	Taos County	Union County
Speak only English	46.20%	52.00%	69.60%	66.10%	79.10%
Speak a language other than English	53.80%	48.00%	30.40%	33.90%	20.90%
SPEAK A LANGUAGE OTHER THAN ENGLISH					
Spanish	45.30%	45.40%	26.20%	28.80%	19.60%
Other Indo-European languages	0.20%	1.00%	2.10%	0.80%	0.30%
Asian and Pacific Island languages	0.70%	0.30%	0.90%	0.50%	0.00%
Other languages	7.70%	1.40%	1.30%	3.70%	0.90%

	New Mexico	Northeast Region
Speak only English	68.40%	65.6%
Speak a language other than English	31.60%	34.4%
SPEAK A LANGUAGE OTHER THAN ENGLISH		
Spanish	24.50%	29.5%
Other Indo-European languages	1.10%	1.6%
Asian and Pacific Island languages	1.10%	1.0%

Other languages	4.90%	2.4%

Overall, the Northeast region has a similar proportion of the population living with a disability compared to the state, however Northeast New Mexico also has some of the highest proportions of the population who have a disability – the counties with a small proportion of the population with a disability pull the average down to near state level. Mora County has nearly 30% of the population living with a disability, followed by Colfax County (26.2% - over a quarter of the population), and San Miguel 24.5% - just under a quarter of the population. The most common disability in this region is

	Colfax County	Guadalupe County	Harding County	Los Alamos County	Mora County
Percent of Population with a Disability	26.20%	22.40%	20.50%	10.40%	28.70%

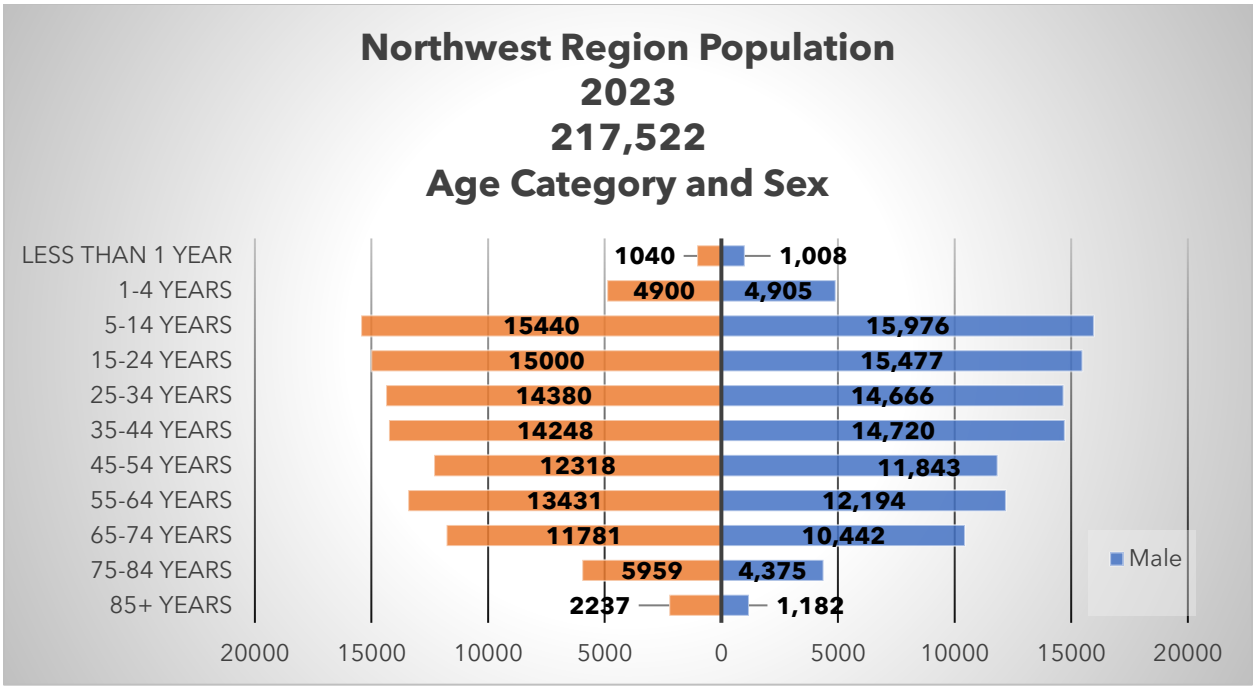
	Rio Arriba County	San Miguel County	Santa Fe County	Taos County	Union County
Percent of Population with a Disability	14.90%	24.50%	14.80%	18.40%	23.30%

	Northeast Region	New Mexico
Percent of Population with a Disability	16.7%	16.70%

Northwest

The Northwest region has a fairy even distribution between genders, understanding the limitations of the gender binary methods of collecting these data. About 51% of the population is female while about 49% of the population is male. The population in Northwest New Mexico is slightly younger, with slightly higher percentages of the population falling into the 5-14 and 15-24 years age categories.

The Northwest region has the highest proportion of the population identifying as Native American, with 53.6% of the population of the three counties combined identifying as such. Within these counties, McKinley County has the highest (both in the region and the state) with 77.3% of the population identifying as Native American.



Northwest New Mexico								
	Cibola		McKinley		San Juan		Northwest Total	
American Indian or Alaska Native	11,875	44.5%	54,627	77.3%	50,027	41.6%	116,529	53.6%
Asian or Pacific Islander	279	1.0%	1,094	1.5%	1,361	1.1%	2,734	1.3%
Black or African American	460	1.7%	590	0.8%	1,158	1.0%	2,208	1.0%
Hispanic	8,905	33.4%	8,640	12.2%	23,717	19.7%	41,262	19.0%
White	5,147	19.3%	5,690	8.1%	43,949	36.6%	54,786	25.2%
Total	26,666	100.0%	70,641	100.0%	120,212	100.0%	217,519	100.0%

Language and Disability

Most counties in this region have a much higher proportion of people who speak "other" languages, which is a diversion from the patterns seen across the state where Spanish is the second most commonly spoken language. In the Northwest region, there is a slightly higher percentage of people who speak a language other than English compared to the state, and half of McKinley County's population speaks a language other than English. About 44% of people in McKinley County speak an "other" language, which across these counties, we can surmise that the "other" language is an Indigenous language.

	Cibola County	McKinley County	San Juan County	Northwest New Mexico	New Mexico
Speak only English	65.0%	49.2%	69.7%	62.5%	68.4%
Speak a language other than English	35.0%	50.8%	30.3%	37.5%	31.6%
SPEAK A LANGUAGE OTHER THAN ENGLISH					
Spanish	13.8%	5.4%	9.5%	8.7%	24.5%
Other Indo-European languages	0.2%	0.6%	0.5%	0.5%	1.1%
Asian and Pacific Island languages	0.7%	0.8%	0.5%	0.6%	1.1%
Other languages	20.3%	43.9%	19.8%	27.7%	4.9%

The Northwest region has a similar proportion of the population living with a disability as New Mexico overall. About 21% of Cibola County's population lives with a disability while McKinley and San Juan counties have disability prevalence lower than the state overall. The most common disabilities identified include ambulatory difficulty followed by cognitive difficulty and hearing difficulty.

	Cibola County	McKinley County	San Juan County	Northwest Region	New Mexico
Percent of Population with a Disability	21.20%	15.90%	15.70%	16.4%	16.70%

In addition to describing our county's population, it is important to describe the Presbyterian patient population to further illustrate our reach and potential for impact. The metrics below should not be compared to the population demographics above as there is likely duplication, data collection methods are different, and many categories are different. The patient population demographics below are intended to illustrate the diversity of patients with whom Presbyterian hospitals interact.

The patient population in Northern New Mexico is majority Hispanic/Latine and trends slightly older. The patient population is slightly more female than male and is mostly English is the most spoken language. Overall, about 32% of patients have a commercial plan across both hospitals, But Presbyterian Española Hospital has a higher percent of patients who use Medicaid compared to Santa Fe Medical Center.

Patient Population Demographics				
	Santa Fe Medical Center		Española Hospital	
AGE	**n**	**(%)**	**n**	**(%)**
0-2	1,081	2.2	726	2.3
3-12	3,328	6.7	2,631	8.4
13-18	2,285	4.6	1,835	5.9
19-24	2,600	5.3	1,718	5.5
25-34	5,106	10.3	3,189	10.2
35-44	5,676	11.5	3,590	11.5
45-54	5,480	11.1	3,534	11.3
55-64	6,944	14.0	4,399	14.1
65-74	8,601	17.4	4,980	15.9
75+	8,096	16.4	4,460	14.3
UNKNOWN	234	0.5	195	0.6
SEX				
FEMALE	28,341	57.3	17,342	55.5
MALE	21,079	42.6	13,914	44.5
UNKNOWN	†	0.0	†	0.0
RACE				
WHITE	35,425	71.7	18,939	60.6
AMERICAN INDIAN OR ALASKA NATIVE	1,562	3.2	1,602	5.1
OTHER	6,201	12.5	9,035	28.9
UNKNOWN	4,072	8.2	1,185	3.8
AFRICAN AMERICAN OR BLACK	480	1.0	165	0.5
MULTIRACIAL	1,125	2.3	161	0.5
ASIAN	501	1.0	123	0.4
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	65	0.1	47	0.2
ETHNICITY				
NOT HISPANIC OR LATINX	21,637	43.8	7,432	23.8
HISPANIC OR LATINX	23,444	47.4	22,402	71.7
UNKNOWN	4,350	8.8	1,423	4.6
PREFERRED LANGUAGE				
ENGLISH	46,586	94.2	29,760	95.2
SPANISH	2,271	4.6	1,222	3.9
NAVAJO	†	†	†	†
OTHER	107	0.2	243	0.8
UNKNOWN	411	0.8	32	0.1
PAYOR				
MEDICAID	11,013	22.3	8,873	28.4
MEDICARE	14,116	28.6	8,383	26.8
COMMERCIAL	17,686	35.8	8,692	27.8
OTHER	5,324	10.8	4,594	14.7
UNKNOWN	1,292	2.6	715	2.3

REAL (Race, Ethnicity, and Language) -- Demographic snapshot of patients who receive care at PHS hospitals in Northern New Mexico in 2024

Patient Population Demographics		
GENDER IDENTITY	**n**	**(%)**
UNKNOWN	14,708	47.1
FEMALE	9,869	31.6
MALE	6,647	21.3
TRANSGENDER	†**	0.1
OTHER	†	<0.1
SEXUAL ORIENTATION		
UNKNOWN	20,920	66.9
STRAIGHT	10,002	32
OTHER	94	0.3
LESBIAN	54	0.2
BISEXUAL	109	0.3
GAY	78	0.2
Data Notes: A value of "UNKNOWN" could indicate that a value was not provided, collected, or recorded (**) Counts less than 10 were suppressed for patient confidentiality Low numbers may be due to recently begun efforts to collect self-reported data		

SOGI (Sexual Orientation and Gender Identity) -- Demographic snapshot of patients who receive care at PHS Hospitals in Northern New Mexico in 2024

THE EFFECTIVENESS OF 2026- 2028 COMMUNITY-INFORMED HEALTH PRIORITIES 2023-2025 CYCLE

In 2022, we implemented an evaluation process to measure our two health outcomes and four health priorities by looking at key metrics using data from two most recent points in time.

Health Outcomes include four key indicators for overarching measures that encompasses the entire statewide goal to:

1. Increase well-being among New Mexicans
2. Reduce the impact of chronic conditions on our communities

Presbyterian Healthcare Services selected the following priorities for the following cycles:

2020-2022 Cycle	2023-2025 Cycle
1. Behavioral Health • Decrease drug overdose deaths *(Drug Overdose Deaths 2017-2020)* 2. Social Determinants of Health • Reduce household food insecurity *(Food Insecurity 2017-2020)* 3. Access to Care • Increase health equity *(Adults who are without care because of cost 2017-2020)* 4. Healthy Eating & Active Living	1. Behavioral Health • Decrease 14+ poor mental health days in the las 30 days for *adults (BRFSS)* • Decrease sadness and hopelessness for youth *(YRRS)* • Decrease death rate *(NMHEALTH DVRHS).* 2. Social Health • Decrease households who spend 50% or more of their income on rent

2020-2022 Cycle	2023-2025 Cycle
• Increase consumption of fresh, locally grown fruits and vegetables *(Fruit and Vegetable Consumption 2017-2020)*	• Increase access to transportation (ACS) • Increase access to healthy foods *(USDA Food Environment Atlas)* 3. Physical Health • Decrease prevalence of diabetes *(BRFSS)* • Decrease heart disease mortality rate *(NMHEALTH BVRHS)* • Increase vaccinations against Influenza *and COVID (BRFSS and NMHEALTH)* Viewed through an **Access & Equity Lens**

Evaluation of Health Outcomes & Priorities From the 2023-25 Cycle

For the evaluation of health outcomes and priorities, the evaluation team analyzed metrics for each key measure that was selected to measure if there were any significant changes overtime. The team utilized data that was collected through various sources for the two counties where Presbtyerian had direct services and programming: Rio Arriba and Santa Fe Counties.

Methodology

To improve upon the process of CHA/CHIP evaluation, we looked at two most recent points in time for each health metrics that was selected. We compared the data to see if there was a negative or positive percentage change over time. We then ran a t-test to determine if the percentage change was statistically significant. If data was not available or suppressed, we were not able to analyze and will be noted. A t-test was done between the two points in time to determine if the prevalence (%) for health metrics increased or decreased in a positive direction.

Data for Life Expectancy, Severe Housing Cost Burden, Limited Access to Healthy Foods were metrics that had no single year of data and only combined data was found on County Health Ranking. It is important to note that there is a recommendation to be cautious when comparing years.

STATUS	KEY	DEFINITION
Needs Improvement		The prevalence % increased or decreased in a **negative** direction or stayed the same
Stable		The prevalence % increased or decreased in a **positive** direction
No change		No Change
**		Data unavailable or suppressed

Table. Definition and key legend for evaluation of health metrics for outcomes and priorities

p-value<0.05	Statistical difference between groups. Can confidently say the direction of change is due to real changes.
p-value>0.05	No Statistical difference. Cannot confidently say the direction of change is due to real changes.

*	Missing comparison group to run statistical significance test

RIO ARRIBA COUNTY

Health Outcomes for Rio Arriba County

Outcomes	Key Measure	Metric	Progress		*p*-value
Increase well-being among New Mexicans	Life Expectancy at Birth	Increase life expectancy at birth	Needs Improvement		*0.05*
	Adult Mental Health	Decrease 14+ poor mental health days in the las 30 days	Needs Improvement		*0.23*
Reduce the impact of chronic conditions	Hypertension	Decrease prevalence of diagnosed hypertension	Needs Improvement		*0.76*
	Diabetes	Decrease prevalence of diagnosed diabetes	Stable		*0.37*

Health Priorities for Rio Arriba County

Priorities	Key Measure	Metric	Progress		*p*-value
Behavioral Health	Adult Mental Health	Decrease 14+ poor mental health days in the las 30 days	Needs Improvement		*0.23*
	Death of Despair	Decrease death rate	Needs Improvement		*0.38*
	Youth Mental Health	Decrease sadness and hopelessness	Stable		*
Social Health	Access to Healthy Foods	Increase access to healthy foods	**		*
	Housing	Decrease households who spend 50% or more of their income on rent	Stable		*0.58*
	Transportation	Increase access to transportation	**		*
Physical Health	Diabetes	Decrease prevalence of diabetes	Stable		*0.37*
	Heart Disease	Decrease heart disease mortality rate	Stable		*0.13*
	Vaccination	Increase vaccinations against Influenza	Needs Improvement		*0.80*
	Vaccination	Increase vaccinations against COVID	Needs Improvement		0.56

SANTA FE COUNTY

Health Outcomes for Santa Fe County

Outcomes	Key Measure	Metric	Progress		*p*-value
Increase well-being among New Mexicans	Life Expectancy at Birth	Increase life expectancy at birth	Needs improvement		*0.31*
	Adult Mental Health	Decrease 14+ poor mental health days in the las 30 days	Stable		*0.15*
Reduce the impact of chronic conditions	Hypertension	Decrease prevalence of diagnosed hypertension	Stable		*0.60*
	Diabetes	Decrease prevalence of diagnosed diabetes	Needs improvement		*0.28*

Health Priorities for Santa Fe County

Priorities	Key Measure	Metric	Progress		*p*-value
Behavioral Health	Adult Mental Health	Decrease 14+ poor mental health days in the las 30 days	Stable		*0.15*
	Death of Despair	Decrease death rate	Needs improvement		*0.15*
	Youth Mental Health	Decrease sadness and hopelessness	Stable		*
Social Health	Access to Healthy Foods	Increase access to healthy foods	**		*
	Housing	Decrease households who spend 50% or more of their income on rent	Stable		*1.00*
	Transportation	Increase access to transportation	Stable		0.71
Physical Health	Diabetes	Decrease prevalence of diabetes	Needs improvement		*0.28*
	Heart Disease	Decrease heart disease mortality rate	Stable		*0.53*
	Vaccination	Increase vaccinations against Influenza	Needs improvement		***0.05***
	Vaccination	Increase vaccinations against COVID	Needs improvement		*0.82*

2026- 2028 COMMUNITY INFORMED PRIORITIES

Through this comprehensive community health assessment process, and in partnership with our community, community-based organizations, and stakeholders, we have identified the following areas as the priorities informed by the community for 2026-2028.

1. Connections to Care
2. Healthy Lifestyle
3. Healthy Communities

During this assessment, we have heard that Connections to Care priority area includes improving access to all types of care: physical and psychological health care, mental wellbeing, substance use, and others such as dental health. This priority area also includes connections to social support services, including those systems designed to help address health-related social needs. The community wants anchor institutions to increase safe, equitable access to health care and social service resources that help more people and families stay healthy.

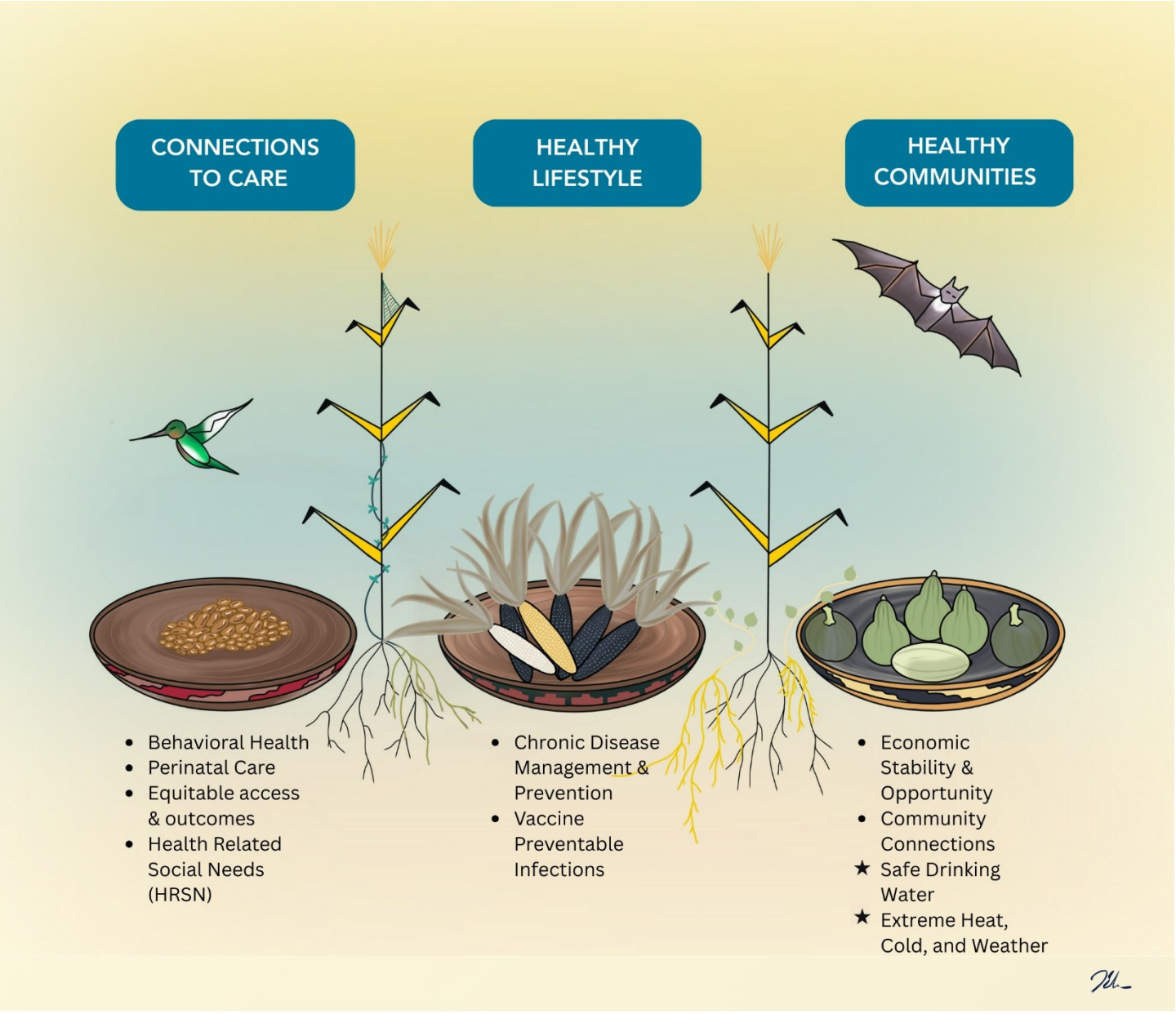
Our definition of Healthy Lifestyle encapsulates the concepts of those aspects of health we as individuals have control over. Our community expressed interest and concern in prevention and management of diseases, communicable and non-communicable, acute, and chronic. This includes topics such as healthy eating, active living, becoming more knowledgeable about health behaviors and factors, and being up to date on recommended vaccinations.

The Healthy Communities priority area is a learning priority for Presbyterian. Communities emphasized the importance of prioritizing the conditions in which we all live and addressing those essentials for life – namely safe water to drink, safe air to breathe, and safety from poisons like lead; economic viability; and connections to each other. These conditions are complex and require attention and innovation by many sectors and groups to see improvements.

Though equity is specifically named in our Connections to Care priority area, it is applicable to all priority areas. Health equity is essential to Presbyterian's purpose to improve the health of the patients, members, and communities we serve. The following assessment includes key metrics framed with equity considerations to inform the Community Health Implementation Plan.

Please see the following page for an artistic representation of the new community health priorities.

About the Artist: Natahlia Enoah is a Diné artist, moccasin maker, hide tanner, and evaluator. She draws her inspiration from her traditional practices. She is deeply passionate about wellness, art, food as medicine, and public health.



★ Exploratory Priority - Need to begin to learn more about needs and innovative solutions

"The mycorrhizal symbiosis enables the fungi to forage for mineral nutrients in the soil and deliver them to the tree in exchange for carbs. The mycorrhizae may form fungal bridges between individual trees, so that all trees in a forest are connected. These fungal networks appear to redistribute the wealth of carbs from tree to tree. *A kind of Robin Hood, they take from the rich and give to the poor so that all trees arrive at the same carbon surplus at the same time. They weave a web of reciprocity, of giving and taking. In this way, the trees all act as one because the fungi have connected them. Through unity, survival."* - Robin Wall Kimmerer (Braiding Sweetgrass)

Inspired by this quote by Robin Wall Kimmerer, I felt connected to create this visual to showcase the priorities that were selected through community input and data. The corn, beans, and squash represent traditional knowledge as they are known as the three sisters in many Indigenous communities. The three sisters support one another with the necessary nutrients, support, and protection. Respect and reciprocity are shown between the three sisters by ensuring the wellbeing of one another. The hummingbird and bat are representation of community knowledge as they travel and pollinate. The spiderweb on the cornstalk is a representation of the Indigenous Health Model created by The Notah Begay III Foundation. The ecological system framework takes into account personal and environmental factors that have impact on a person's overall health. -Natahlia Enoah

PROCESS AND METHODS FOR CONDUCTING THE ASSESSMENT

During the 2023–2025 Community Health Assessment and Implementation Plan cycle, we recognized the burden of over-assessment felt by communities. Multiple organizations were conducting assessments simultaneously or sequentially, often requesting the same information. In response, Presbyterian and the New Mexico Department of Health (NMHealth) partnered to form the Community Health Improvement Plans and Systems Alignment for Sustainable Action (CHIPs & SALSA) NM Collaborative—a public-private initiative to align statewide assessments, share resources, and reduce duplication.

The Collaborative began in 2024, engaging Tribal and County Health Councils—local public health planning bodies. Recognizing recent assessments already conducted by these Councils, and supported by epidemiological data, we adopted their identified community health priorities to minimize further burden.

This assessment reflects broad health issues and community context through a mix of epidemiological data, existing assessments, and community input. Data sources include secondary data analysis, key informant interviews, and asset/gap identification.

Conducting the Health Assessment

The assessment provides a comprehensive view of community health using both primary and secondary data. Secondary data included population-level surveys, mortality and incidence data, and PHS system indicators (Appendix A).

Given recent county-level assessments and the formation of CHIPs & SALSA, we adopted Health Council priorities from publicly available sources (Appendix C). These were analyzed alongside epidemiological data to draft initial priority areas.

We validated these priorities through Community Conversations, engaging stakeholders to confirm relevance, provide specific context, and identify additional concerns. These forums informed the final priority areas by integrating community feedback with data.

Each Community Conversation explored:

- Who is most affected (health disparities)
- Community assets
- Existing programs
- Gaps (programmatic, resource, policy)
- Potential collaborators

This input added an equity lens and guided CHIP development.

Data Collection

Quantitative Data

Population-level data highlighted major needs and disparities. Due to concerns of 'over-assessment' neither NMHealth nor Presbyterian Healthcare Services opted to conduct any additional surveys but encouraged any organizations conducting surveys to share their findings with the collaborative.

Secondary metrics were selected collaboratively by PHS and NMHealth epidemiologists. Details are provided in each topic area's description.

Qualitative Data

Qualitative insights helped contextualize health outcomes. Data from Community Conversations were hand-coded to identify themes and priorities by county. In addition, Presbyterian, and many other community partners are constantly

assessing specific health topics, geographies, and population-based needs to inform program development and improvement. Many of the high-level themes identified including through focus groups, key informant interviews, and other methods have been incorporated into the assessment of priorities, needs, gaps, and assets.

Community Conversations

Designed to reduce assessment fatigue and bring resourced action-takers together to align better for impact, these two-hour sessions presented preliminary findings and invited community input. Participants used tools like paper notes, Mentimeter, and Miro to share perspectives.

Three sessions were held in Northern New Mexico: Northwest, Northeast, and a Hybrid in person and virtual meeting held in person at Santa Fe Medical Center and online with zoom. Findings are in Appendix D.

Stakeholder Engagement

The 2026-2028 CHA/CHIP cycle included a different community and stakeholder engagement strategy compared to previous cycles.

Community and Proxy Engagement

Engagement occurred via CHIPs & SALSA Collaborative meetings (quarterly and ad hoc) and Community Conversations (in-person/virtual).

Community Health Advisory Board

This statewide board of public health, healthcare, and business leaders provided input during quarterly meetings, offering guidance on methods and outcomes.

Presbyterian Healthcare Services Leadership Engagement

Hospital and system executive leadership participated through the Community Health Steering Team, reviewing needs, strategies, and suggesting additional focus areas.

The Health Equity/SDOH Committee is an interdisciplinary committee of clinical and administrative staff across Presbyterian focused on health equity related initiatives who come together quarterly to maximize opportunities for coordination and collaboration and to identify gaps and make recommendations.

Departmental Engagement

Presbyterian Community Health collaborated with internal departments (Analytics, Strategy, Patient Experience, Quality, Population Health Management and more) to differentiate community and patient data and ensure expert review.

Additional Assessments

To inform strategy and programming, we also incorporated high level themes and findings from:

- Vaccine Equity for COVID and Flu vaccines listening sessions
- Native American Community Health Assessment
- LGBTQIA+ Population Assessment
- Diabetes care key informant interviews (prepared for the CDC Diabetes and Health Equity Collaborative Agreement)
- SDOH Closed-Loop Referral System Environmental Scan

We remain committed to ongoing, collaborative assessments to reduce burden and refine focus.

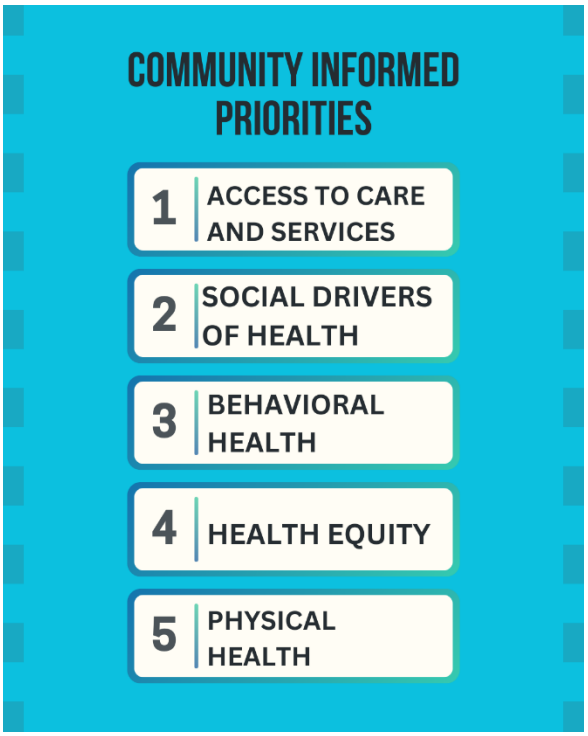
Prioritizing Needs

Priority areas were developed from the following sources: epidemiological data, Health Council priorities, and community feedback via Community Conversations. The top ten indicators and topics were selected for each source in different ways. Epidemiological data were ranked based on burden in the community (death rates, high ranking incidence and prevalence of disease, and upstream indicators). Health Council priorities were adopted at face value. Community Conversation participants ranked health needs in order of importance before providing additional topics for consideration (Figure 7). These were synthesized by Community Health staff to develop the order of the final priority areas.

Community Health used the following criteria to synthesize data and make decisions about priorities:

- Importance to community (Community Conversations)
- Size and severity of the need (Data)
- Health inequities (Data, Community Conversations)
- Alignment with Presbyterian's purpose, vision, values, and strategy
- Existing interventions and sustainability
- Resources potentially available to address significant health needs including community assets.
- Potential for greatest impact
- Readiness for action

Forum participants provided input on what they felt was the most pressing public health priority that should be addressed in the Northern New Mexican counties in the next three years.



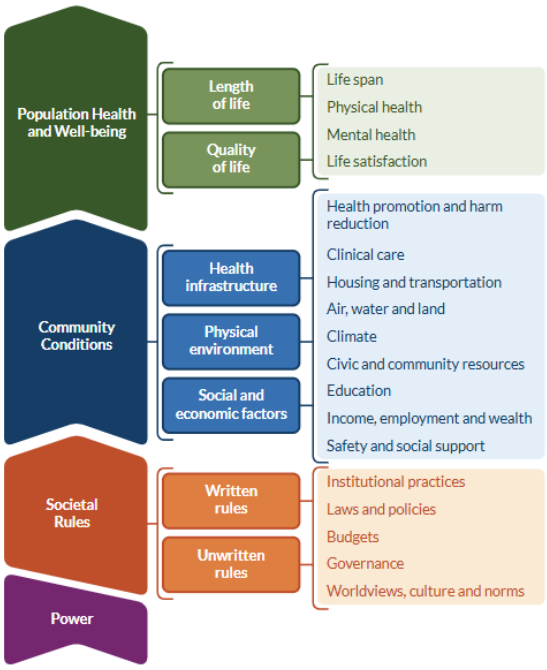
Final considerations for health areas in which to prioritize for the 2026-2028 CHA cycle include access to healthcare and social services (including providers and specific call-outs for improving access to health information through culturally and linguistically appropriate communications), economic stability, substance use, mental health, transportation, and housing.

These health needs discussed during Community Conversations generally fall under one of the following priority topic areas (carried over from last cycle for ease of communication and discussion with community members): Access to Care, Physical Health, Behavioral Health, Social Drivers of Health, and Health Equity.

Ranking Presbyterian Community Health Priorities
Community Conversations consistently ranked Access to Care as the top need, followed by Social Drivers of Health, Behavioral Health, Health Equity, and Physical Health.

Adopting a Model of Health

The University of Wisconsin Population Health Institute's Model of Health draws on two decades of research to illustrate what impacts health at the population level. This model provides a roadmap to improving health equity and outcomes among populations while acknowledging the complex relationships between health care, environment, societal rules, and power (social/political). It highlights the role systems play in public health that is beyond the individual level of influence, but still addressable to improve opportunities for health overall.



University of Wisconsin Population Health Institute Model of Health © 2025

These four aspects – Population Health and Well-Being, Community Conditions, Societal Rules, and Power – are integral in impacting health and are interpreted with the understanding that there are systemic advantages and disadvantages that get expressed on communities that impact health.

Population Health and Well-being describes the quality and quantity of life and includes mental, physical, and social health understanding that not everyone within a community has the same opportunities for good health.

Community Conditions include environmental and social determinants of health including lean water, wealth, and housing quality, to name a few. This part of the Model of Health examines conditions in which people live, learn, work, and play (often connected to social determinants of health) with the underlying understanding that there are identifiable patterns of advantage and disadvantage in community conditions that are linked to and impacted by the other components of the Model.

Societal Rules, in this model, are determined by people with power and impacts population health. This takes the form of two types of rules: written and unwritten. Written rules and policies and laws while unwritten rules are societal norms and expectations, which can look different between communities. A key component of this part of the Model is the fact that people with power determine these rules, which often result in disparities among communities.

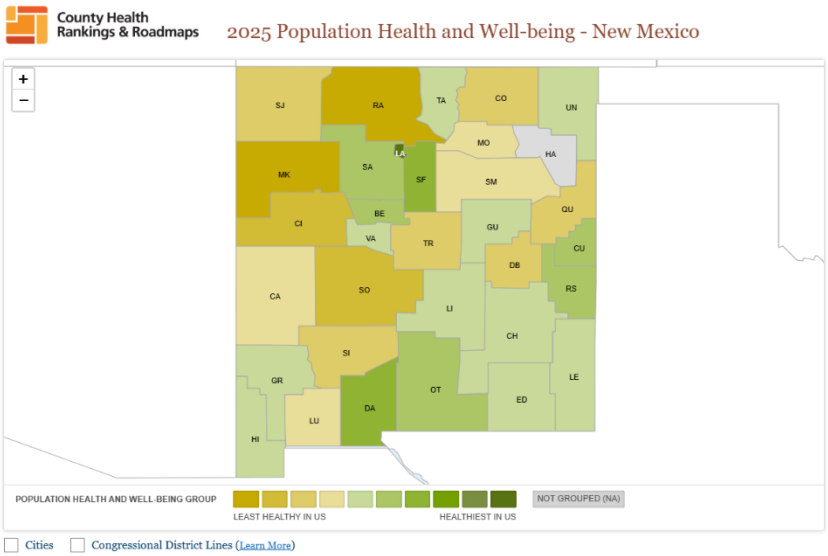
Finally, Power in this model refers to the ability to create change. This is both an understanding of the power of the individual and collective to make change, and acknowledging the power that the few currently hold, which impact community conditions and societal rules, therefore impacting population health and well-being. The Model acknowledges how the impact of consolidated power among few with specific shared interests can result in leaving communities behind. It emphasizes that community power can be built to create change, a strategy PHS Community Health works in known as collective impact.[1]

This Model of Health helps us understand how we can go about addressing the health needs of our communities in ways that build community power, include voices that have historically been silenced, and strive for equity in all spaces. We use this model to understand root causes of the indicators we explore in the following sections and to identify and commit to strategies in our CHIP.

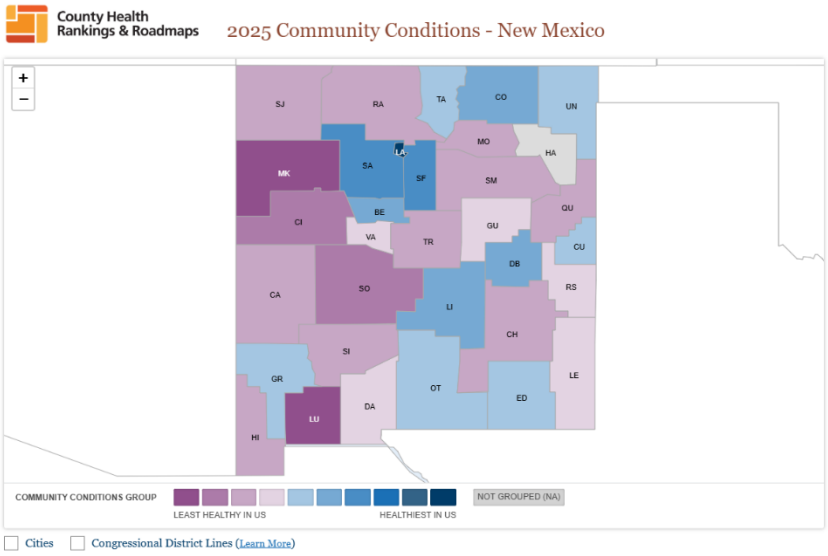
[1] Building Power for Health and Equity: 2025 County Health Rankings & Roadmaps Report. 2025. University of Wisconsin Population Health Institute School of Medicine and Public Health. Retrieved from *https://www.countyhealthrankings.org/sites/default/files/media/document/2025%20CHRR%20Report_0.pdf* on 8/20/2025

For more information about the Model of Health, visit *https://www.countyhealthrankings.org/what-impacts-health*.

County Health Rankings and Roadmaps (CHR&R) use this model of health to compile population data to illustrate, down to the county level, overall health of a population. The first two aspects of the Model can be quantified with population-level data to identify which counties are among the healthiest and least healthy. Population health and well-being, the first aspect of the Model, is noted as being something created by society and not something that can be attained through clinical care alone. CHR&R identifies health as "the ability to thrive" and describes the quality and quantity of life.[2]



Overall, compared to other counties and regions in the state, Northern New Mexico has counties that are healthier and unhealthier than other counties in some respects, which will be explored below. These counties, as illustrated above, trend to the least healthy end compared to similar counties across the country.



In addition to population health and well-being, CHR&R quantifies Community Conditions based on factors including social and economic factors, health infrastructure, and the physical environment.[3]

Several counties in Northern New Mexico are around midpoint for healthiest in the US, but many counties are among the least healthy when it comes to Community Conditions. This region also has counties that are considered among the healthiest, including Santa Fe and Los Alamos counties. This illustrates a need to address the social and environmental drivers of health in this region as well as understanding the disparities observed in these graphics.

Counties are ranked in a complex comparison process that identifies similarities and differences in data between counties nationwide. For more information on the methodology CHR&R uses, visit *https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods*.

Policy Brief

We recognize the impact that the political environment has had on communities across New Mexico. As a healthcare system, we understand the influence we hold and remain committed to uplifting all communities so that every New Mexican has a fair and equitable opportunity to live a healthy life. We believe that every community member deserves

[2] County Health Rankings and Roadmaps. 2025. Retrieved from *https://www.countyhealthrankings.org/health-data/new-mexico?year=2025&measure=Population+Health+and+Well-being* on 8/21/2025

[3] County Health Rankings and Roadmaps. 2025. Retrieved from *https://www.countyhealthrankings.org/health-data/new-mexico?year=2025&measure=Community+Conditions&mapView=state* on 8/21/2025

access to affordable healthcare, nutritious food, safe housing, and other essential services that support their health and wellbeing.

In our research, we must explore various credible sources to understand the historical context. Many times, we find the root causes of health disparities are linked to policies shaped forth by larger governing agencies. It is essential to acknowledge the lasting effects of these policies and the impact of colonization and forces assimilation to many communities in New Mexico, throughout the US, and globally. These policies continue to directly influence the environment, overall health, and wellbeing. Addressing health inequities requires us to dismantle foundations of historical and institutional racism. It is vital that we understand the power relationships between large systems, institutions and communities to create meaningful change.

New Mexico is home to many tribal communities and immigrant seeking refuge - communities that are or will be directly affected by current policy decisions, including those passed through via the One Big Beautiful Bill. It is anticipated that this newly passed legislation will cut essential funding to Medicaid, which many families across New Mexico depend upon for their healthcare. According to the NM Health Care Authority, Medicaid is the largest payor of healthcare in the State. Proposed work requirements for Medicaid could disproportionately affect vulnerable populations, including older adults, children, people experiencing homelessness, and individuals with disabilities.

Medicaid

In 2024, Medicaid in New Mexico underwent changes and the implementation of the new Medicaid Managed Care Program, *Turquoise Care* which includes a large list of value-added services and renewed emphasis on health equity. We examined "Medicaid Unwinding" trends which helped illustrate the vital role Medicaid plays in healthcare access in New Mexico. Additionally in community conversations, Medicaid and services it helps to provide and sustain were consistently listed as an asset in communities. Much more can be read about this, and we are only beginning to try to understand what and when additional changes to Medicaid like those in the One Big Beautiful Bill will mean for Medicaid recipients and all New Mexicans, regardless of their insurance coverage.

In the State of New Mexico, Medicaid began "unwinding" in April 2023. As of June 28, 2024, 217.2K New Mexicans have been disenrolled and 572.2K have had their coverage renewed (*KFF Medicaid Enrollment and Unwinding Tracker*). In New Mexico, 85% of those disenrolled were terminated for procedural reasons and 15% were determined ineligible. Medicaid is the single largest health insurer for children in New Mexico however 45,408 (12%) children lost coverage during the unwinding (*NM Voices*). For those terminated for procedural reasons, it means that the individuals may still be eligible for coverage but the paperwork for their continued coverage and to prevent disenrollment was not completed or processed in time. Kaiser Family Foundation (KFF) anticipated that the last cohort of Medicaid disenrollments among the last cohort of unwinding renewals would be May 2024. Many states are reporting a large backlog of pending renewals. For Medicaid, there is no open enrollment period, and individuals can apply for coverage at any time (*KFF).* However, in February 2024, it was reported that New Mexico processed more than 40% of their applications beyond the federally mandated 45-day timeframe (*Center on Budget and Policy Priorities*).

Most individuals on Medicaid in New Mexico are in managed care (*HCA*). On July 1, 2024, New Mexico launched Turquoise Care, the new name for the New Mexico Medicaid Managed Care program. Open enrollment took place April 1 through May 31, 2024. For those that lose Medicaid coverage, they may still be eligible for other forms of health coverage, such as employer-sponsored coverage or affordable health plans through beWellnm (*beWellnm*). Accessing Medicaid resources could be improved. One study found that about one-quarter of people who are uninsured are eligible for Medicaid and not enrolled *(KFF)*. This suggests that Medicaid was not reaching everyone who could be helped by the program before the pandemic.

Steps to For the Future:

- Offering extended hours for enrollment to increase opportunities to enroll in benefits that are outside the traditional working hours
- Fully staffing operators at local offices and through the call system to increase opportunities to enroll in Medicaid

- Continue to identify trends in enrollment data to understand distribution of coverage among historically marginalized groups and children to foster ways to further support our *(KFF)*.

The Community Perspective

To kick off the Community Conversations, we asked participants to describe, in one word, what a healthy community looked like to them. Support, thriving, connected, engaged, and resourced are all words many used to describe a healthy community. Other words included green space, access, loving, thriving, well, and safe. See word clouds below from both Northern New Mexico Community Conversations.

What does a healthy community look like to you? 5/13/2025 Community Conversation.

What does a healthy community look like to you? 5/24/2025 Community Conversation

What does a healthy community look like to you? 5/8/2025 Community Conversation.

Community Needs, Assets, and Gaps

Our community described needs, assets, and gaps in each county/community during the Community Conversations conducted in May 2025. These perspectives not only informed the development of the priority areas, but gave valuable insight and depth to the nuance and root causes of key health outcomes. The full list of comments, topics, and themes can be found in Appendix D.

Needs

Access and social needs rose to the top of the needs discussed in our Community Conversations. Topics including mental health care, access to health care, housing and transportation were key topics our community focused on. Specifically, our community discussed the need to train providers better and to recruit and establish more providers, whether that's for general health care or mental/behavioral health care. Communities discussed the need to reduce stigma around substance use and mental health, especially on tribal land. Specific program needs that were identified include naloxone training on reservations, increasing the liquor tax, specific work to change social norms around many

of the health topics that come with stigma including eating disorders and substance use, and generally more funding. Our communities were interested in exploring food sovereignty initiatives and more integration of tribal organizations/governments in county health planning and implementation. The need for safer walking and biking trails, and more places to engage in physical activity, was a need that was identified multiple times across the conversations. Finally, communities talked about needs surrounding intergenerational interaction and supporting elderly with addressing isolation and loneliness and general community building.

Assets

Many of the assets named in the community conversations were organization specific. These included specific community health councils, detox organizations, traditional healing services, street medicine, various counseling providers, schools, hospitals, clinics, health systems, community health centers, and nonprofits that can support connections to programs and services. The key takeaway from the community conversations is that the Northern New Mexico region is rich in assets and resources that are there to help improve population health, but there is a general lack of coordination and awareness of these resources to reach maximum effectiveness.

Gaps

Key gaps our communities identified in our Community Conversations centered around identifying the assets and engaging in discussions about how to better use those resources in the community. A primary gap that arose was the lack of knowledge about services that are available to the public, so simple messaging and awareness campaigns may be beneficial in connecting people to resources. Primarily, in some communities, they identified leader support to expand and build evidence-based programs in our communities, realizing political will and funding are two major gaps in the ability to do so. More collaboration between organizations was mentioned several times during the conversations, leading to the conclusion that collective action can have collective impact on health outcomes in our communities, especially around connecting people to services that have availability.

Population-Specific Assessments

In the time between assessment cycles, Presbyterian Community Health engaged in several population - and topic-specific assessments to build a deeper understanding of the findings of the last assessment for developing programs. Those findings are included here to help us understand some of the nuance in health needs for historically marginalized populations.

Title: Community Health Assessment/Community Health Improvement Plan Key Informant Interview
Years: 2023-2025
Overview: One of the priorities of the 2023-25 CHA/CHIP development included ensuring that Native American communities voices would be included. Presbyterian Community Health conducted two key informant interviews focusing social health, behavioral health, chronic conditions, and community resources. The goal of these interviews was to confirm and expand on information that had been shared in previous community forums.

Key Insights

Community Needs

- Increase availability of affordable housing.
- Access to low-cost quality health care and traditional medicine.
- Support for behavioral health providers to work in Tribal Nation settings.
- Meet people where they are in the community.

Challenges

- Address root cause issues such environmental racism and historical trauma.
- Lack of clear messaging for healthcare coverage options.
- Accessibility of healthcare and behavioral health services.

Resources and Assets

- A strong focus on community and collective care.

- "Caution with vaccination, but the big strength with tribal communities in terms of getting vaccinated really came down to them protecting each other and protecting their people."
    - Support for Community Health Workers
    - "We just need a lot more of them. A lot of them are based in health centers but we need to integrate CHW into based organizations such as libraries, bus stops, or rec centers. Having them only in health centers is a barrier because people want to avoid it because it is so expensive."
    - "We can provide the guidance and help to our tribal members. Care coordinators, CHW that are tribal members that understand both worlds by living on the reservation and how to navigate resources off the reservation."

Title: PHS LGBTQIA+ Population Assessment

Year: 2023

Overview: Presbyterian conducted an assessment that included reviewing national, state, and local statistics, analyzing high-level LGBTQIA+ population data for Presbyterian, identifying barriers to care, and completing community and PHS asset mapping. The goal for this assessment was to better understand population demographics, experiences with the healthcare system and future opportunities to improve care.

Key insights

Community Needs

- Access to Gender-affirming Care and LGBTQIA+ affirming care.
- Educational resources for patients and training for providers.
- Accepting and affirming environments to access care.
- Improve data linkages such as linking SOGI questions in Epic with Press Ganey responses so questions are not asked more than once.

Challenges

- Insurance coverage
- Ineffective IT and other systems
- Social drivers of health especially financial security and housing.
- Stigma and Discrimination
- Procedural and Medical Incompetence
- The current political climate

Resources and Assets

- Centering lived experience and firsthand accounts.
- Gender-affirming Care and LGBTQIA+ affirming care provider network.

Title: PRESBYTERIAN COMMUNITY HEALTH AND SHARE OUR STRENGTH PERINATAL NUTRITION GRANT Report

Years: 2023-2024

Overview: Presbyterian used human and equity-centered design to conduct a total of five in-person community listening sessions – three in English and two in Spanish – as well as one key informant interview with an internal OB/GYN provider. The goal of these efforts was to align, co-create and co-brand perinatal food skills education content that is specific to the community's needs.

Key Insights:

Community Needs

- Access to Digital Resources
- Safe spaces to connect in-person with peers and experts.
- Materials for every stage of childhood

Challenges

- Time and availability of expert staff such as dieticians in the clinic setting.

Resources and Assets

- Presbyterian Healthcare Services Perinatal Health Equity Committee, Presbyterian Medical Group OB/GYNs and Presbyterian Health Plan.
- Existing curriculum that will undergo clinical review and branding and will be used as formal nutrition education.
- Opportunities to align nutrition education content to be added to current clinic materials and the PHS OB/GYN webpage.

Epidemiological Data

The following sections contain the suite of epidemiological data analyzed for this assessment. Each topic area includes information on the sources, interpretations, and notes about the data. For more information, contact the PHS Community Health Epidemiologist.

Years of Potential Life Lost and Life Expectancy

Years of potential life lost (YPLL) is a calculation of premature mortality (death) given a calculation of estimating average length of life if early death had not occurred. This measure confers important information about social and economic impacts on mortality and is key to understanding the importance of prevention in public health.[4] YPLL is expressed as number of years.

Life expectancy is the average number of years from birth people are expected to live. This is calculated using birth and death data and are age-adjusted. Deaths are attributed to the county in which the individual lived, regardless of where the actual death occurred.

Life expectancy in the United States is 77.1 years, which is higher than New Mexico's life expectancy. YPLL in the United States is 8,400 years, which is about one-third lower than New Mexico's.

Data for this section were obtained from County Health Rankings and Roadmaps, 2025 measures (2010-2022).

Northeast

All counties in this region, with the exception of Los Alamos County, have YPLL rates that are higher than the national rate of 8,400 years. Los Alamos County has the lowest YPLL in this region, with 3,583 years while Rio Arriba County has the highest YPLL in the region – 21,299 years. Life expectancy in this region is, in general, lower than the national life expectancy of 77.1 years. Los Alamos and Santa Fe counties have life expectancies that are higher than the national rate – 83 and 79.3 years, respectively. Rio Arriba has the lowest life expectancy in the region – a value of 69.3 years.

County	Deaths	Years of Potential Life Lost	Life Expectancy
Colfax	285	13075	75.2
Guadalupe	90	12651	73.9
Harding	**	**	**
Los Alamos	130	3583	83.0
Mora	84	14982	76.1
Rio Arriba	1036	21299	69.3
San Miguel	576	14085	74.1
Santa Fe	2191	8950	79.3
Taos	663	12930	76.5
Union	82	12002	73.8

[4] Gardner, John W.; Sanborn, Jill S.. Years of Potential Life Lost (YPLL)—What Does it Measure?. Epidemiology 1(4):p 322-329, July 1990.

**Data not available for Harding County

Northwest

Deaths in Northwest New Mexico were more numerous in San Juan County yet the YPLL is highest in McKinley County, which suggests that deaths are occurring among younger populations in that county compared to San Juan County. The life expectancy in McKinely County is the lowest in the state and this region – 63.9 years. Cibola County has the highest life expectancy in this region – 70.7 years. Across all three counties, life expectancy is lowest among non-Hispanic Native Americans and highest among non-Hispanic White people. All three counties have life expectancies and YPLL that are worse than the state and the US, suggesting a need to address predictors of death in this region.

County	Deaths	Years of Potential Life Lost	Life Expectancy
Cibola	657	16697	70.7
McKinley	2231	27593	63.9
San Juan	2814	18277	69.8

Top Fifteen Leading Causes of Death

To understand those factors that contribute to the health and well-being of our communities, we must understand what the most common causes of mortality are both across the state and at the regional and county levels. By identifying and quantifying the causes of death, we can identify primary, secondary, and tertiary prevention strategies to lower the death rates due to preventable diseases.

Data for this section were pulled for 2023 (the most recent year available) from NM Indicator-Based Information System (NM IBIS), which is populated with data from the NM Bureau of Vital Records and Health Statistics (HVRHS).

Northeast

Heart disease, cancer, and unintentional injuries remain the top three leading causes of death in Northeastern New Mexico, consistent with statewide trends. In this region, we see the age-adjusted death rate for unintentional injuries much higher than the statewide rate, indicating a need to address unintentional injuries in this region. That being said, heart disease and cancer death rates are lower than the statewide rates.

15 Leading Causes of Death in Northeastern New Mexico	Deaths per 100,000 Population, Age-adjusted	Number of Deaths
Heart disease	125	661
Cancer	107.6	597
Unintentional injuries	104	309
Chronic lower respiratory diseases	31.1	175
Chronic liver disease, cirrhosis	28.6	103
Stroke	25.2	130
Suicide	24	72
Diabetes	21.8	108
Alzheimer's disease	16.2	86
Coronavirus disease 2019 (COVID-19)	13.5	69
Nutritional deficiencies	12.5	65
Homicide	12.5	33
Kidney disease	10.7	60
Influenza and pneumonia	10.3	47
Septicemia	7.1	35

Northwest

This region has a slightly lower death rate due to heart disease compared to the state overall, but cancer mortality and unintentional injuries are much higher that the state's rates, indicating a need to focus on prevention activities in these areas. Chronic lower respiratory diseases (such as COPD and asthma) death rate is much lower in this region compared to the state and other regions. The homicide death rate is higher in this region than statewide.

15 Leading Causes of Death in Northwest New Mexico	Deaths per 100,000 Population, Age-adjusted	Number of Deaths
Heart disease	150.3	371
Cancer	135.1	344
Unintentional injuries	122.6	259
Chronic liver disease, cirrhosis	74.4	163
Diabetes	43.7	111
Stroke	37	89
Influenza and pneumonia	26.6	61
Suicide	25.7	55
Chronic lower respiratory diseases	22.9	61
Coronavirus disease 2019 (COVID-19)	22.3	51
Homicide	16.3	34
Septicemia	12.9	31
Kidney disease	12.6	31
Alzheimer's disease	10.6	24
Nutritional deficiencies*	4.2	10

*Data unreliable due to low numbers

Poor or Fair General Health

The Behavioral Risk Factor Surveillance System (BRFSS) assesses a multitude of physical, mental, and social health issues and statuses among populations. A calculated variable assesses overall health among adults, creating two main categories: good or better health and fair or poor health based on individual responses to the question asking how they think their general health is. To assess self-perceived health status, we began by examining the prevalence of individuals reporting fair or poor health, before exploring the specific health factors that may influence overall self-reported and perceived health.

Data for this section are from 2022. County-level averages were weighted using 2022 population estimates from the University of New Mexico Geospatial and Population Studies program, abstracted from NMIBIS. These estimates were selected for their methodological rigor and alignment with the BRFSS 2022 survey year, ensuring temporal consistency and improved accuracy in regional aggregation.

Northeast

This region of New Mexico has the lowest overall prevalence of fair or poor health, with about 18% of the population reporting having fair or poor health. This is largely driven by Losa Alamos and Santa Fe counties, whose prevalence of fair and poor health are 8.8% and 15.8%, respectively. Guadalupe and Rio Arriba have similar prevalences of fair or poor health and are the highest in this region, each with about a quarter of the population reporting fair or poor health.

County	% Fair or Poor Health
Colfax	20.0%
Guadalupe	25.4%
Harding	21.9%
Los Alamos	8.8%
Mora	23.1%
Rio Arriba	25.2%
San Miguel	21.5%
Santa Fe	15.8%
Taos	18.9%
Union	24.8%
Northeast	18.0%

Northwest

The Northwest Region of New Mexico has the highest regional prevalence of fair or poor health, with over a quarter of the population reporting having fair or poor health (27.3%). McKinley County sees almost a third of the population reporting fair or poor health while San Juan County has the lowest prevalence (though still high compared to other counties and the state's prevalence) of 24.9%.

County	% Fair or Poor Health
Cibola	26.4%
McKinley	31.6%
San Juan	24.9%
Northwest	27.3%

Poor Physical and Mental Health Days

By understanding the number of poor mental and physical health days people have, we can begin to estimate levels of physical and mental health in communities. Because these two metrics work congruently to shape overall health, improving mental and physical health by reducing the number of poor mental and physical health days should be a priority.

The BRFSS quantifies the average number of poor physical and mental health days with the past 30 days as a referent point. There is understandably some variability in this 30-day period in the year because the BRFSS is administered continuously throughout the year[5] so these metrics are understood to be an estimate of current prevalence.

Because of the nature of the BRFSS, we can't say for sure there is overlap in these days or that that poor physical health days cause poor mental health days. As a cross-sectional study design, we can't establish temporality and additional analyses on these data are needed to understand if there is a correlation between the two. New Mexicans have a marginally higher average number of poor mental health days (5.0 days) than they do physically unhealthy days (4.2 days).

Data for this section are from 2022. County-level averages were weighted using 2022 population estimates from the University of New Mexico Geospatial and Population Studies program, abstracted from NMIBIS. These estimates were

[5] BRFSS Frequently Asked Questions. Centers for Disease Control and Prevention. 2025. Retrieved from *https://www.cdc.gov/brfss/about/brfss_faq.htm* on 9/2/2025

selected for their methodological rigor and alignment with the BRFSS 2022 survey year, ensuring temporal consistency and improved accuracy in regional aggregation.

Northeast

People in Northeastern New Mexico typically have more mentally unhealthy days than physically unhealthy days, by about a day, with 5.5 average mentally unhealthy days and 4.4 average physically unhealthy days. From county to county, the number of physically unhealthy and mentally unhealthy days are very similar with the exception of Los Alamos County, which sees the lowest average physically unhealthy days in the state, with people reporting an average of only 2.9 days. The difference between physically unhealthy days and mentally unhealthy days in Los Alamos County is important to identify because most counties have differences of less than a day to just over a day whereas the difference between physically unhealthy days and mentally unhealthy days in Los Alamos County is nearly 2 days (1.7 days).

County	Average Number of Physically Unhealthy Days	Average Number of Mentally Unhealthy Days
Colfax	4.6	5.6
Guadalupe	5.0	5.5
Harding	4.7	5.6
Los Alamos	2.9	4.6
Mora	4.8	5.5
Rio Arriba	5.0	5.9
San Miguel	5.2	5.8
Santa Fe	4.2	5.5
Taos	4.5	5.7
Union	4.9	5.6
Northeast	4.4	5.5

Northwest

The Northwest Region has the highest average number of mentally unhealthy days across counties in the state, with an average of 6.6 average mentally unhealthy days among counties. This region also has the highest average physically unhealthy average days, at 5.7 days. McKinley County has the highest average number of mentally and physically unhealthy days in this region.

County	Average Number of Physically Unhealthy Days	Average Number of Mentally Unhealthy Days
Cibola	5.5	6.5
McKinley	6.3	7.1
San Juan	5.4	6.3
Northwest	5.7	6.6

Perinatal and Infant Health

Understanding parental and infant health is key to improving long-term health outcomes and in the pursuit of equity in the perinatal space. Here, we reviewed data from the following sources to understand the landscape of this topic: infant mortality (NM Bureau of Vital Records and Health Statistics), prevalence of pre-existing gestational diabetes, adequacy of prenatal care utilization, percent of pregnant people with prenatal care covered by Medicaid, prevalence of postpartum depression, percent of people who received prenatal home visits, and percent of people who received postpartum home visits (from PRAMS – Pregnancy Risk Assessment Monitoring System, 2020-2022).

Mortality data cover a period of 2019-2023 to provide as many statistically stable values as possible. Even so, many counties do not have statistically stable values or even enough deaths/births to be displayed in a way that maintains confidentiality.

Adequacy of prenatal care (tables below) is derived from the Adequacy of Prenatal Care Utilization (APNCU) Index, which comprises two main aspects: when prenatal care began and the number of prenatal visits.

Adequacy of initiation is categorized into the following groups:

- Pregnancy months 1 and 2
- Pregnancy months 3 and 4
- Pregnancy months 5 and 6
- Pregnancy months 7 to 9

Adequacy of received services is calculated by counting the number of prenatal visits and comparing those to the expected number of visits for the time period between when care began and the delivery date. The categories are as follows:

- Inadequate (received less than 50% of expected visits)
- Intermediate (50%-79%)
- Adequate (80%-109%)
- Adequate Plus (110% or more)

Northeast

The infant mortality rate for this region as a whole is 4.4 deaths per 1,000 live births. Data are suppressed for several counties who have extremely low numbers for infant mortality, and indeed, all counties but Santa Fe and Rio Arriba have mortality rates that are statistically unstable, so it is important to use caution when interpreting these data. Colfax County's high mortality rate is a reflection of the proportion of deaths and low population. For this region, Rio Arriba has the highest infant mortality rate

Infant's County of Residence	Deaths per 1,000 Live Births
Colfax*	12.8
Guadalupe	**
Harding*	0
Los Alamos	**
Mora	**
Rio Arriba	6.4
San Miguel*	5.4
Santa Fe	3
Taos*	5
Union*	0

**Data suppressed due to low numbers

*Statistically unstable values

Most people in the Northeast did not have pre-existing gestational diabetes while 13.6% did. Nearly one in four people had inadequate prenatal care utilization, which is the second highest in the state. Over half of people in this region used Medicaid for prenatal care and about 12% had prenatal home visits. About 15% of people had postpartum home visits and about 10% had postpartum depression.

Metric	Value	Percent
Pre-Existing Gestational Diabetes	No	86.4
	Yes	13.6
Adequacy of Prenatal Care	Inadequate	24.0
	Intermediate	13.0
	Adequate	33.5
	Adequate plus	29.6
Medicaid Payor for Prenatal Care	No	43.7
	Yes	56.3
Postpartum Depression	No	89.5
	Yes	10.5
Prenatal Home Visit	No	87.9
	Yes	12.1
Postpartum Home Visit	No	84.7
	Yes	15.3

Northwest

The infant mortality rate for this region is 5.5 deaths per 1,000 population. Data for Cibola County are statistically unstable, but appear lower than the other counties in this region.

Infant's County of Residence	Deaths per 1,000 Live Births
Cibola*	4.5
McKinley	5.6
San Juan	5.6

*Statistically unstable values

From 2020-2022, nearly two-thirds of pregnant people surveyed did not have pre-existing gestational diabetes. About the same proportion of people said they had inadequate and adequate prenatal care utilization. Medicaid was the payor identified for almost four-fifths of the population of the Northwest Region for prenatal care and most people in the region did not have postpartum depression and did not receive home visits for prenatal or postpartum care. All of this points to the opportunities to improve access to prenatal and postpartum care. A quarter of the population had pre-existing gestational diabetes and about 16% had postpartum depression, which, in combination with the low utilization of home visiting and the proportion of prenatal care that is inadequate or intermediate, these data show there are opportunities for health improvement for the perinatal population in this region.

Metric	Value	Percent
Pre-Existing Gestational Diabetes	No	74.2
	Yes	25.8
Adequacy of Prenatal Care	Inadequate	30.6
	Intermediate	17.3

Metric	Value	Percent
	Adequate	30.9
	Adequate plus	21.2
Medicaid Payor for Prenatal Care	No	22.8
	Yes	77.2
Postpartum Depression	No	83.6
	Yes	16.4
Prenatal Home Visit	No	91.0
	Yes	9.0
Postpartum Home Visit	No	87.9
	Yes	12.1

Behavioral and Mental Health

The broad area of behavioral and mental health covers multiple facets including substance use and general mental health status. In this section, we examine suicide death rates (per 100,000 population), prevalence of poor mental health days, youth mental health (feelings of sadness and hopelessness), substance use prevalence including smoking, excessive alcohol use, and alcohol impaired driving. Sources of data for this section include mortality data from the NM Bureau of Vital Records and Health Statistics, the Behavior Risk Factor Surveillance System, and the Youth Risk & Resiliency Survey.

Behavioral Health and Substance Use Social Needs

Every six months, all patients at Presbyterian facilities are screened for health-related social needs including drug use treatment/dependency issues and mental health needs. By understanding patient needs, we can identify areas of support for patients and members to connect to resources to meet these needs.

Within the Northern region, among behavioral health needs, mental health and tobacco needs have the highest prevalence, with 10% of people identifying a mental health need at PEH, 9.2% identifying a mental health need at SFMC. Tobacco needs are elevated compared to other hospitals – at SFMC, 14.1% of people identified as having a tobacco need while 7.3% of people at PEH identified as having the same need. Alcohol needs are also higher in this region compared to other regions.

Counts of Northern New Mexico patients screened for behavioral health in 2024

	Presbyterian Española Hospital		Santa Fe Medical Center	
SDOH: BEHAVIORAL HEALTH	**n**	**(%)**	**n**	**(%)**
Alcohol Need				
Screenings Completed	33,835*		18,720*	
Unique Patients Screened	27,904		16,071	
Unique Patients Reporting Any Need	1,071	3.8%**	803	5.00%
Tobacco Need				
Screenings Completed	29,976		17,706	
Unique Patients Screened	24,797		15,259	
Unique Patients Reporting Any Need	1,818	7.30%	2,150	14.10%
Opioid Need				
Screenings Completed	34,500		19,483	
Unique Patients Screened	28,547		16,785	
Unique Patients Reporting Any Need	207	0.70%	552	3.30%

Mental Health Need				
Screenings Completed	30,622		14,208	
Unique Patients Screened	25,501		11,767	
Unique Patients Reporting Any Need	2,537	10.00%	1,088	9.20%

(*) A maximum of one screening per six months per patients was recorded; only the first screening was counted if a patient received more than one screening per SDOH need within a six-month period
(**) Denominator of percentage is "Unique Patients Screened"

Suicide Deaths

Deaths due to suicide re noted on death certificates, and these data are collected by the Bureau of Vital Records and Health Statistics within the NM Department of Health Epidemiology and Response Division. These data are age-adjusted.

Northeast

Colfax County has the highest statistically stable suicide mortality rate in the region, with 32.1 deaths per 100,000 population and Los Alamos County has the lowest statistically stable rate in the region and state, at 12.9 deaths per 100,000 population. We are unable to draw meaningful conclusions about Guadalupe, Harding, Mora, or Union counties due to statistical instability.

Decedent's County of Residence	Deaths per 100,000 Population, Age-adjusted
Colfax	32.1
Guadalupe	19.8*
Harding	0.0*
Los Alamos	12.9
Mora	33.9*
Rio Arriba	23.9
San Miguel	23.9
Santa Fe	22.6
Taos	28.6
Union	16.0**

***** This rate is statistically unstable (RSE >0.30) and may fluctuate widely across time periods due to random variation (chance). Please use caution in interpreting this value.

****** The estimate has a relative standard error greater than 50% and does not meet standards for reliability. A count or rate such as this should not be used to inform decisions. (Source: NMDOH IBIS *https://ibis.doh.nm.gov/query/result/mort/MortCnty/AgeRate.html*)

Northwest

This region has the overall highest mortality rate, and that is likely due to the fact it has the fewest counties that all have high mortality rates. Cibola County has the highest, with 34.4 deaths per 100,000 population.

Decedent's County of Residence	Deaths per 100,000 Population, Age-adjusted
Cibola	34.4
McKinley	29.1
San Juan	33.2

Poor Mental Health Prevalence

As identified in a previous section, the BRFSS measures the number of poor mental health days among populations as part of their annual survey. This measure asks respondents to indicate how many days within the prior thirty-day period their mental health was "not good," focusing on stress, emotions, and depression. While the above metric describes the average number of poor mental health days, the following analysis describes the prevalence of poor mental health – that is, the percent of the population who have 14 or more poor mental health days in the 30-day period the question on the survey references. This measure is an indicator of the overall prevalence of mental wellbeing in our communities.

This is an average measure of self-reported mental health status and not an indication of any type of diagnosed mental condition.

This measure comes from 2021-2023 BRFSS 3-year estimates to provide statistically stable data for most counties.

Northeast

Colfax and San Miguel counties have the highest prevalences of poor mental health in this region while Los Alamos County has the lowest, with a little less than one fifth of the population experiencing poor mental health.

County of Residence	Percentage
Colfax	36.7%
Guadalupe	**
Harding	**
Los Alamos	19.1%
Mora	**
Rio Arriba	26.6%
San Miguel	33.8%
Santa Fe	25.9%
Taos	26.0%
Union	**

**These data are suppressed due to low numbers

Northwest

McKinley County has the lowest prevalence of poor mental health in this region, with about a fifth of the population experiencing poor mental health. Cibola County has the highest prevalence, with about a fourth of the population experiencing poor mental health.

County of Residence	Percentage
Cibola	26.6%
McKinley	19.6%
San Juan	22.2%

Youth Mental Health

The Youth Risk Resiliency Survey (YRSS) is a statewide survey administered in schools across the state. This survey collects a variety of risk and resiliency factors associated with youth health, including mental health. To describe youth mental health, we look at several key factors: persistent feelings of sadness or hopelessness, frequent mental distress (which includes stress, anxiety, and depression), having symptoms of depressive disorder, and the presence of symptoms of anxiety disorder.

Because the YRRS is conducted in schools, the survey does not capture youth who are not in school or who are homeschooled. Additionally, not every school in every community participates, which means that there may be higher

risk or lower risk students included/excluded from the results if the school or district decided not to participate. While the results of the survey are weighted by enrollment data to represent all students enrolled in public schools, there may be significant differences in these metrics between schools. For more information on the YRRS, please visit *https://youthrisk.org/*.

Northeast

Data for Harding County are suppressed due to low numbers. In this region, Union County has the highest prevalence of persisting sadness and hopelessness among high school students with a prevalence of 42%, about 4 percentage points higher than the state's prevalence while Mora County has the lowest prevalence both in the region and in the state. All counties except for Union County have a prevalence lower than the state's. In fact, this region has the lowest prevalence of all regions, indicating a smaller proportion of the population experiences persistent sadness and hopelessness compared to other regions. That being said, Union County has the highest prevalence of all youth mental health indicators in this region, indicating a need to address youth mental health in this county.

Region	Persistent feelings of sadness and hopelessness	Frequent mental distress	Symptoms of depressive disorder	Symptoms of anxiety disorder
	Percent (%)	Percent (%)	Percent (%)	Percent (%)
Colfax	34.0	17.4	19.4	22.9
Guadalupe	34.8	21.8	23.3	26.6
Harding	*	*	*	*
Los Alamos	32.3	26.3	19.6	30.5
Mora	20.0	13.5	18.1	14.4
Rio Arriba	35.1	22.3	23.3	22.3
San Miguel	27.9	18.4	16.9	21.7
Santa Fe	30.0	18.8	21.2	25.6
Taos	33.2	26.1	21.3	27.5
Union	42.0	29.8	33.4	38.8

Northwest

Cibola and McKinley counties both have prevalences of persisting feelings of sadness and hopelessness among high school students that are higher than the state's prevalence, at 37.1% and 39.3%, respectively. Frequent mental distress and symptoms of depressive and anxiety disorders are more prevalent in San Juan County, indicating the need to address youth mental health in this region.

Region	Persistent feelings of sadness and hopelessness	Frequent mental distress	Symptoms of depressive disorder	Symptoms of anxiety disorder
	Percent (%)	Percent (%)	Percent (%)	Percent (%)
Cibola	37.1	25.1	24.4	29.5
McKinley	39.3	23.8	24.2	24.6
San Juan	36.4	26.2	24.4	31.4

Substance Use

Smoking and Vape Use – Adults and Youth

Smoking is a significant risk factor for many health issues, most notably respiratory diseases, cardiovascular disease, and cancer. Smoking exposure comes in several forms, including firsthand exposure (active smoking), secondhand exposure (inhaling the smoke from the burning end of a cigarette or exhaled smoke), and thirdhand exposure (being exposed to the residue smoking leaves in clothes and other fabrics). Firsthand exposure (active smoking) is considered the leading cause of respiratory diseases and cancer among the exposure types. To assess these risks, we included data from the BRFSS (2022) that assesses the prevalence of active smoking (age-adjusted).

It is important to note that there has been a shift in tobacco use trends, leaning more toward vaping and the use of e-cigarettes and other vape products compared to tobacco. This analysis did not include vaping due to lack of reliable data for adults. This section does, however, include youth vaping as well as youth cigarette smoking. The youth data were abstracted from the 2023 Youth Risk and Resiliency Survey (YRRS).

Northeast

In Northeast New Mexico, Harding County has the lowest prevalence of current smoking, with 7.8% of the population reporting current smoking status. San Miguel County has the highest prevalence of 20.7% of the population reporting current smoking. Half of the region has smoking rates that are lower than the state's prevalence of 15.5%. High school youth vape usage is more prevalent than cigarette usage, which is consistent with statewide trends. In this region, Union County has the highest prevalence of vape usage among high school youth while Los Alamos County has the lowest. Cigarette smoking is highest in Mora and Taos counties. Overall, the region has a slightly higher prevalence of cigarette smoking among high school youth compared to the state's prevalence, but the region has a lower prevalence of vape use compared to the state.

County	Prevalence of Current Smoking - Adult (%)	Prevalence of Cigarette Smoking - Youth (%)	Prevalence of youth electronic vapor product use (%)
Colfax	17.5	4.6	18.2
Guadalupe	17.8	4.2	21.1
Harding	7.8	*	*
Los Alamos	14.3	2.3	12.6
Mora	13.6	8.5	19.3
Rio Arriba	11.4	4.6	21.1
San Miguel	20.7	3	19
Santa Fe	15.9	3.2	14.5
Taos	17.5	7.7	25.8
Union	17.8	7	35.9
Northeast Region	NA	3.8	17.1

*Data suppressed due to low numbers

Northwest

McKinley County has the highest prevalence of smoking in the state and the region, with almost a third of the population reporting current smoking. All counties in this region have current smoking prevalences that are higher than the state's prevalence of 15.5%. Cigarette smoking is less common among high school youth in this region than vape use, which is consistent with the rest of the state. However, this region and the counties within all have cigarette use prevalence for youth that is higher than the state's prevalence. Overall, the region also has higher vape use prevalence than the state overall. San Juan County has a rate that is similar to the state's.

County	Prevalence of Current Smoking - Adult (%)	Prevalence of Cigarette Smoking - Youth (%)	Prevalence of youth electronic vapor product use (%)
Cibola	23.2	6	22.1
McKinley	31.1	4.8	22.9
San Juan	24.9	3.5	18.5
Northwest Region	NA	4.1	20.3

Alcohol Use – Adult and Youth

Excessive drinking is defined as engaging in binge drinking[6] or heavy drinking[7] behaviors. These data are age-adjusted and come from the Behavioral Risk Factor Surveillance System, a nationally representative telephonic cross-sectional survey. Data in this analysis are from 2022. Youth data for this section come from the YRRS – 2023.

Northeast

Taos and Los Alamos counties have the highest prevalences of excessive drinking in this region, with 20.5% of residents in Taos County reporting excessive drinking and 20.4% of people in Los Alamos County reporting the same. These prevalences are the highest in the state. Otherwise, most counties have a prevalence of excessive drinking lower than the state's. Alcohol use among high school youth is most prevalent in Union County, with 34.1% of youth reporting using alcohol. Taos County has the second highest prevalence, at 22.2%. Union County also has the highest prevalence of binge drinking, with nearly 14% of high school youth reporting binge drinking. Santa Fe County has the lowest prevalence of binge drinking int his region, with only about 4% of high school youth reporting binge drinking.

County	Prevalence of Excessive Drinking (Binge and Heavy Drinking) – Adults (%)	Prevalence of Alcohol Use – High School Youth (%)	Prevalence of Binge Drinking – High School Youth (%)
Colfax	17.3	19.1	8.9
Guadalupe	16.8	15.5	8.4
Harding	17.7	*	*
Los Alamos	20.4	18.3	6.1
Mora	16.6	12.9	5.6
Rio Arriba	16.7	15.8	6
San Miguel	16.2	13.5	7.1
Santa Fe	17.1	12.5	3.9
Taos	20.5	22.2	12
Union	17.8	34.1	13.9
Northeast Region	NA	15.2	5.8

*Data suppressed due to low numbers

Northwest

All counties in the Northwest region have excessive drinking prevalence rates that are lower than the state's overall. Cibola has the highest, at 16.2% of the population reporting excessive drinking. Cibola County has the highest

[6] On one occasion: 4 or more drinks for women or 5 or more drinks for men
[7] In one week, 8 or more drinks for women or 15 or more drinks for men
Source for footnotes 7 and 8: *https://www.cdc.gov/drink-less-be-your-best/facts-about-excessive-drinking/index.html*

prevalence of alcohol use in this region, though McKinley and San Juan counties have similar rates. Binge drinking is also highest in Cibola County, but again, similar rates are seen across this region.

County	Prevalence of Excessive Drinking (Binge and Heavy Drinking) – Adults (%)	Prevalence of Alcohol Use – High School Youth (%)	Prevalence of Binge Drinking – High School Youth (%)
Cibola	16.2	12.3	6.4
McKinley	15.1	12	6.3
San Juan	15.6	11.7	5
Northwest Region	NA	11.9	5.5

Alcohol-Impaired Driving Deaths

Alcohol-impaired driving deaths are deaths related to driving that involved alcohol impairment. These data come from the Fatality Analysis Reporting System for 2018-2022 and can be useful in public health planning to understand how communities are impacted by this type of death and subsequently plan public health action around reduction of driving while impaired.

It is important to note that there are many small numbers in this section. As such, care must be taken when interpreting the percentages associated with those small numbers. Small numbers in one or both categories often skew the percentage into seeming more severe, which is why both prevalence (percentage) and count data are provided.

Northeast

Nearly all counties in Northern New Mexico have prevalences of alcohol-involved driving deaths that are higher than the state prevalence of 28.8% of driving deaths. Again, considerations for small numbers must be taken into account, but we do see that Union and Tao counties have the highest prevalence of driving deaths with alcohol involvement while Guadalupe has the lowest. Though driving deaths are low in Los Alamos and Union counties, the proportion of those involving alcohol reflects as high because of the high number of deaths involving alcohol relative to the number of driving deaths (which are both low), which is why we interpret these data with caution.

County	# Alcohol-Impaired Driving Deaths	# Driving Deaths	% Driving Deaths with Alcohol Involvement
Colfax	8	21	38.1
Guadalupe	4	41	9.8
Harding	*	*	*
Los Alamos	2	6	33.3
Mora	7	21	33.3
Rio Arriba	23	60	38.3
San Miguel	9	27	33.3
Santa Fe	32	115	27.8
Taos	27	50	54.0
Union	4	8	50.0

*Data not available

Northwest

San Juan has the highest proportion of driving deaths attributable to alcohol in this region with 43.2% of driving deaths involving alcohol. Cibola has the lowest prevalence with 29.1% of driving deaths involving alcohol.

County	# Alcohol-Impaired Driving Deaths	# Driving Deaths	% Driving Deaths with Alcohol Involvement
Cibola	23	79	29.1
McKinley	43	155	27.7
San Juan	63	146	43.2

Drug Overdose Mortality

Drug overdose deaths have historically been incredibly high in New Mexico, among the highest in the nation. Statewide, though, drug overdose deaths have decreased, likely in part due to the collective approaches throughout the state to increase access to treatment resources, promote harm reduction, and increase access to naloxone.

Drug overdose death data come from the NM Bureau of Vital Records and Health Statistics and are presented as a number of deaths per 100,000 population.

Northeast

The drug overdose death rate is highest in Rio Arriba County, with 141.6 deaths per 100,000 population. This is by far the highest drug overdose death rate in the state.

	2019	2020	2021	2022	2023
Colfax	11.1	38.1	54.6	78.5	41.7
Guadalupe	40.6	0	57.6	72.3	30.7
Harding	0	0	0	0	0
Los Alamos	22.4	11.8	8.4	18.3	38.2
Mora	0	67	75.7	0	70.6
Rio Arriba	65.1	100.5	131.1	141.4	141.6
San Miguel	30.1	59.4	83.4	97.7	93.8
Santa Fe	40.7	42.8	58	50.4	58.7
Taos	15.8	39.9	63.7	60.5	63.8
Union	0	33.4	27.4	17.1	30.7

Northwest

Drug overdose death rates are currently highest in Cibola County in this region, with McKinley and San Juan counties having slightly lower death rates, both of which are similar to one another.

	2019	2020	2021	2022	2023
Cibola	20.1	16.6	40.3	44.7	49.5
McKinley	21.6	20.7	33.7	40.3	43.9
San Juan	27.5	32.5	35.4	40.6	42.2

Alcohol Mortality

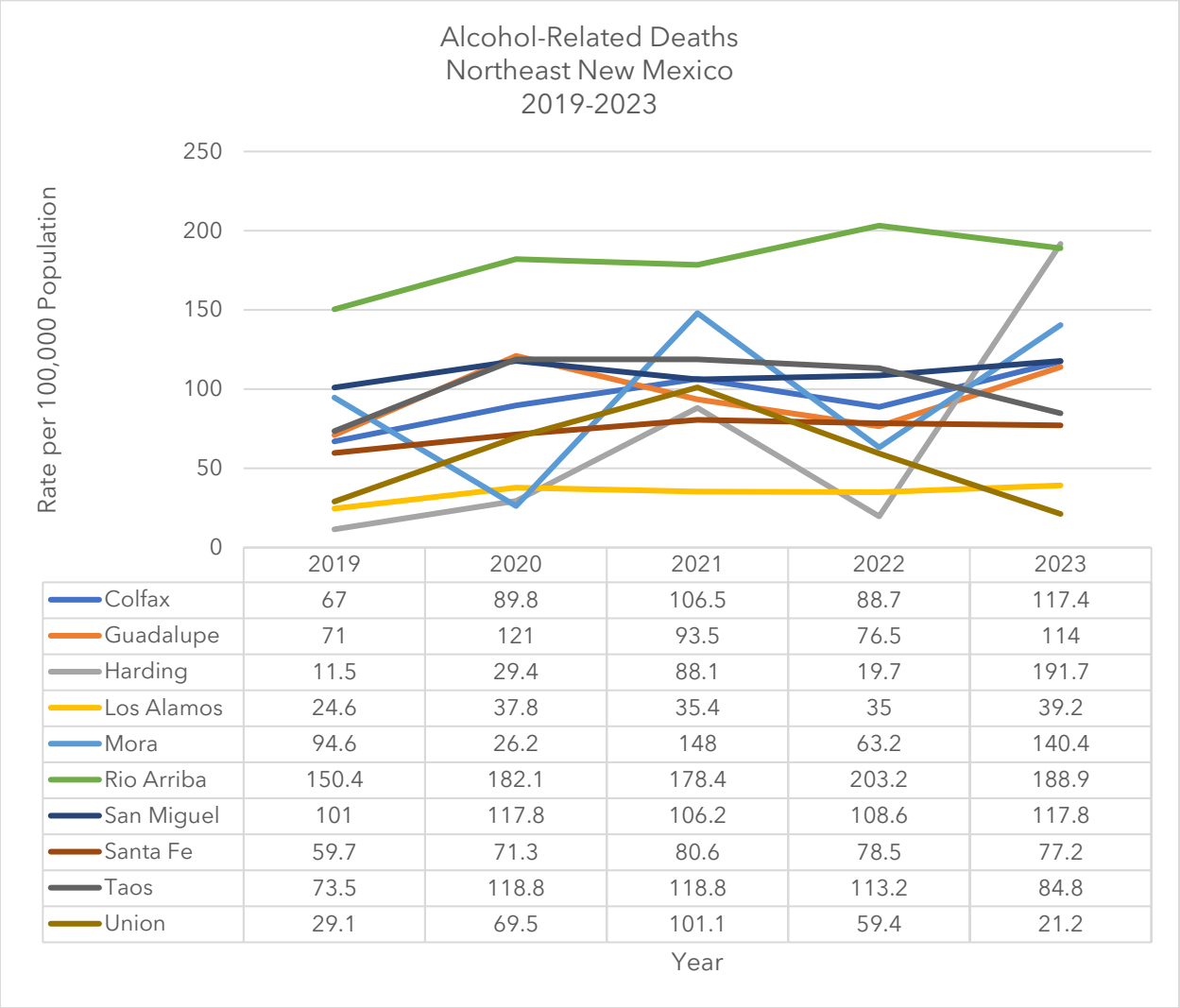
Alcohol mortality is characterized in this report as deaths that are either partially attributable to alcohol and those 100% attributable to alcohol. This includes chronic and acute causes of mortality. Chronic causes (100% attributable) include alcohol abuse, alcohol dependence syndrome, alcoholic liver disease, alcohol-induced acute pancreatitis, and

chronic conditions that are partially attributable to alcohol include cancer, heart disease, and liver disease. Acute causes include alcohol poisoning, motor vehicle traffic crashes, suicide, drowning, falls, fire, and homicide.[8]

In 2023, the statewide alcohol-related death rate was 84.5 deaths per 100,000 population.

Northeast

Rio Arriba has consistently had the highest alcohol-related mortality rate from 2019 to 2023. Harding County's mortality rate spiked in 2023 to be just higher than Rio Arriba, but it is important to note that in counties with small populations, a small increase in the number of alcohol-related deaths will reflect a large increase in the death rate.



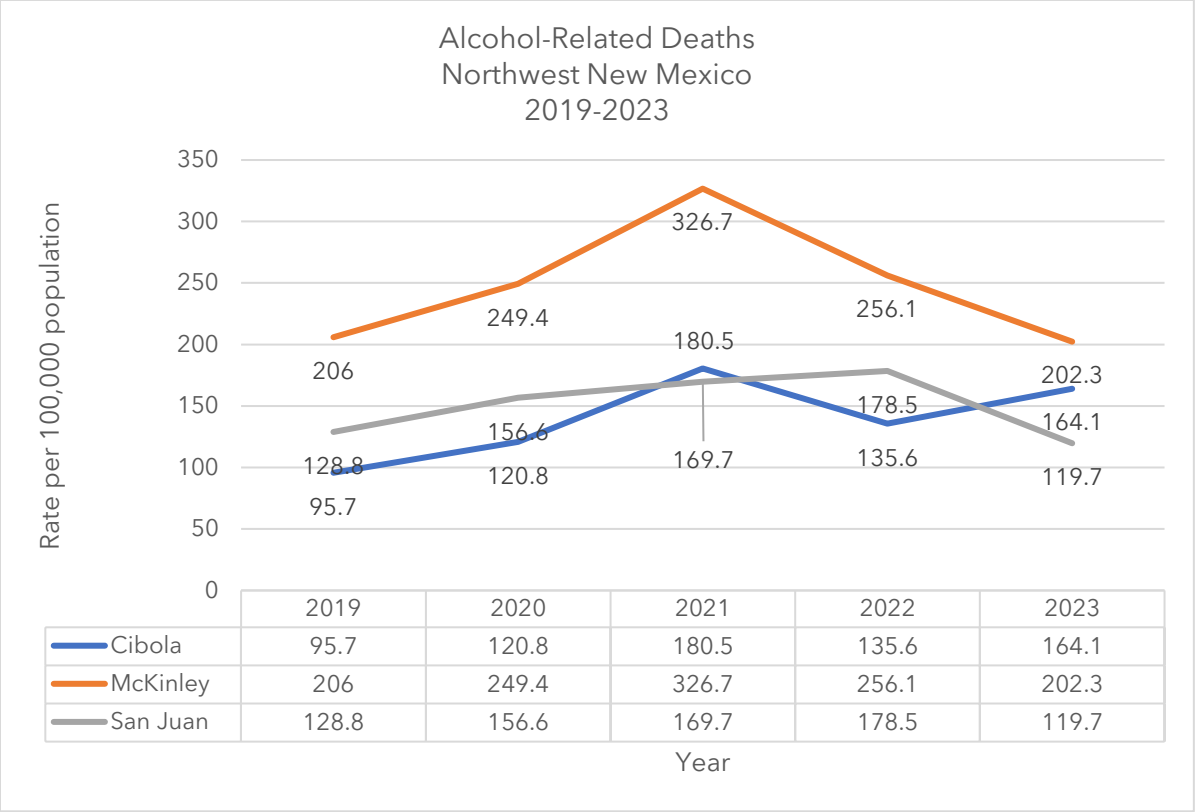
	2019	2020	2021	2022	2023
Colfax	67	89.8	106.5	88.7	117.4
Guadalupe	71	121	93.5	76.5	114
Harding	11.5	29.4	88.1	19.7	191.7
Los Alamos	24.6	37.8	35.4	35	39.2
Mora	94.6	26.2	148	63.2	140.4
Rio Arriba	150.4	182.1	178.4	203.2	188.9
San Miguel	101	117.8	106.2	108.6	117.8
Santa Fe	59.7	71.3	80.6	78.5	77.2
Taos	73.5	118.8	118.8	113.2	84.8
Union	29.1	69.5	101.1	59.4	21.2

Northwest

Consistent with other counties across the state, alcohol-related deaths increased in 2021 before decreasing again by 2023. The spike in alcohol-related deaths in 2021 was most drastic in McKinley County, which has historically seen higher alcohol-related death rates compared to the rest of the state. For additional context, in 2021, McKinley County's

[8] Alcohol-Related Disease Impact (ARDI). 2025. Retrieved rom *https://nccd.cdc.gov/DPH_ARDI/Default/Report.aspx?T=AAM&P=AE26596E-BE6F-4574-9FB8-C862072496E7&R=850C75E3-02E5-41CE-BEC9-9C5C660E4720&M=692189EB-7702-473F-A8CA-2CC7EDDCA138&F=&D=*

alcohol-related death rate was 327.7 deaths per 100,000 population and the next highest death rate statewide that year, Cibola County, had a death rate of 180.5 deaths per 100,000 population. Three of the four highest death rates that year were the three Northwestern counties. In 2023, McKinely County had the highest alcohol-related death rate statewide.



	2019	2020	2021	2022	2023
Cibola	95.7	120.8	180.5	135.6	164.1
McKinley	206	249.4	326.7	256.1	202.3
San Juan	128.8	156.6	169.7	178.5	119.7

Social Drivers of Health and Health-Related Social Needs

Social drivers of health (SDoH) are non-medical factors that affect health outcomes and risks and are characterized by the conditions and environments in which people exist across the lifespan.[9] Health-related social needs (HRSNs), including transportation, food security, housing stability, utility needs, and more, refer to the individual-level social and economic conditions of this category that directly impact a person's ability to maintain their health and wellbeing. Unmet health HRSNs can lead to delayed or avoided medical care, so-called 'non-compliance' with medication or other treatments and poor management of chronic conditions, increased emergency department visits and hospitalizations, and worse overall health outcomes. These factors are often considered root cause factors of health at the individual and population level, and interventions directed in this area should span the socioecological model.

Health-Related Social Needs

Presbyterian facilities screen patients for health-related social need (HRSN) every six months. Within the Northern region, food needs were the most commonly identified among patients at Presbyterian Española Hospital and Santa Fe Medical Center with 3.1% and 3.6% screening positive for food needs, respectively. Transportation needs were the second most commonly identified at both facilities, followed by housing, then safety.

[9] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://odphp.health.gov/healthypeople/objectives-and-data/social-determinants-health

Counts of Northern New Mexico patients screened for social needs in 2024

	Presbyterian Española Hospital		Santa Fe Medical Center	
SDOH: SOCIAL NEEDS	**n**	**(%)**	**n**	**(%)**
Food Need				
Screenings Completed	38,007*		17,883*	
Unique Patients Screened	31,626		15,245	
Unique Patients Reporting Any Need	981	3.1%**	645	3.60%
Housing Need				
Screenings Completed	38,007		18,356	
Unique Patients Screened	32,189		15,635	
Unique Patients Reporting Any Need	371	1.20%	231	1.50%
Transportation Need				
Screenings Completed	38,429		18,274	
Unique Patients Screened	32,004		15,578	
Unique Patients Reporting Any Need	578	1.80%	460	2.50%
Safety Need				
Screenings Completed	44,232		26,942	
Unique Patients Screened	36,518		22,294	
Unique Patients Reporting Any Need	185	0.10%	147	0.70%

(*) A maximum of one screening per six months per patients was recorded; only the first screening was counted if a patient received more than one screening per SDOH need within a six-month period

(**) Denominator of percentage is "Unique Patients Screened"

Food Environment and Food Insecurity

Food environment index is a measurement created by combining data from the United States Department of Agriculture's (USDA) Food Environment Atlas[10] and Feeding America's Map the Meal Gap project to describe food-related risk in a geography by analyzing factors that contribute to a healthy food environment, including outlets for fresh, healthy food, density of fast food, and distance to grocery stores. This is a 0 to 10 scale with 0 being the worst food environment and 10 being the best. People who have limited access to healthy foods are those who are low-income and do not live close to a grocery store. Food insecurity is defined as lacking adequate access to food, which is often characterized by lack of affordability of food and an individual's income affecting their ability to access food. In this section, food insecurity is identified using the same validated tool (Hunger Vital Signs) as is implemented in Presbyterian facilities but identified through separate means. Therefore, there is likely overlap in identifying people with food insecurity between the two metrics. The important distinction here is understanding food insecurity at the population level (across everyone in the community) versus the prevalence of food insecurity only among patients of Presbyterian facilities (above).

It is important to acknowledge that while a county may have overall high access to healthy foods, it does not mean that access is equitable. Food deserts still exist in each county and access to healthy foods is both a social and an environmental issue that should be addressed. More information is needed when undergoing public health initiative planning to understand the populations and geographies most affected by lack of access to healthy food and food insecurity.

[10] Economic Research Service (ERS), U.S. Department of Agriculture (USDA). Food Environment Atlas. https://www.ers.usda.gov/data-products/food-environment-atlas/

Northeast

Los Alamos County has the highest food environment index in the state with a value of 9.3 while Mora County has the lowest, with a value of 1. Food insecurity is lowest in Los Alamos County, which is not surprising given the demographics, landscape, and small nature of the county including its food environment index. Only 5% of Los Alamos County's population has limited access to healthy foods, which is the lowest in the state.

Mora County, having the lowest food environment index, also has the highest prevalence of food insecurity and the highest percent of the population with limited access to healthy foods. Mora County leads the state in these metrics, indicating a significant need to address access to healthy food in the county.

County	% Limited Access to Healthy Foods	% Food Insecure	Food Environment Index
Colfax	14.6	16.2	6.4
Guadalupe	14.4	16.7	6.3
Harding	48.1	14.7	3.3
Los Alamos	5.0	7.5	9.3
Mora	60.0	19.6	1.0
Rio Arriba	*	16.1	8.0
San Miguel	22.7	18.3	5.1
Santa Fe	9.3	12.2	7.9
Taos	13.8	14.4	6.9
Union	11.0	16.1	6.8

*Rio Arriba's prevalence of limited access to healthy foods should be excluded from interpretation because there was a data issue that led to the inability to calculate the access metric.

Northwest

McKinley County has among the highest food insecurity rates in the country and very limited access to healthy food, therefore it is no surprise that the food environment index is a mid-to-low value of 3.4. Within this region, San Juan has the best food environment and lowest percent of people with limited access to healthy food as well as the lowest food insecurity rate (though the county's rate and this region's rates as a whole are higher than the state's rate of 15.2%).

County	% Limited Access to Healthy Foods	% Food Insecure	Food Environment Index
Cibola	21.9	19.8	4.9
McKinley	34.1	20.9	3.4
San Juan	19.2	17.3	5.7

Housing and Homelessness

Two key metrics for understanding housing instability and risks of homelessness are severe housing cost burden and severe housing problems[11]. Households who experience severe housing cost burden are those that spend 50% or

[11] The U.S. Department of Housing and Urban Development (HUD). Comprehensive Housing Affordability Strategy. 2017-2021. Retrieved from County Health Rankings and Roadmaps 2024 Measures.

more of their income on housing while households with severe housing problems are those with any one of the following issues: overcrowding, high housing costs, lack of kitchen facilities, and/or lack of plumbing facilities. Overcrowding is defined as when "…there are more than 1, or sometimes 1.5, household members per room (PPR). Another frequently used measure is the number of individuals per bedroom, with a standard of no more than 2 persons per bedroom (PPB)"[12]. Overcrowding is also a contributing factor to the spread of infectious diseases, including respiratory diseases such as flu, COVID-19, RSV, other airborne infections like measles and tuberculosis, and skin infections. This is also true in homeless shelters, where buildings are often not designed for the purpose of housing a large number of people overnight in the spaces provided, often don't have adequate ventilation, and tend to be at or near capacity most of the time.

Northeast

In Northeast New Mexico, Los Alamos County has the lowest percent of households in the region and the state in both severe housing problems and severe housing cost burden while McKinley County has the highest severe housing problems in the state. San Miguel County has the highest severe housing cost burden in the region. McKinley County is also characterized as having the highest percent of households with overcrowding and inadequate facilities.

County	% Severe Housing Problems	Severe Housing Cost Burden	Overcrowding	Inadequate Facilities
Colfax	10.7	8.1	2.6	0.7
Guadalupe	10.0	7.0	2.5	0.9
Harding	10.0	9.2	4.0	2.0
Los Alamos	5.9	4.2	1.1	0.9
Mora	11.7	4.2	0.0	7.5
Rio Arriba	13.1	9.3	2.1	2.5
San Miguel	19.1	14.4	3.5	3.4
Santa Fe	17.9	14.9	3.1	0.6
Taos	15.3	12.7	2.1	1.4
Union	9.8	6.8	2.3	2.4

Northwest

McKinley County has the highest prevalence of people with severe housing problems in the Northwest Region and the state overall, with over a quarter of the population experiencing these problems. About 10 percent of people have inadequate facilities and 12% experience overcrowding. San Juan County has the highest percent of people with severe housing cost burden in this region, with almost 12% experiencing this burden.

County	% Severe Housing Problems	Severe Housing Cost Burden	Overcrowding	Inadequate Facilities
Cibola	19.5	7.9	8.8	4.5
McKinley	27.6	9.2	12.3	10.4
San Juan	19.6	11.8	6.6	3.1

[12] US Department of Housing and Urban Development. Measuring Overcrowding in Housing. Retrieved from *https://archives.huduser.gov/periodicals/researchworks/march_08/RW_vol5num3t4.html#:~:text=The%20amount%20of%20living%20space,space%20available%20to%20each%20inhabitant* on 3/6/25

Vehicle Availability and Getting to Work

Transportation is a vital driver of health and impacts everything from accessing health care to accessing services and resources within the community, including food, community engagement, and education.

The American Community Survey (ACS) includes questions about transportation, namely, how many vehicles are available at each household. These are grouped into several categories: 0 (no vehicles are available), one, two, three, four, and five or more vehicles available.

We analyzed these data in two main frames of reference: among workers (and their commute to work) and among tenancy – whether someone owns or rents their dwelling. Data in this section are 5-year estimates from 2019-2023.

Northeast

In this region, Union County has the highest percent of people with no vehicles available (4.1%), followed by San Miguel County, with 2.1% of people not having access to a vehicle. Regionally, on average, most people who work from home have three or more vehicles available to them. People who took public transportation to work in this region were more likely to not have a vehicle available compared to other methods of transportation to work.

Similar to other regions and the state overall, homeowners are more likely to have more vehicles available than people who rent. In this region, 9.4% of people who rent their homes do not have a vehicle while only 2.3% of owners do not have a vehicle. Similarly, 5.1% of homeowners have three ore more vehicles, while only 0.2% of renters have 3+ vehicles.

Colfax County, New Mexico					
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	2.0%	1.7%	7.3%	0.0%	0.0%
One	16.4%	17.4%	21.0%	100.0%	5.5%
Two	31.1%	28.7%	35.4%	0.0%	28.0%
Three or more	50.5%	52.2%	36.3%	0.0%	66.6%
Guadalupe County, New Mexico					
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	0.8%	0.9%	0.0%	-	0.0%
One	13.7%	12.3%	23.4%	-	22.9%
Two	27.9%	26.4%	42.6%	-	40.0%
Three or more	57.6%	60.4%	34.0%	-	37.1%
Harding County, New Mexico					
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	0.8%	0.5%	0.0%	-	0.0%
One	5.3%	6.8%	0.0%	-	0.0%
Two	30.1%	32.0%	56.3%	-	38.5%
Three or more	63.9%	60.7%	43.8%	-	61.5%
Los Alamos County, New Mexico					
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	1.3%	0.8%	0.0%	23.4%	2.2%
One	19.2%	18.4%	18.3%	38.6%	19.1%
Two	38.2%	37.7%	28.8%	19.9%	45.6%
Three or more	41.3%	43.1%	52.9%	18.1%	33.2%

Mora County, New Mexico					
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	1.2%	0.0%	0.0%	-	4.0%
One	27.3%	37.8%	4.6%	-	44.4%
Two	15.1%	23.1%	11.9%	-	5.6%
Three or more	56.4%	39.1%	83.5%	-	46.0%
Rio Arriba County, New Mexico					
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	1.0%	0.9%	0.0%	5.8%	1.4%
One	15.7%	14.7%	16.8%	6.7%	26.1%
Two	28.5%	30.1%	25.2%	54.8%	18.1%
Three or more	54.9%	54.3%	58.0%	32.7%	54.4%
San Miguel County, New Mexico					
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	2.1%	2.9%	0.0%	0.0%	0.0%
One	17.8%	16.9%	22.6%	0.0%	11.6%
Two	34.9%	36.4%	26.8%	100.0%	34.9%
Three or more	45.2%	43.9%	50.6%	0.0%	53.5%
Santa Fe County, New Mexico					
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	1.6%	0.7%	2.4%	16.3%	0.7%
One	21.3%	19.4%	19.7%	47.5%	26.3%
Two	39.5%	39.4%	40.1%	21.4%	43.0%
Three or more	37.6%	40.5%	37.9%	14.8%	30.0%
Taos County, New Mexico					
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	1.8%	0.8%	2.9%	0.0%	0.3%
One	24.9%	18.3%	27.3%	1.4%	47.8%
Two	29.8%	32.1%	32.4%	91.3%	18.0%
Three or more	43.5%	48.8%	37.4%	7.2%	33.9%
Union County, New Mexico					
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	4.1%	2.9%	0.0%	-	0.0%
One	13.7%	14.4%	0.0%	-	14.4%
Two	29.9%	31.9%	16.3%	-	31.4%
Three or more	52.3%	50.7%	83.7%	-	54.2%

Northwest

On average, more people have three or more vehicles than other numbers of vehicles available to them. Across the region, of those who took public transportation to work, a large proportion did not have a vehicle available to them.

Consistent with other regions, this region sees an opposite relationship between the number of vehicles available and homeownership. Households that are owner-occupied are more likely to have more vehicles available than households that are renter-occupied. For example, only 5.9% of owner-occupied households do not have a vehicle available while 11.4% of renter-occupied households do not have a vehicle available. Similarly, 3.5% of owner-occupied households have five or more vehicles available while only 1.2% of renter-occupied households have five or more vehicles available.

	Cibola County, New Mexico				
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	1.1%	1.1%	1.7%	0.0%	0.5%
One	17.1%	16.4%	16.0%	22.6%	17.7%
Two	33.3%	30.1%	60.8%	0.0%	34.3%
Three or more	48.4%	52.4%	21.5%	77.4%	47.5%
	McKinley County, New Mexico				
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	4.5%	2.2%	6.4%	62.4%	7.7%
One	24.4%	23.2%	17.7%	18.3%	37.5%
Two	35.8%	38.3%	26.0%	0.0%	30.5%
Three or more	35.3%	36.4%	50.0%	19.4%	24.4%
	San Juan County, New Mexico				
VEHICLES AVAILABLE	**Total**	**Drove Alone**	**Carpooled**	**Public Transport**	**Worked from home**
None	2.0%	1.8%	2.3%	26.6%	0.5%
One	20.4%	20.3%	23.8%	8.9%	14.6%
Two	34.8%	34.8%	21.5%	45.6%	41.4%
Three or more	42.8%	43.1%	52.5%	19.0%	43.4%

Chronic Disease

High Blood Pressure

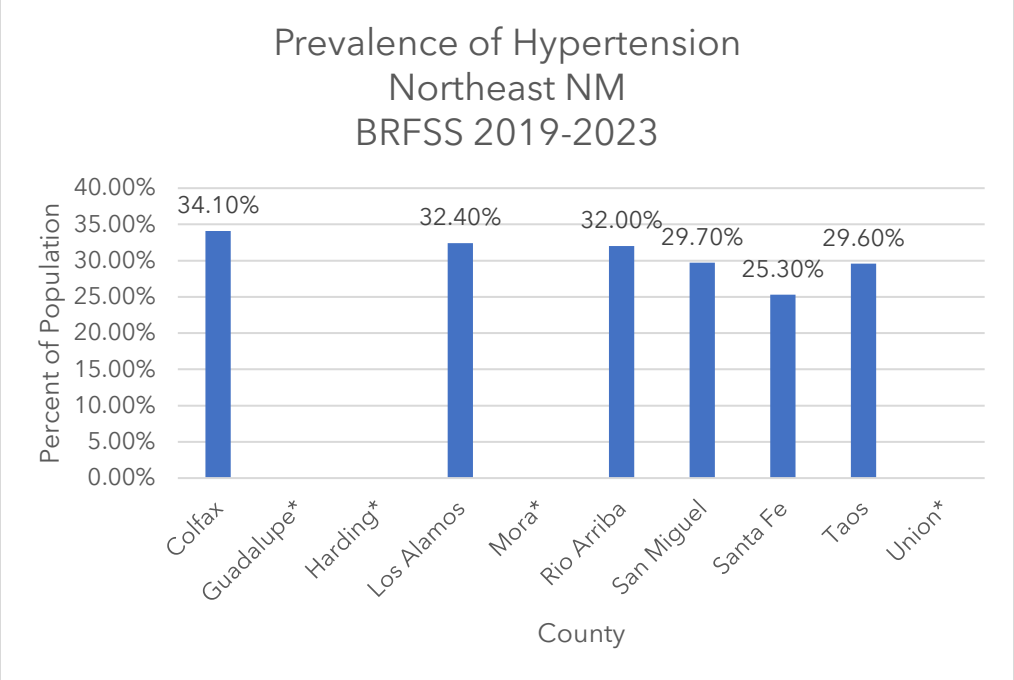
High blood pressure, also called hypertension, is characterized by blood pressure levels at or above 130/80 mmHg and can lead to problems related to the heart, brain, kidneys, and eyes. Blood pressure may be controlled by engaging in a healthy lifestyle and/or through medication.[13]

Statewide, 30.8% of the population has been told by a doctor that they have blood pressure.

Northeast

Hypertension is more prevalent in Colfax County than the other counties in this region. Santa Fe has the lowest prevalence of hypertension. Guadalupe, Harding, Mora, and Union are suppressed due to low numbers of responses to the BRFSS.

[13] About High Blood Pressure. CDC (2025). Retrieved from *https://www.cdc.gov/high-blood-pressure/about/index.html*



Diabetes

Diabetes is a chronic health condition associated with how food is processed by the body into sugar and energy. There are three main types of diabetes: type 1, type 2, and gestational. Type 1 diabetes is characterized by a discontinuation of production of insulin, likely due to an autoimmune reaction. Type 2 diabetes is characterized by inefficient or insufficient use of the insulin produced by the body, resulting in an inability for the body to regulate blood sugar levels. This type can develop over time. Gestational diabetes develops in pregnant people with no prior indication of diabetes. Gestational diabetes can lead to higher risk health issues and often goes away after the baby is born but can increase the risk of type 2 diabetes in both the parent and child.[14] Prediabetes is when blood sugar levels are higher than normal but not high enough to be considered diabetes (A1c between 5.7 and 6.4%[15]) and can be treated effectively with diet and lifestyle changes, preventing the onset of type 2 diabetes.[16]

Statewide, 10.7% of the population has been told by a doctor they have diabetes (2023).

Northeast

For the period of 2019-2023, Rio Arriba and Guadalupe counties had the highest prevalence of prediabetes with 16.1% and 15.9% of the population reporting having been told by a doctor they have prediabetes. Data are unavailable for Harding County due to low response rates and data are statistically unstable for Union County for both diabetes and prediabetes as well as Mora's diabetes prevalence and Colfax County's prediabetes prevalence. However, diabetes and prediabetes prevalences are both lowest in Los Alamos County. Overall, in this region, there is a higher prevalence of prediabetes than diabetes, which presents an opportunity for public health programming to prevent diabetes in a portion of the population.

[14] Centers for Disease Control and Prevention (2024). Diabetes Basics. Retrieved from *https://www.cdc.gov/diabetes/about/index.html*
[15] American Diabetes Association. 2025. What is the A1c Test? Retrieved from: *https://diabetes.org/about-diabetes/a1c#:~:text=If%20your%20A1C%20level%20is,were%20in%20the%20diabetes%20range*.
[16] Centers for Disease Control and Prevention. 2024. Prediabetes – Your Chance to Prevent Type 2 Diabetes. Retrieved from *https://www.cdc.gov/diabetes/prevention-type-2/prediabetes-prevent-type-2.html*

County	Prediabetes	Diabetes
Colfax	6.30%*	12.20%
Guadalupe	15.90%	16.20%
Harding	**	**
Los Alamos	7.90%	4.30%
Mora	9.50%	9.10%*
Rio Arriba	16.10%	12.00%
San Miguel	13.70%	13.20%
Santa Fe	13.30%	7.60%
Taos	14.00%	7.60%
Union	5.50%*	8.10%*
Northeast	13.20%	8.90%

**Percentages based on fewer than 50 completed surveys are not shown because they do not meet the DOH standard for data release.
*This count or rate is statistically unstable (RSE >0.30) and may fluctuate widely across time periods due to random variation (chance). Please use caution in interpreting this value, or combine years, areas, or age groups to increase the population size.

Northwest

A higher percentage of people in the Northwest region reported having been told by a doctor they had diabetes than prediabetes – 14.4% vs 13.5%. In this region, just under a fifth of the population has diabetes and a little more than a tenth has prediabetes. The Northwest region has the highest prevalence of prediabetes and diabetes of all the regions, indicating a need to address underlying causes of type 2 diabetes.

County	Prediabetes	Diabetes
Cibola	14.60%	15.40%
McKinley	14.00%	15.80%
San Juan	13.00%	13.40%
Northwest	13.50%	14.40%

Chronic Lower Respiratory Diseases – COPD and Asthma

Chronic lower respiratory diseases (CLRDs) are among the top 15 leading causes of death in New Mexico. The most common chronic lower respiratory diseases are chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, and asthma.

Many factors contribute to the development and worsening of CLRDs including genetics, pollution, allergies, smoking, poor diet, and occupational exposures.[17] Addressing social, behavioral, and environmental drivers may improve quality of life and reduce burden of disease while also potentially contribute to a decrease in deaths related to chronic lower respiratory diseases.

Data for this section come from the Behavioral Risk Factor Surveillance System (BRFSS). In an effort to stabilize prevalence rates, we analyzed combined data from 2019-2023. While this stabilized most prevalence rates, some remained statistically unstable and should be interpreted with caution.

17 Burney P, Perez-Padilla R, Marks G, et al. Chronic Lower Respiratory Tract Diseases. In: Prabhakaran D, Anand S, Gaziano TA, et al., editors. Cardiovascular, Respiratory, and Related Disorders. 3rd edition. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2017 Nov 17. Chapter 15. Available from: https://www.ncbi.nlm.nih.gov/books/NBK525159/ doi: 10.1596/978-1-4648-0518-9_ch15

Northeast

Excluding the counties with statistically unstable or suppressed prevalences, we see that San Miguel and Los Alamos counties have the highest prevalences of asthma in this region, with 13.9% and 12.6% of the population experiencing asthma, respectively. This is an interesting situation in which Los Alamos County, which usually has the best health outcomes, has among the highest prevalences of asthma and may be an area to explore further. However, consistent with other health metrics, Los Alamos County has the lowest COPD prevalence (3.5%) and San Miguel County has the highest statistically stable prevalence – 5%.

County	Asthma Prevalence	COPD Prevalence
Colfax	9.10%*	13.00%*
Guadalupe	10.50%*	6.20%***
Harding	**	**
Los Alamos	12.60%	3.50%
Mora	8.90%***	9.10%*
Rio Arriba	10.10%	4.40%
San Miguel	13.90%	5.00%
Santa Fe	9.50%	3.90%
Taos	7.30%	4.50%
Union	9.90%*	7.60%*
Northeast	10.10%	4.40%

**Percentages based on fewer than 50 completed surveys are not shown because they do not meet the DOH standard for data release.
*This count or rate is statistically unstable (RSE >0.30), and may fluctuate widely across time periods due to random variation (chance). Please use caution in interpreting this value, or combine years, areas, or age groups to increase the population size.
***The estimate has a relative standard error greater than 50% and does not meet standards for reliability. A count or rate such as this should not be used to inform decisions. Try combining years, areas, or age groups to increase the population size.

Northwest

The prevalence of asthma is similar across the three Northwestern counties with San Juan County expressing the highest prevalence. In contrast, Cibola County has the highest prevalence of COPD in this region, with 5.4% of the population reporting they have the condition.

County	Asthma Prevalence	COPD Prevalence
Cibola	8.20%	5.40%
McKinley	9.00%	3.30%
San Juan	9.90%	4.80%
Northwest	9.40%	4.50%

Active Living

Access to Exercise Opportunities

Increased physical activity is an important protective factor for health and is associated with lower risk of type 2 diabetes, hypertension, and other cardiovascular diseases. This metric is included in the social drivers of health as it measures the percentage of individuals within the county who live close to a location that can be used for physical activity – for example, a park or a recreational facility. Specifically, this is the measure of the percentage of people in the county who live in a census block that is within half a mile of a park or within one mile of a recreational facility within an urban area, or within three miles of a recreational facility in rural areas. This metric is a composite metric sourced from several sources including the YMCA, US Census TIGER/Line Shapefiles and ArcGIS, combined and processed by researchers at County Health Rankings and Roadmaps as part of their 2025 measures.

Key considerations for how much people exercise include how easy and safe they feel exercising indoors and outdoors where they live, and whether they have immediate access to safe, free opportunities for adequate amounts of recommended exercise. Data indicates that racial and ethnic minorities and people with low income, people experiencing poverty, and under-resourced populations disproportionately have access to fewer acres of parks (parks in these neighborhoods are smaller) which results in fewer park acres per person, and parks in these areas tend to be lower quality, lacking safety and maintenance compared to wealthier communities.[18]

Measures like these give us more context into the barriers our communities face in implementing healthy lifestyles including integrating more physical activity. Without understanding the context behind this structural and environmental driver of health (as well as others that interplay with it such as safe streets, accessible sidewalks, etc.), recommendations to simply exercise more are inadequate.

Physical Inactivity

Physical activity is important for maintaining a healthy lifestyle. By understanding how common physical inactivity is in the community, we can identify opportunities to increase physical activity by leveraging resources and community assets to encourage and enable people to be more physically active. Access to resources, sidewalks, walking trails, and parks is vital to increasing physical activity. Many things affect the ability to engage in physical activity including climate and weather, sidewalks and urban design, physical pain or other mobility differences, childcare and breaks from house/paid work, cultural and gender norms, time spent sitting for learning, work, or recreation, and low confidence or skills, among others. Remaining physically inactive has been linked to poorer health outcomes including type 2 diabetes, stroke, hypertension, and other cardiovascular diseases.[19]

This metric comes from the Behavioral Risk Factor Surveillance System (BRFSS), a population-representative cross-sectional telephonic survey conducted in each state every year. Data for this report are from 2022 and are considered representative of the population. This measure is a percentage of adults surveyed who reported no leisure-time physical activity in the month prior to being surveyed.

Northeast

This region is home to the county with the highest percent of people with exercise opportunities and that with the lowest. Nearly everyone in Los Alamos County has access to exercise opportunities and the lowest prevalence of physical inactivity statewide. Very few (1.2%) people in Harding County have access. Mora County also has relatively low access to these opportunities while counties that are wealthier (such as Santa Fe and Taos) have better access. The prevalence of inactivity is highest in Guadalupe, Union, and Mora counties.

County	% of People with Access to Exercise Opportunities	% of People who are Physically Inactive
Colfax	79.8	24.9
Guadalupe	57.4	30.1
Harding	1.2	25.9
Los Alamos	99.3	11.9
Mora	16.9	28.1
Rio Arriba	49.7	27.7
San Miguel	56.4	26.1
Santa Fe	83.4	17.8
Taos	79.1	23.3

[18] Rigolon, A. (2016). A complex landscape of inequity in access to urban parks: A literature review. Landscape and Urban Planning, 153, 160–169. https://doi.org/10.1016/j.landurbplan.2016.05.017

[19] Lee IM, Shiroma EJ, Lobelo F, et al. Effect of physical inactivity on major non-communicable diseases worldwide: An analysis of burden of disease and life expectancy. The Lancet. 2012;380(9838):219-229.

County	% of People with Access to Exercise Opportunities	% of People who are Physically Inactive
Union	69.9	29.1
Region Average	59.3	24.5

Northwest

Almost half of the people living in this region have access to exercise opportunities with Cibola County leading with 53.3% of their population having this access while McKinley County displays the lowest percent – 41.2% – in this region. In fact, McKinley having the lowest percent of people with access to exercise opportunities and the highest percent of people who are physically inactive may indicate a relationship between the two variables.

County	% of People with Access to Exercise Opportunities	% of People who are Physically Inactive
Cibola	53.3	27.0
McKinley	41.2	31.6
San Juan	50.9	27.3
Region Average	48.5	28.6

Access to Health Care and Health Literacy

Access to health care is quantified for the purposes of this assessment as a factor of the ratio of population to primary care physicians, mental health providers, dentists, and other non-physician primary care providers; the percent of people who delayed care due to cost; the rate (per 100,000 population) of preventable hospitalizations; and the percent of people who do not have health insurance.

For additional context, the ratio metrics are ratios of population to a provider, not provider to population. For example, New Mexico has a ratio of population to primary care physicians of 1344:1, meaning for every 1 primary care physician, there are 1,344 people in the population. This means that, if everyone in the state had insurance and all other barriers to care were solved, each physician in the state would have a panel of 1,344 patients. This is similar to the US ratio of 1330:1.

The Behavioral Risk Factor Surveillance System (BRFSS) asks participants the following question about delaying care: "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?" The wording of this question is important to consider when interpreting these data because participants are not provided clarification on what the interviewers mean by "cost". Cost in the most traditional interpretation of this variable would be the actual cost of the care (i.e. copay, deductible, out of pocket cost), but it could also mean the cost of the travel to the clinic if the clinic is out of town (gas, vehicle costs, etc.) or the cost of lost wages due to missing work, to name a few.

Preventable hospital stays are displayed as a rate per 100,000 Medicare enrollees and are not reflective of the entire population. However, this metric is important to understand several key aspects of access to care that can affect many populations, especially marginalized populations. This metric quantifies hospital visits for preventable conditions that can be treated at the outpatient level including congestive heart failure, bacterial pneumonia, and urinary tract infections. This metric is also an indicator of overuse of urgent care and emergency room visits as the primary source for health care. This can be for reasons such as the inability to get care even if established at a clinic (long wait lists, no available appointments with a primary care provider).

For more information on this metric, *click here*.

The prevalence of people who are uninsured is an important access to care metric because it acts as a primary barrier to receiving care. Routine care is more expensive without insurance unless the clinic provides a sliding scale or special ultra-low rate for people who do not have health insurance. Because of this, people who do not have health insurance are less likely to seek routine care or access preventive services/care and are often more likely to utilize urgent care and emergency rooms for care that could have been prevented with earlier access to care. This can cause a higher financial burden on patients because the cost of hospitalization is often much higher for those without insurance compared to what someone with health insurance would pay. Even though we present the percent of people who are uninsured, it's also important to understand that most people in New Mexico do have health insurance – about 89% of people have some kind of health insurance coverage.

Northeast

Most counties in this region have population to primary care physician ratios that are much higher than the state's ratio of 1344:1 and the US ratio of 1330:1. This indicates and validates much of what communities in this region brought up during forums: that there are not nearly enough providers in communities. According to data obtained from County Health Rankings and Roadmaps (table below), Harding County does not have any providers, which poses a significant access to care issue, forcing county residents to travel to nearby counties for health care access.

Access to Care – Ratio of Providers to Population

County	Ratio of Population to Primary Care Physicians	Ratio of Population to Mental Health Providers	Ratio of Population to Dentists	Ratio of Population to Other Primary Care Providers
Colfax	2474:1	98:1	2449:1	943:1
Guadalupe	2225:1	59:1	2155:1	613:1
Harding	639:0	624:0	628:0	624:1
Los Alamos	644:1	354:1	1010:1	670:1
Mora	**	589:1	1390:1	1374:1
Rio Arriba	2009:1	183:1	1335:1	973:1
San Miguel	2088:1	91:1	1925:1	833:1
Santa Fe	908:1	125:1	1120:1	788:1
Taos	1154:1	115:1	2034:1	732:1
Union	4107:1	117:1	3980:0	1321:1

**Values not populated in the data

This region has a slightly higher percent of people overall who delayed care due to cost compared to New Mexico overall.

Los Alamos County has the highest percent of people with health insurance (98% of people in that county are insured) which reflects the low percent of people who delayed care due to cost (3.6%). In general, though, there is a lower percent of people uninsured compared to other counties and the state overall. The preventable hospitalization rates in this region are lower than the state's rate for all counties except for Union and Guadalupe counties. Colfax County has the highest percent of people who reported delaying medical care due to cost in the entire state at nearly a quarter of the county's population.

County of Residence	Percent Delayed Care	Percent Uninsured	Preventable Hospitalization Rate (per 100,000 population)
Colfax	24.2%	10.2%	1793
Guadalupe	6.1%	8.6%	3301
Harding	**	10.6%	

County of Residence	Percent Delayed Care	Percent Uninsured	Preventable Hospitalization Rate (per 100,000 population)
Los Alamos	3.6%	2.1%	1067
Mora	13.0%	6.4%	1679
Rio Arriba	11.3%	9.1%	1877
San Miguel	14.6%	8.6%	1810
Santa Fe	13.1%	12.0%	1187
Taos	14.5%	11.3%	1033
Union	14.6%	12.1%	2278
Northeast	12.6%	NA	NA

Northwest

The ratios of population to providers in this region are higher in most cases for all counties for all metrics compared to the state's ratios with some exceptions. McKinley County's ratio of population to primary care physicians is lower than the state's ratio, and McKinley County and San Juan County have ratios of population to dentists is lower than the state's ratio. All counties in this region have ratios of population to mental health providers higher than the state's ratio.

Access to Care – Ratio of Providers to Population

County	Ratio of Population to Primary Care Physicians	Ratio of Population to Mental Health Providers	Ratio of Population to Dentists	Ratio of Population to Other Primary Care Providers
Cibola	2091:1	268:1	1497:1	609:1
McKinley	1217:1	521:1	1369:1	1638:1
San Juan	1891:1	355:1	933:1	868:1

The percent of people who delayed care due to cost in this region is highest in San Juan County, but the regional percent is not the highest in the state. McKinley and San Juan counties have relatively high percents of people who report being uninsured compared to Cibola County. This uninsured rate is slightly higher than the state's overall percentage.

County of Residence	Percent Delayed Care	Percent Uninsured	Preventable Hospitalization Rate (per 100,000 population)
Cibola	8.4%	9.2%	2632
McKinley	9.1%	13.8%	2681
San Juan	13.0%	12.8%	2798
Northwest	11.1%	NA	NA

Healthcare Utilization – Presbyterian Healthcare Services

Utilization of the Presbyterian hospitals in NorthernNew Mexico is an important factor to consider when thinking about the health of a population, especially because access to care and services rose to the top priority area this CHA cycle. With the help of the Presbyterian Healthcare Services Analytics Organization, we analyzed the type of health care utilization at both Northern New Mexico hospitals as well as the emergent/urgent care utilization by number of visits.

The first metric helps us understand inpatient versus outpatient versus urgent/emergent care frequently and where patients are coming from (to help understand our reach) while the second metric helps us understand which hospitals have the highest ED utilization rates. This helps us understand where interventions may be beneficial.

As expected, most patients who presented to Santa Fe Medical Center facilities were from Santa Fe, followed by San Miguel, Sandoval, Bernalillo, Rio Arriba, then Taos counties. At Presbyterian Española Hospital, most patients came from Rio Arriba County, then Santa Fe, Taos, Los Alamos, Sandoval, and San Miguel counties. This context is important to understand the more regional reach each of our hospitals have beyond the borders of the counties in which they reside. For example, these data tell us that a significant enough number of people from San Miguel County receive care at Presbyterian Northern New Mexico hospitals, which leads us to expand our current community health implementation plans to include that county.

SFMC	**Source**	**Santa Fe**	**San Miguel**	**Sandoval**	**Bernalillo**	**Rio Arriba**	**Taos**
	ED/UC*	11,297	991	878	667	658	115
	IP	1,710	277	163	89	183	20
	OP	29,218	2,694	1,521	2,208	3,118	935
PEH	**Source**	**Rio Arriba**	**Santa Fe**	**Taos**	**Los Alamos**	**Sandoval**	**San Miguel**
	ED/UC*	9,869	2,946	1,333	199	158	40
	IP	1,553	425	244	102	26	†
	OP	14,458	4,737	3,463	1,490	193	139

Count of patients who received care in 2024 by county of residence and encounter type, by hospital
(*) "ED" = emergency department; "UC" = urgent care
"†" indicates the value is suppressed due to low numbers that could lead to identification.

Presbyterian Española Hospital has a relatively high percent of people who visited the emergency department or urgent care two or more times in 2024.

	Metric	**Any # Of Visits**	**1 Visit**	**2+ Visits**	**5+ Visits**	**20+ Visits**
SFMC	COUNT	12,494	4,351	325	29	NA
	PERCENT	100.00%	34.80%	2.60%	0.20%	NA
PEH	COUNT	14,597	9,189	5,408	679	†
	PERCENT	100.00%	63.00%	37.00%	4.70%	0.00%

Count of patients who received emergent and/or urgent care in 2024 by number of repeat visits and hospital
"†" indicates the value is suppressed due to low numbers that could lead to identification.

Infectious Disease and Immunizations

Infectious disease continues to rise to the forefront of local public health. During community conversations, community members expressed interest in addressing key outbreaks and emerging infections. While some outbreaks involve vaccine preventable diseases (VPD), others require medical intervention (treatment) and targeted prevention work.

Immunization is a key and revolutionary public health response that has prevented countless illnesses, deaths, and even contributed to the elimination or near-elimination of certain infectious diseases. At the time of this writing, two outbreaks are of particular interest to public health officials in New Mexico: congenital syphilis and measles, the latter of which is prevented by the MMR vaccine.

Vaccinations

Influenza and COVID-19 vaccinations are available yearly to protect against the latest and most prominent strains of flu and SARS-CoV-2 viruses. Additionally, children younger than 5 years old and adults older than 50 are eligible for the

pneumococcal vaccine, which protects against pneumonia. Data on these three vaccinations are illustrated below and are self-report among adults only (BRFSS 2019-2023).

Northeast

Union County has the lowest flu vaccine coverage in the Northeast region while Los Alamos County has the highest coverage (where data are statistically stable). Many counties do not have interpretable data for COVID and pneumococcal vaccination, but of those that do, we see that Colfax County has a very high COVID vaccine rate compared to other counties in this region with 40.4% of adults reporting having at least one dose while Santa Fe has the lowest vaccine coverage for COVID vaccines, at 11.8% of the population. Los Alamos also has the highest coverage for pneumococcal vaccines while Taos has the lowest (60.5%). See data notes below the table below for more information on the suppressed or unstable county data.

	Flu 2019-2023	COVID 2021-2023	Pneumococcal 2019-2023
County of Residence	**Percentage**	**Percentage**	**Percentage**
Colfax	37.00%	40.40%	64.70%
Guadalupe	46.60%	**	**
Harding	**	**	**
Los Alamos	58.30%	0.90%***	75.20%
Mora	35.60%	**	**
Rio Arriba	42.00%	14.20%	66.60%
San Miguel	35.50%	13.00%	63.80%
Santa Fe	44.70%	11.80%	70.70%
Taos	34.20%	12.20%*	60.50%
Union	29.20%	**	**
Northeast	42.60%	13.70%	68.00%

****Percentages based on fewer than 50 completed surveys are not shown because they do not meet the DOH standard for data release.

***This count or rate is statistically unstable (RSE >0.30) and may fluctuate widely across time periods due to random variation (chance). Please use caution in interpreting this value.

*****The estimate has a relative standard error greater than 50% and does not meet standards for reliability. A count or rate such as this should not be used to inform decisions.

Northwest

COVID vaccine coverage from 2021-0223 is highest in San Juan County, with about one out of four people saying they've had at least one dose. Additionally, half of McKinley County reports having been vaccinated for flu in the last year and San Juan County has the highest pneumococcal vaccine coverage in the region.

	Flu 2019-2023	COVID 2021-2023	Pneumococcal 2019-2023
County of Residence	**Percentage**	**Percentage**	**Percentage**
Cibola	40.00%	9.90%	65.80%
McKinley	50.20%	15.90%	58.80%
San Juan	42.70%	25.20%	67.20%
Northwest	45.00%	20.60%	64.80%

Cancer Incidence and Mortality

Cancer incidence and mortality in this report are presented as age-adjusted and are both illustrated as number of events identified per 100,000 population and are displayed for the 5-year moving average of 2018-2022. In other words, if the incidence rate for the metro region for prostate cancer was 35.2, that means from 2018 to 2022, there were 35.2 cases of prostate cancer for every 100,000 people in that region. Here, we present the most identified cancers in this region.

Northeast

Breast cancer (among men and women) is the most common type of cancer in the Northeast region, followed by prostate cancer. From 2018-2022, 34.3 cancer cases for every 100,000 people in the population had an unknown site. Prostate cancer is the second most incident type of cancer in this region.

Cancer Incidence by Cancer Site	Northeast
Breast (male and female)	72.6
Male Genital System: Prostate	42.2
Unknown	34.3
Digestive System: Colon and Rectum	31.1
Respiratory System: Lung and Bronchus	23.7
Skin: Melanomas of the Skin	17

Harding and Union counties have the highest mortality rate for all cancer types in this region; however, it is important to note that very low numbers of deaths among counties with very low population sizes inflates the death rate. For context, though Union County has the highest overall cancer mortality rate, from 2018-2022 there were 50 deaths attributable to cancer. Overall, cervical cancer deaths in this region are unreliable for interpretation as are the values for some counties for female breast cancer and colorectal cancer deaths – see table below.

County	Cancer Death Rate – All Cancers	Cervical Cancer Death Rate	Female Breast Cancer Death Rate	Colorectal Cancer Death Rate
Colfax	119.5	0.6##	23.8#	12.3
Guadalupe	135.8	13.7##	6.5##	21.9#
Harding	160.7	0.0##	**	9.0##
Los Alamos	103.4	1.2##	11.4#	10.9
Mora	118.2	7.5##	18.5##	11.5#
Rio Arriba	125.7	3.4#	12.3	11.6
San Miguel	129.2	1.8##	16.2	11.2
Santa Fe	115.1	0.9#	18.9	9.9
Taos	119.6	3.0#	19.7	9.1
Union	164.4	6.8##	73.3#	14.7##
Northeast	118.4	1.9	18.3	10.5
New Mexico	130.2	2.2	18.9	12.1

##The estimate has a relative standard error (RSE) greater than 50% and does not meet standards for reliability. A count or rate such as this should not be used to inform decisions. #This count or rate is statistically unstable (RSE

>0.30) and may fluctuate widely across time periods due to random variation (chance). Please use caution in interpreting this value.

**The estimate has been suppressed because the number of events and population size are small and not appropriate for publication.

Northwest

Breast cancer has the highest incidence of all cancer sites in Northwest New Mexico. The second most identified cancer site in Northwest New Mexico is colon/rectum, then prostate, lung and bronchus, then urinary system cancers. Cancers of an unknown site had an incidence of 38.4 cases per 100,000 population from 2018-2022.

Cancer Incidence by Cancer Site	Northwest
Breast (male and female)	46.2
Unknown	38.4
Digestive System: Colon and Rectum	35.8
Male Genital System: Prostate	31.3
Respiratory System: Lung and Bronchus	24.8
Urinary System: Kidney and Renal Pelvis	22.7

The Northwest region has an overall lower cancer death rate due to all cancers than the state overall, with 118.4 deaths per 100,000 population compared to 130.2 deaths per 100,000 population. Cervical cancer has a very low death rate in this region. Cibola County has the highest breast cancer death rate (among women) with 21.9 deaths per 100,000 population. Colorectal cancer deaths are higher in McKinley County.

County	Cancer Death Rate – All Cancers	Cervical Cancer Death Rate	Female Breast Cancer Death Rate	Colorectal Cancer Death Rate
Cibola	125.6	1.1	21.9	11.8
McKinley	138.8	2.6	17.6	17.5
San Juan	127.3	2.8	14.4	13.8
Northwest	130.4	2.5	16.5	14.6
Northeast	118.4	1.9	18.3	10.5
New Mexico	130.2	2.2	18.9	12.1

Environmental Health

Environmental health topics, such as clean water, air, and climate change, were community health needs identified in each region of the state during our Community Conversations and through health council priorities.

To assess environmental health related to topics surfaced by communities, it is important to identify trends in cold and heat-related illnesses, adverse climate events, air pollution, and drinking water quality (in the form of drinking water violations).

Particulate matter is quantified in the Environmental Public Health Tracking Network as the average daily density of fine particulate matter in micrograms per cubic meter ($PM_{2.5}$). According to the Environmental Protection Agency (EPA), fine particle pollution exposure has been linked to health conditions including nonfatal heart attacks, irregular heartbeat, aggravated asthma, decrease in lung functioning, general irritation of the airways, an increase in respiratory symptoms, and premature death in people with lung disease. People with lung diseases, children, older adults, immunocompromised people, minority populations, and people living in poverty are most at risk of complications of

fine particle pollution exposure.[20] Fine particulate matter is often seen as a general haze in the air and is generated by natural means and by human means. Human sources include combustion, including exhaust from vehicles, home heating and cooking, industrial processes and power plants, demolition from construction sites, burning agriculture waste, and fireworks. Natural sources include forest fires, wind erosion, dust, and pollen.

Important context for particulate matter: the measure provided is an average daily density of fine particulate matter for 2020. It is important to note that because of the COVID-19 pandemic, there was significant reduction in the use of vehicles as many people voluntarily self-isolated before the stay-at-home orders began. This could disproportionately deflate the average density of fine particulate matter compared to prior years and current "post-pandemic" status.

Because lung and heart diseases are among the leading causes of death in New Mexico, it is important to understand the potential impacts environmental factors can have.

The EPA provides a real-time resource for air quality monitoring, which displays $PM_{2.5}$, ozone, and PM_{10} levels as a way for individuals to assess risk of exposure at any given time. This resource can be found at *www.airnow.gov*.

The water violations metric comes from the Safe Drinking Water Information System and is a binary indicator (yes/no) of the presence of health-related drinking water violations.

Adverse Climate events come from several data sources including the Environmental Public Health Tracking (EPHT) Network, the US Drought Monitor, and OPEN FEMA Disaster Declaration Statements. This metric quantifies the number of adverse climate events, the number of days above 90F, the number of weeks in moderate or greater drought, and the number of disaster declarations for the 5-year period of 2019 to 2023. An adverse climate event is identified when the indicators within reach certain thresholds: extreme heat (300 or more days above 90F), moderate or greater drought for 65 or more weeks, and 2 or more presidential disaster declarations over the five-year period. The highest value for Adverse Climate Events is 3, meaning each of the aforementioned categories have reached their threshold for the time periods associated with each. Presidential disaster declarations across counties are not mutually exclusive. For example, the presidential disaster declaration on May 4th, 2022, for the Calf Canyon/Hermits Peak Fire included Colfax, Lincoln, Mora, San Miguel, and Valencia counties.

Finally, we look at heat and cold exposure, which includes illness and deaths related to heat and cold exposure. While anyone can be affected by heat and cold-related illness and exposure, those most at risk include older adults, very young children, people with chronic diseases, and people without access to air conditioning or heating. Finally, people experiencing homelessness and outdoor workers, which include construction and agriculture are at greatest risk of heat and cold exposure.[21]

Northeast

This region has a slightly lower average daily fine particulate matter density than the state, with an average of 5.05 µg/cubic meter. Santa Fe experienced the highest air quality as it relates to fine particulate matter in this region and Taos County had the lowest, but the differences are not very large. Harding, Los Alamos, and Union counties did not have any reported drinking water violations in 2023. This region had slightly fewer adverse climate events on average compared to the state (1.67 events statewide) and lower average number of days above 90F (82 for the region compared to 264). That being said, this is largely due to the extremely low number of days counted in counties that occupy higher altitudes at the norther boarder of the state. Counties toward the south and central part of this region still experienced a large number of days above 90F – higher than the state's average of 264 days. Guadalupe County (the

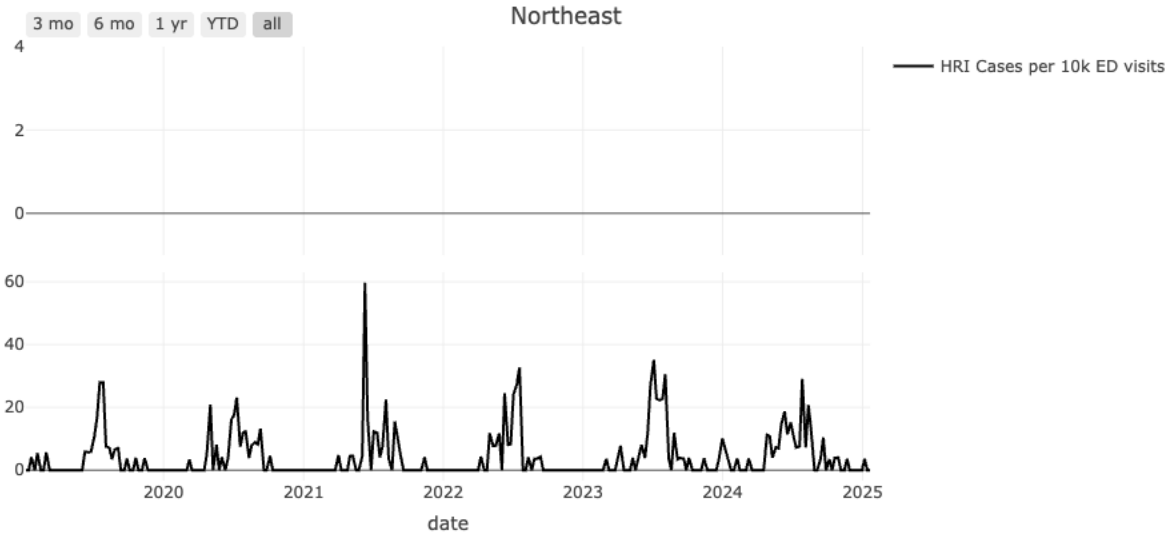
most county in the region) experienced 342 days above 90F from 2019-2023 while Harding County had 334. This region has seen the most presidential disaster declarations compared to other regions (9 declarations) and San Miguel County received the most statewide (4), tied with Lincoln County (who also received 4).

[20] Health and Environmental Effects of Particulate Matter (PM). 2025. Environmental Protection Agency. Retrieved from *https://www.epa.gov/pm-pollution/health-and-environmental-effects-particulate-matter-pm*
[21] Heat Related Illness. 2024. NMTracking. Retrieved from *https://nmtracking.doh.nm.gov/health/climate/HeatIllness.html* and *https://nmtracking.doh.nm.gov/health/climate/ColdIllness.html*

Northeast	Air Pollution: Particulate Matter (2020)	Drinking Water Violations (2023)	Adverse Climate Events (2019-2023)			
County	**Average Daily PM2.5**	**Presence Of Water Violation**	**Adverse Climate Events**	**Days Above 90F**	**Weeks In Moderate Or Greater Drought**	**Disaster Declarations**
Colfax	4.9	Yes	2	6	235	2
Guadalupe	4.9	Yes	2	342	174	0
Harding	4.9	No	2	334	235	0
Los Alamos	4.9	No	1	8	209	1
Mora	NO DATA	Yes	2	1	239	2
Rio Arriba	5.4	Yes	1	36	253	0
San Miguel	4.9	Yes	2	19	236	4
Santa Fe	4.5	Yes	1	39	218	0
Taos	5.9	Yes	1	1	219	0
Union	4.9	No	1	269	235	0
Region Average	5.05		1.25	82	227	NA

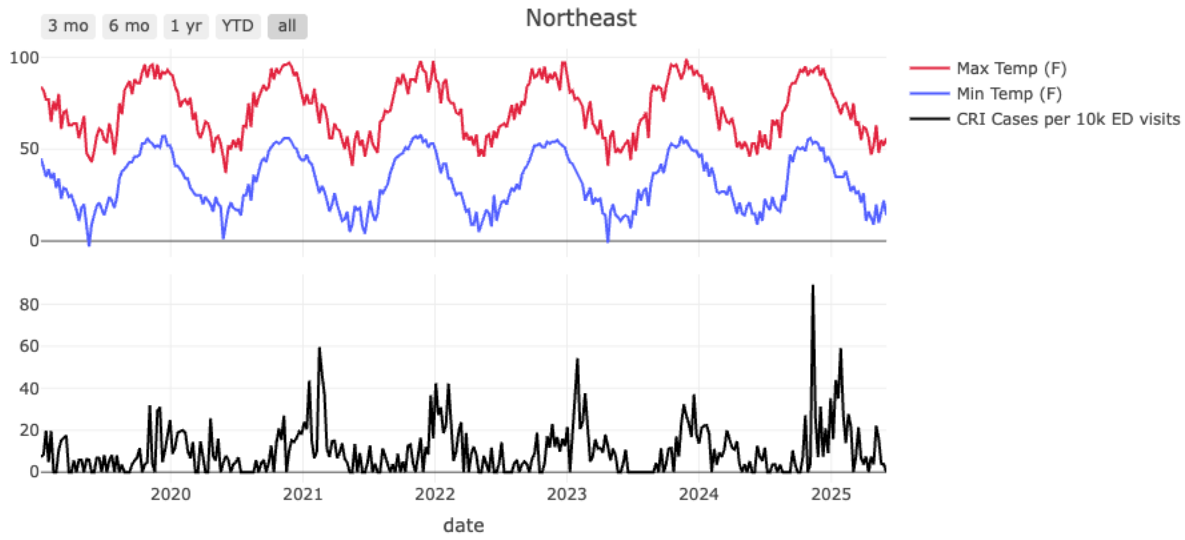
Heat-Related Illness

June 2021 had the highest incidence of heat-related illnesses in this region, with an ED visit rate of 59.7 cases per 10,000 ED visits. 2024 seems to have overall higher incidence of ED visits for this region compared to prior years. There were 58 heat-related ED visits in this region in Summer 2024.



Cold-Related Illness

November 2024 had the highest rate of cold-related illnesses since 2019 with 89.3 cases per 10,000 population. Overall, 2024 appears to have overall larger ED visits due to cold-related illnesses than previous years. Since October 1st, 2024, there were 147 cold-related ED visits in this region.



Northwest

McKinley County did not have any documented drinking water violations in 2023, and this region overall has air pollution particulate matter density similar to the state, though San Juan has the highest average daily density (6.4 µg/cubic meter). San Juan County has a significant natural gas production, specifically methane. Oil and gas production is a known contributor to fine particulate matter pollution.[22]

Though San Juan County is the northernmost county in the region, from 2019-2023 it had the highest number of days over 90F – at 235 days over the 5-year period. This region had higher average number of weeks in moderate or greater drought compared to the state overall (253 weeks vs 207 weeks statewide). There were no Presidential Disaster Declarations in this region during this period.

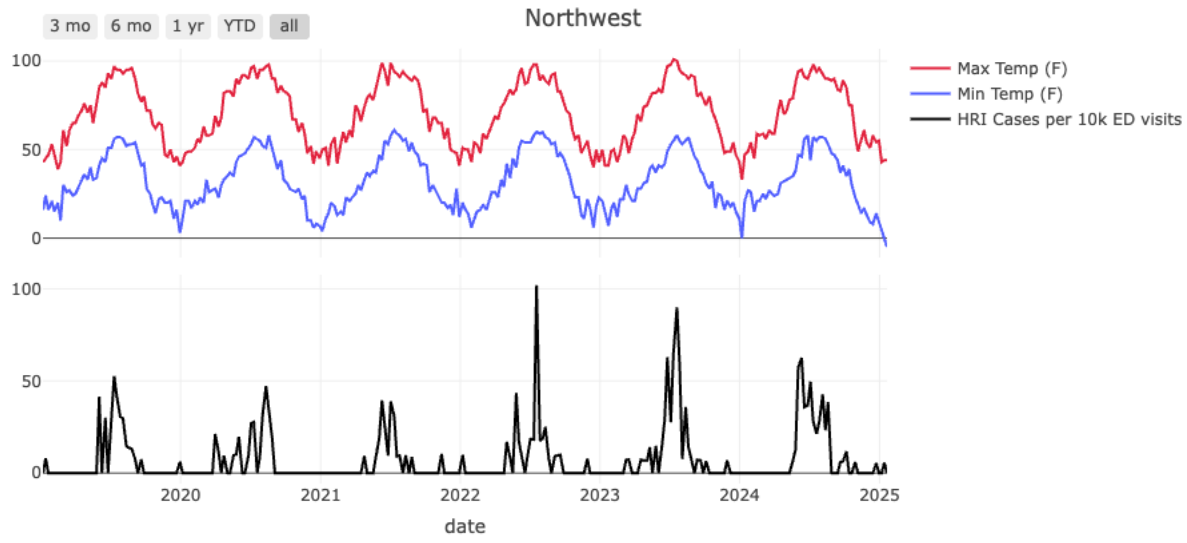
Northwest	**Air Pollution: Particulate Matter (2020)**	**Drinking Water Violations (2023)**	**Adverse Climate Events (2019-2023)**			
County	**Average Daily Pm2.5**	**Presence Of Water Violation**	**Adverse Climate Events**	**Days Above 90f**	**Weeks In Moderate Or Greater Drought**	**Disaster Declarations**
Cibola	5.1	Yes	1	33	243	0
Mckinley	5.3	No	1	38	261	0
San Juan	6.4	Yes	1	235	255	0
Region Average	5.6		1	102	253	Na

[22] Michanowicz, D. 2023. Air Pollution and Health Impacts of Oil and Gas Production. Retireved from: *https://www.psehealthyenergy.org/work/air-pollution-and-health-impacts-of-oil-and-gas-production/*

Heat- and Cold-Related Illnesses

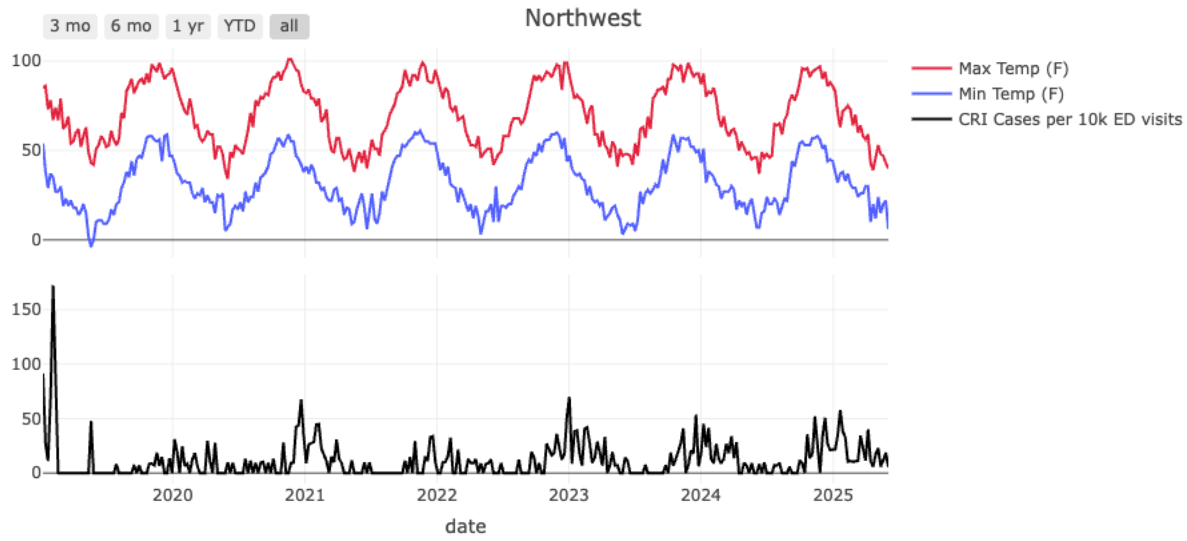
Heat-Related Illness

The incidence rate of heat-related illness ED visits peaked in July 2022 with 101.9 cases per 10,000 ED visits. Consistently, every year since, the peak of heat-related ED visit incidence was higher than years prior to 2022 – see chart below – with could indicate a trend in increasing ED visits every summer due to heat-related illness. In the summer of 2024, there were 67 heat-related illness ED visits in the Northwest region.



Cold-Related Illness

The incidence of ED visits due to cold-related illness peaked in February 2019, with 172.4 cases per 10,000 ED visits. In fact, since 0ctober 2024, there have been 116 cold-related ED visits in this region.



Conclusions

The Community Health Assessment for Northern New Mexico illustrates multiple key health needs and considerations for developing our Northern New Mexico Community Health Improvement Plan. Our community tells us of the importance of addressing systemic issues that contribute to poor health, including social and structural determinants of health. They noted the need to change social norms, bring community together, and work better together to address our most pressing health needs. Identification of disparities and the systemic inequities that contribute to furthering those inequities was a top concern for the community. Access to care and services, as with other communities, arose as the top concern and need for this region. The community has many assets that can be leveraged to increase access to care and services, improve cultural and linguistic approaches to public health, and to modify social norms and perceptions (especially around stigma) to create change. Dedicated interagency coordination is deeply needed to build collective action for collective impact.

APPENDIX A: REFERENCES AND SOURCES OF SECONDARY DATA

Key Data Sources:

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3. American Community Survey. US Census Bureau. 2019-2023
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5. University of New Mexico Geospatial and Population Sciences Studies (GPS) Program 2025
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APPENDIX B: EXISTING RESOURCES

Resource Directory and Referral Network Initiative Inventory

Prepared by the Community and Clinical Linkages Division of Presbyterian Community Health, August 2025

Purpose: To better understand the landscape of community resource information across New Mexico.

Many groups and organizations have developed their own community resource lists, but these efforts are scattered and often vary in quality, scope, and timeliness. To better understand the landscape of community resource information across New Mexico, we conducted a structured search of each county in New Mexico to identify and catalog the most current directories available.

To ensure consistency and quality across the inventory, the following inclusion criteria were applied when selecting directories:

- **Recency:** Only directories created or updated within the past two years were included.
- **Population focus:** Directories designed exclusively for special populations (e.g., adults age 55 and older) were excluded, while those aimed at youth and families were included.
- **Organizational type:** Directories produced by for-profit entities were excluded to prioritize publicly available, community-oriented resources.
- **Scope of content:** Directories listing fewer than ten resources were excluded to maintain a minimum threshold of comprehensiveness.
- **Accessibility:** Only public-facing directories were included, meaning they could be accessed and used directly by individuals without requiring enrollment in a program or mediation through a case manager.

The result is an inventory of existing resource directories and resource coordination initiatives that highlights where resource information already exists and lays the groundwork for identifying gaps, overlaps, and opportunities for alignment across the state.

Statewide Directories

Statewide directories are developed by organizations and agencies that serve the entire state of New Mexico, rather than focusing on a single geographic region. While the services listed may be concentrated in particular areas, the directories themselves are searchable by region and designed for use statewide. YES NM, run by the New Mexico Health Care Authority (HCA), goes beyond a traditional directory by developing a technology-driven referral network to power real-time referrals and feedback. Others are maintained by statewide organizations, such as the New Mexico Alliance of Health Councils, or United Way New Mexico, which provide broad access to community resource information across counties.

- **ShareNM**: Online resource database, searchable by service type, county and population and maintained by the New Mexico Alliance of Health Councils *www.sharenm.org*
- **Yes New Mexico**: Website from the New Mexico Health Care Authority to find, apply for and manage Health and Human Service programs and services available statewide *YES.NM.Gov*
- **988 NM Lifeline**: Hotline/Text Chat. 24/7 free and confidential lifeline for emotional, mental or alcohol and drug use support, available via telephone or text, through the Behavioral Health Services Division of the New Mexico Health Care Authority. More info: *www.988nm.org*

- **United Way New Mexico 211:** Hotline. Provides information and referrals via telephone, during business hours, to Health and Human Services, government agencies, and community-based organizations statewide. More info: *www.uwswnm.org/2-1-1*
- **New Mexico Native American Resource Directory:** Online resource database, searchable by service type. Offers a comprehensive listing of resources specifically tailored to support Native American communities. Supported by the NM Health Care Authority. *www.nativeamericanresourcesnm.org*
- **NM LGBTQ Roundtable Resources:** Online resource database, searchable by service type and region. A collective of New Mexican organizations that serve and support LGBTQ+ New Mexicans. *www.nmlgbtqrt.org/rtresources*

Regional Directories

Regional directories are developed with a focus on specific geographic areas within New Mexico, such as individual counties or multi-county regions. While they are designed to serve local communities, many also include statewide resources to ensure users can access a broader range of services when needed. Together, they reflect the efforts of local organizations, coalitions, and agencies to curate resource information that is responsive to the unique needs of their communities.

Several regional initiatives go beyond static resource lists by integrating technology to support referral networks. For example, the CONNECT resource functions similarly to the Health Care Authority's YES.NM initiative by leveraging a referral network and technology that enables closed-loop referrals. Likewise, the City of Albuquerque and Bernalillo County are partnered to build a comparable system. However, until their public-facing platform is live, they continue to rely on their existing city and county resource directories to provide information. These examples illustrate how some regional efforts are evolving from traditional directories into technology-enabled referral networks.

Northern New Mexico (Cibola, Colfax, Harding, Los Alamos, McKinley, Mora, Rio Arriba, San Miguel, San Juan, Santa Fe, Taos, Union Counties)

- **CONNECT (formerly Santa Fe Connect**): Website with printable resource directory and assistance request form to connect with a network of navigators at clinics, community organizations, and city and county programs. Navigators use a shared technology platform to send and receive electronic referrals to one another *www.santafenm.gov/community-services/connect*
- **Family Services Directory**: A project of the 100% New Mexico initiative. Online resource database searchable by county. Includes resources for Rio Arriba, San Miguel, San Juan and Taos Counties *www.tenvitalservicesnm.org*
- **Community Mental Health Resources Directory:** Website from Colfax County with information about nearby behavioral health community resources *www.co.colfax.nm.us/community/mental_health_resources.php*
- **Community Resource Directory**: Website from Regional Agency Intervention Network (RAIN) Colfax County with information about nearby behavioral health community resources *www.raincolfax.org/business-community-resources/*

- **Community Resource Directory**: Website from Los Alamos County Government's Social Services Division with information about nearby resources *www.losalamosnm.us/Government/Staff-Directory-and-Departments/Community-Services/Social-Services*
- **Therapist List**: Searchable online database of nearby therapists, maintained by Los Alamos Mental Health Access Project *www.losalamosnm.us/Government/Staff-Directory-and-Departments/Community-Services/Social-ervices*

APPENDIX C: COMMUNITY PRIORITIES

Thank you to the New Mexico Alliance of Health Councils for supporting health council capacity, coordination, communication, and advocacy.

Per the NM Alliance of Health Council Website *nmhealthcouncils.org/healthcouncils*:

> "New Mexico has 33 County and 10 Tribal Health Councils. County and Tribal Health councils, established in 1991 by the New Mexico legislature, help communities organize to identify and focus on local health priorities. The functions of Health Councils were reaffirmed in *2019 by the County and Tribal Health Councils Act (HB 137).*
>
> Health Councils are mandated to identify community needs, resources, and priorities; evaluate the community's system of care with an equity lens; and support education, programming, and advocacy efforts to improve community health.
>
> - Health Councils continue to produce detailed assessments of local health needs and resources on an annual basis.
> - Health Councils mobilize communities to address important local health problems.
> - Health Councils develop comprehensive, detailed, long-range community health improvement plans that have guided the work of healthcare providers, non-profit organizations, and state, county, city, and tribal government agencies.
>
> New Mexico's 33 County Health Councils and 10 Tribal Health Councils are supported by the collaborative efforts of the New Mexico Alliance of Health Councils and the New Mexico Department of Health's Health Promotion Regional Teams."

	Health Council Name	Priority Areas	Year Report was Published	Link to health council website	Link to report website ***Website FACT Sheets - Google Drive https://tinyurl.com/5n6pcf6m***
Northeast	Colfax County Health Council	Mental Health Substance Misuse Healthy Lifestyle	2025	Colfax County Health Council NMAHC	**Colfax County Health Council Fact Sheet 2025**
	Guadalupe County Health Council	Address Mental/Behavioral Health Issues 988 Help Line Promotion Chronic Disease Prevention	2025	Guadalupe County Health Council – NMAHC	**Guadalupe County HC Fact Sheet 2025**
	Harding County Health Council	Access to Health Care Transportation Telehealth Services for Veterans	2025	Harding County Health Council – NMAHC	**Harding County Fact Sheet 2025**

Northeast

Health Council Name	Priority Areas	Year Report was Published	Link to health council website	Link to report website *Website FACT Sheets - Google Drive https://tinyurl.com/5n6pcf6m*
Los Alamos County Health Council	Youth and Families Older Adult Network Regional Collaboration Responding to Community Needs	2025	Los Alamos County Health Council - Incorporated County of Los Alamos, NM	**LACHC Fact Sheet 2025**
Mora County Health Council	Alcohol & Substance Misuse Mental Health Health & Wellness	2025	Mora County Health Council – NMAHC	**Mora HC Fact Sheet 2025**
Rio Arriba Community Health Council	Behavioral Health Food Insecurity Housing Medical & Dental Transportation	2025	Health Council | Bridge To Health NM	**FY24-25 Health Council Rack Card**
San Miguel County Family & Community Health Council	Access to Care Environmental & Social Justice and Climate Resiliency- Mental and Behavioral Health- Access to Basic Needs Advocate for the Needs of Families with Young Children	2024	San Miguel County Health Council – NMAHC	**SMCFCHC Fact Sheet FY25**
Santa Fe County Health Policy Planning Commission	Increase Access Increase Access to Behavioral Health Substance Misuse	2024	Santa Fe County Health Council – NMAHC	**HPPC Fact Sheet 2024**
Taos County Health Council	Capacity Building	2025	Taos County Health Council – NMAHC	**TAOS COUNTY HEALTH COUNCIL 2025 FACTSHEET**
Union County Health Council	N/A	N/A	Union County Health Council – NMAHC	**N/A**

	Health Council Name	Priority Areas	Year Report was Published	Link to health council website	Link to report website *Website FACT Sheets - Google Drive https://tinyurl.com/5n6pcf6m*
Northwest	Cibola County Health Council	Mental Health Substance Misuse	2024	Cibola County Health Council – NMAHC	**Cibola Health Council Factsheet**
	McKinley Community Health Alliance	Housing	2025	*McKinley County Health Council – NMAHC*	**MCHA Fact Sheet 2025**
	San Juan County Partnership Health Council	Access to Care Health Equity	2024	San Juan County Health Council – NMAHC	**Health Council Fact Sheet Dec 2024**
Tribal	Acoma Pueblo	Access to Quality Health Care	2025	Acoma Pueblo Health Council – NMAHC	**Acoma Pueblo HC Factsheet FY25**
	Nambe Pueblo	Mental Health/Substance Abuse Screening	2024	Nambé Pueblo | Nambé Falls - Health, Wellness, and Education Program	**Nambe Pueblo Fact sheet FY25**
	Picuris Pueblo	Diabetes Prevention	2025	Picuris Pueblo Health Council – NMAHC	**Picuris Pueblo Health Council Fact Sheet 2025**
	San Ildefonso Pueblo	Substance Misuse Diabetes Prevention	2025	Pueblo de San Ildefonso Health Council – NMAHC	**San Ildefonso Puebo HC Fact Sheet FY25**
	Santa Clara Pueblo	Alcohol Misuse Climate Change Health Impacts - Water	2025	Health & Human Services | Santa Clara Pueblo	**Santa Clara Pueblo Factsheet 2023**
	Tesuque Pueblo	Awareness of Diabetes and other Chronic Diseases Behavioral Health Narcan Awareness Substance Abuse Awareness	2025	Tesuque Pueblo Health Council – NMAHC	**Tesuque Fact Sheet 2025**

While all counties have health councils in the Northern region, not all tribal areas in the region have health councils. We have attempted to provide some links that may bring insight into the health and priorities of some of the areas not represented by official health councils.

Taos Pueblo *www.taospueblo.com*

Ohkay Owingeh *www.ohkay.org*

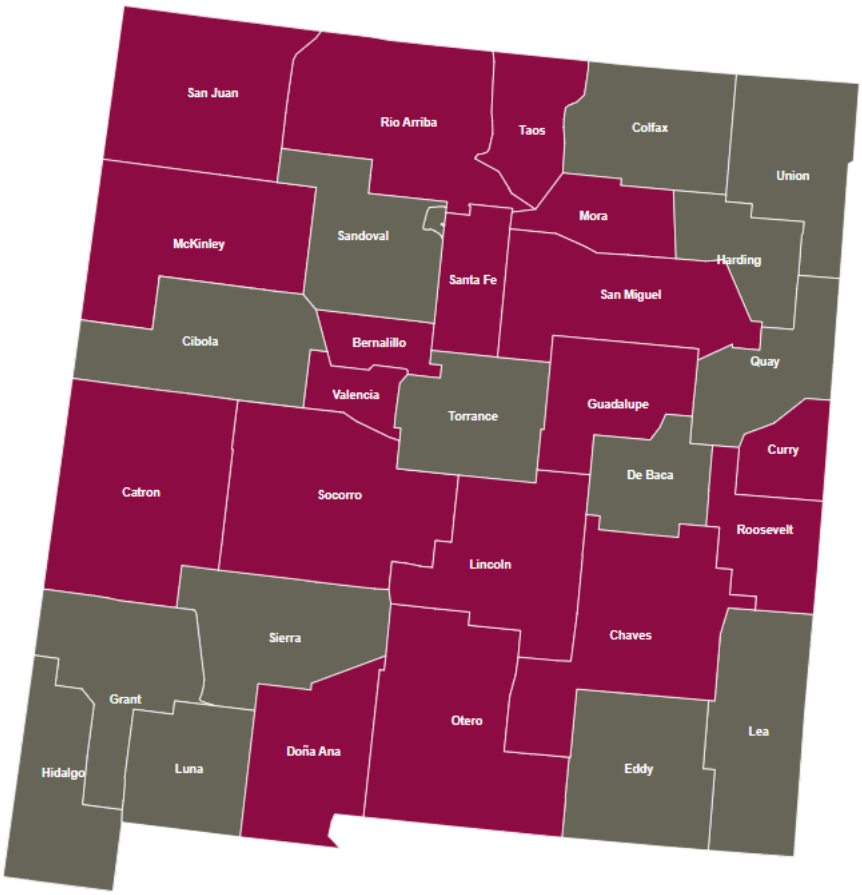
Jicarilla Apache Nation *Jicarilla Apache Nation - Keepers of the River*

Pojoaque Pueblo *www.pojoaque.org*

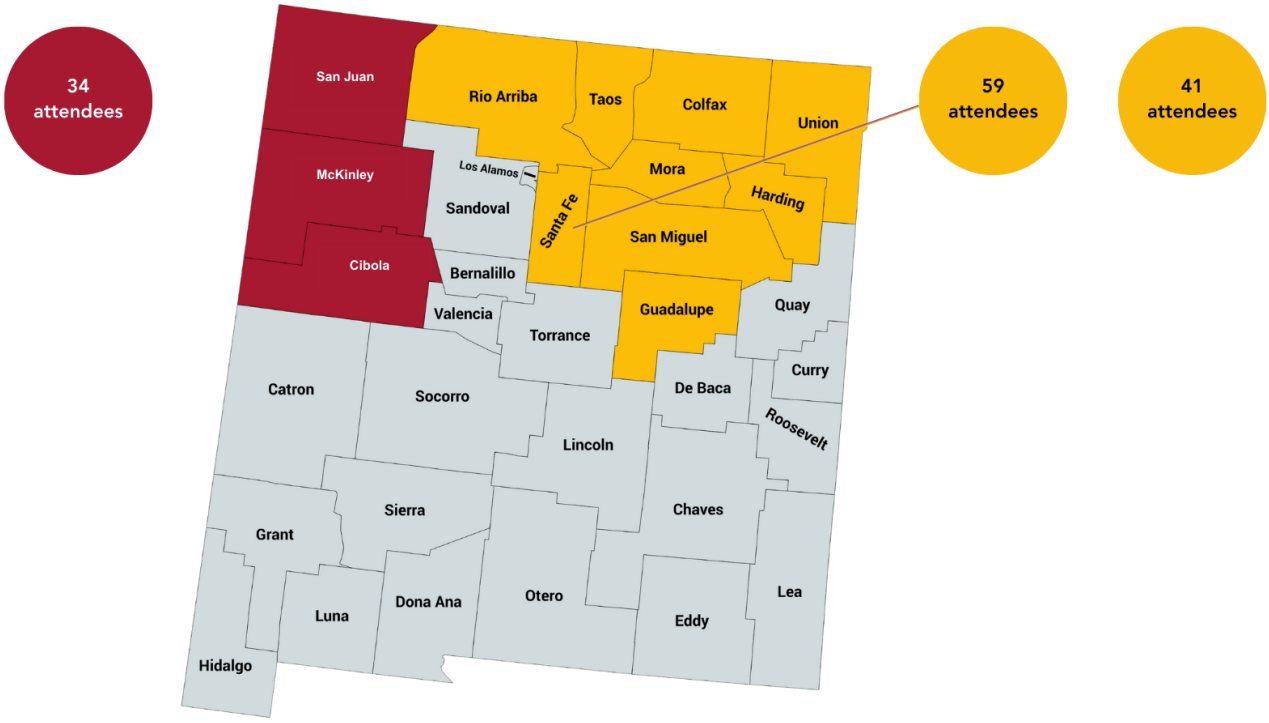
Laguna Pueblo *www.lagunapueblo-nsn.gov*

Zuni Pueblo *www.ashiwi.org*

Additionally, there are many coalitions and groups working together toward shared community priorities. 100% Communities works in many counties across New Mexico as shown below. Here is a link to their website: [100% New Mexico Initiative – Home - 100% New Mexico]



APPENDIX D: COMMUNITY CONVERSATIONS



A total of ninety-four (94) unique participants engaged in three (3) Community Conversations held virtually and in-person hybrid in the northern region. These virtual conversations utilized interactive software called Mentimeter and *Miro* to prompt discussion and feedback on needs, priorities, gaps, assets and opportunities to collaborate for action to improve the health of communities.

PDF copies of each Mentimeter presentation and full results for all conversations can be found here: *www.chipsandsalsanm.com/resources*

Community Conversation Details

Conversation 1: Northeast
Los Alamos County, Nambe Pueblo, Picuris Pueblo, Rio Arriba County, San Ildefonso Pueblo, Santa Clara Pueblo, Santa Fe County, Taos County, Taos Pueblo, Tesuque Pueblo
Date: May 8, 2025
Hybrid: In person at the Santa Fe Medical Center and Online with the use of Mentimeter and Zoom
59 participants

Conversation 2: Northwest
San Juan, Cibola, and Mckinley Counties
Date: May 13, 2025
Virtual: Use of Zoom, Mentimeter, and Miro
34 participants

Conversation 3: Northeast
Colfax, Harding, Guadalupe, Mora, San Miguel, and Union Counties
Date: May 14, 2025
Virtual: Use of Zoom, Mentimeter, and Miro
41 Participants

People Participating in Conversation

Participants reported that they are community members, employees of non-profits or other community-based organizations, public health workers, college/university employees or researchers, local government employees, health insurance or manage care organization staff or leadership, and healthcare providers.

Organizations represented include: New Mexico Department of Health (NM Health), United Way of Central NM, Social Services Division, Pueblo of Tesuque, Santa Fe County, Healthy Climate New Mexico, Bridge to Health NM, UNM Taos, Anchorum, Pueblo de San Ildefonso, The Food Depot, Blue Bus, Nambe Pueblo, Growing Up NM, Taos County, Santa Fe Farmers Market Institute, NewMexicoWomen.org, Tewa Women United, New Mexico Alliance for School Based Health Centers, Guadalupe County Hospital, New Mexico State Congress, Roadrunner Food Bank, Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC), San Juan County Partnership, Valley High School, among others.

Conversation 1: Northeast Los Alamos County, Nambe Pueblo, Picuris Pueblo, Rio Arriba County, San Ildefonso Pueblo, Santa Clara Pueblo, Santa Fe County, Taos County, Taos Pueblo, Tesuque Pueblo Date: May 8, 2025 59 participants	**Conversation 2: Northwest San Juan, Cibola, and Mckinley Counties Date: May 13, 2025 34 participants**	**Conversation 3: Northeast Colfax, Harding, Guadalupe, Mora, San Miguel, and Union Counties Date: May 14, 2025 41 Participants**
		
In what community do you primarily live, work, learn or play?		
Santa Fe 25 Rio Arriba 4 Taos 3 Santa Clara Pueblo 2 Taos Pueblo 1 Tesuque Pueblo 1 Ohkay Owingeh 1 San Ildefonso Pueblo 1 Los Alamos 1 Picuris Pueblo 0 Nambe Pueblo 0	San Juan 26% Navajo Nation 22% McKinley 22% Other 17% Cibola 9% Acoma Pueblo 4%	San Miguel County 21% Colfax County 16% Harding County 13% Union County 13% Mora County 13% Guadalupe County 13% Other 11%
What public health priorities need to be included?		
Poverty Adolescents Free healthcare for all; Universal healthcare.	This falls under sdoh... emergency prep. Things are about to get real.	Housing reading, math, and science literacy childcare

Conversation 1: Northeast **Los Alamos County, Nambe Pueblo, Picuris Pueblo, Rio Arriba County, San Ildefonso Pueblo, Santa Clara Pueblo, Santa Fe County, Taos County, Taos Pueblo, Tesuque Pueblo** **Date: May 8, 2025** **59 participants**	**Conversation 2: Northwest** **San Juan, Cibola, and Mckinley Counties** **Date: May 13, 2025** **34 participants**	**Conversation 3: Northeast** **Colfax, Harding, Guadalupe, Mora, San Miguel, and Union Counties** **Date: May 14, 2025** **41 Participants**
Harm reduction Economic Opportunity, Employment Why the access to care segment isn't a part of the health equity segment Air pollution Youth and teen mental health Postpartum depression screening and treatment Water quality and access; Clean water access Substance abuse Water pollution; safer water Infant health and healthy births Access to dental care (lack of dentists) Nutrition security; Healthy food access criminalization of social problems Making sure all our communities are for secure Housing Re Entry programs Transportation It seems well covered. I appreciate the simplification of the model. Things overlap and have layers in other areas but if we never simplify, language and work get muddled Natural Environment (safe water, air, etc.) Culturally Considerate Healthcare; Cultural Competency Food sovereignty prevention Healthcare Worker Support Combine cold and heat exposure into extreme weather? Aging Population Services Linguistic accessibility Rural and frontier communities Integration of care that encompasses all areas of wellbeing under one roof Childcare; access to childcare Healthcare and community health workers Specialty providers People with disabilities Criminalization of Social Inequity Affordable housing Sewage water dumped in Tesuque by Bishops Lodge	environmental contamination from oil, gas, coal, uranium, and other extracted resources climate "local EMS/Fire Station Healthier foods-gas station food is not healthy, but it is convenient." Closing gaps around resources that exist... create more sustainability, work together for a better network. access to housing Access to healthy foods asthma Transportation Strengthening food assistance programs and access to healthy food Access to basic needs like water and electricity access to behavioral health providers Provider shortage in NW region Advocating for stronger regulations/laws to address environmental pollutants (e.g., anthropogenic pollutants) more school education on STI/STD prejudice Access can be at least 6 aspects . Affordability, vibe, location, eligibility, language, physical barriers, discrimination. access to healthy affordable food road maintenance/update-dirt roads during inclement weather make it difficult for emergency response team to respond in proper time during life/death situations. Trauma informed services Cultural relevant to many sub-sets of people that live in the area addressing substandard housing homeless/housing instability, SUD, AUD Mobile outreach Hiring local professionals and making space for more local	early childhood development Transportation Access to utilities (some households in northern Sandoval lack running water and electricity) housing Water access natural disasters (fire, flood) Employment emergency preparedness and response Food systems Child hygiene in rural areas with low access Environmental racism Utility access physician/health profession shortage Access to Care

Conversation 1: Northeast Los Alamos County, Nambe Pueblo, Picuris Pueblo, Rio Arriba County, San Ildefonso Pueblo, Santa Clara Pueblo, Santa Fe County, Taos County, Taos Pueblo, Tesuque Pueblo Date: May 8, 2025 59 participants	Conversation 2: Northwest San Juan, Cibola, and Mckinley Counties Date: May 13, 2025 34 participants	Conversation 3: Northeast Colfax, Harding, Guadalupe, Mora, San Miguel, and Union Counties Date: May 14, 2025 41 Participants
Providing support to justice involved populations; Carceral involvement; smart decarceration Healthcare workforce shortages Youth strengthening and support Immigrant health Environmental (natural environment, includes water, climate change, air	professionals within the NW region to have a seat at the table for public health strategies and interventions Internet access Access to landfills ex: trash dumping More "easy" access to rapid testing for STI's. And also Harm Reduction County-wide efforts inclusive of Tribal communities	
What assets exist in the community to address Behavioral Health?		
988 ACT Programs ARU BH Program has many activities that are posted by program and also listed in our community newsletter Churches Community Health Workers, Peer Supports, Care Coordinators, CHRs Crisis Lines Family, religious communities, medical clinics, counseling, psych providers, nature Grant that helps find resources In Santa Fe, CONNECT navigation and care coordination partners who are working together to get individuals connected to the resources they are seeking. La Sala Crisis Center Mental Health First Aid training MIHO Mobile Crisis Mutual Aid Networks Pallet Homes Peer Support Programs Santa Fe county has lots of programs Santa Fe Recovery Center School-based health centers Serna Solutions Solice in SFe 💯 % action teams, sbhc, training, providers The Mountain Center Hospital-based MAT Programs Sky Center	Tribal: Acoma Behavioral Health Services IHS BH providers -Gallup "San Juan County/McKinley County/Apache county-Crystal, NM. CHR/CHW TMC-mobile unit-behavioral health NM 988 line" Bernalillo County - UNM's ACT team IHS BH provider - Acoma Health Clinic Navajo Department of Heath has several programs such as Behavioral & Mental Health Services, Navajo Health Education. TMC-Ft Defiance Medical Health Center Iina' Counseling at Northern Navajo Medical Center in Shiprock IHS - Zuni 988 billboard on US 550 ACT = Assertive Community Treatment IHS-Shiprock 988 Traditional healing services Four-corners Detox - Gallup IHS NNMC Street Medicine as a CHW-coordinating health fairs to bring awareness IHS Northern Navajo Medical Center Street Medicine New Mexico Indian Affairs Department Behavioral Health Program	Guadalupe has a task force and participates in LC 4 and a youth heath council focusing on BH our community is working on 988 promotion, QPR and MHFA training San Miguel County Family & Community Health Council-Behavioral Health-988 Mental Health Crisis Hotline Outreach, QPR Training CARES program at El Centro has recently started a behavioral health and substance use partnership Harding County has a very strong Health Council as a driving force. We have settled transportation to and from health care for all residents, vaccinations, health fairs, etc... but mental health is underserved. San Miguel County Family & Community Health Council-Behavioral Health-988 Mental Health Crisis Hotline Outreach, QPR Training Drug Court El Centro - CARES program at El Centro has recently started a behavioral health and substance use partnership Krossroads, NMHU Cares Counseling for student

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211 help line thru United Way of North Central New Mexico NAMI CCBHC initiatives EMT initiation of MAT pilot programs Social Service Program have activities also Telehealth Presbyterian Medical Services La Familia's integrated behavioral health Trainings In Rio Arriba, the shortage of behavioral health professionals has been impactful. Too many people in need, not enough professionals within the few agencies that we have Senior Center's Public Awareness messaging and education TGRC All youth programs, after school Giraffe house Strategic planning Affordable housing. Certified Prevention Specialist Youth Mental Health First Aid instructors Community Health Worker Health Councils Community Health Workers Naloxone training and distribution hubs Polysubstance community coalition Santa Fe Connect FANN FQHC'S Presbyterian MCOs Santa Fe County Religious communities Nonprofits Many efforts are de-centralized which can create its own inertia to implement change COMPOSTELA- :) Dra. Trinidad de Arguello Mother Nature Gerard's house NM Leaders in Recovery The Life Link PMS	Days At A Time - AA center in Ft. Defiance AZ Totah Behavioral Health - San Juan Nizhoni Center detox - Gallup Surely UNM - Gallup students have some access on campus?/ I'm asking for confirmation. Presbyterian Medical Services/ The Navigation Center - San Juan Gallup Community Health - MOUD Acoma Community Health Council - community outreach w/ Tribal programs Healing Circle in Shiprock Johns Hopkins Center for Indigenous Health in Shiprock with many programs focused on mental health (e.g., +Connection is Medicine). Tsehootsooi Medical Center in Ft Defiance has a mental health department. They provide a lot of preventative education and they also have a youth in patient Acupuncture Services https://www.tenvitalservicesnm.org/san-juan-choose-service/ BH/MH Provider Shortage - NW Region Gallup- more behavioral health services/providers, transportation, mobile outreach, prevention activities Youth treatment - adolescent treatment centers Mental Health Taskforce (San Juan) "City of Gallup BH programs Navajo Nation BH programs" Capacity builders for Narcan San Juan Health Council San Juan County Partnership Acoma Health and Human Services Division PMS/San Juan County Acoma Community Health Council San Juan County- Navajo Nation Division of Behavioral and Mental Health	

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Fitness instructors Santa Fe Public schools Peer recovery specialists Nutritionists (gut connection to mood) NM DOH PHOs NM Solutions @ La Sala The Friendship Club The city of Santa Fe with their community fitness centers Dancers and artists brining joy TRIBAL GOVERNOR National dance Institute and their public school programs The Food Depot Internet at public libraries Mobile Food Pantry Closed Loop Referral systems to enable linkage to care My Blue Public Uber/Lyft for $1 each way Specific health rate for BH community members Substance abuse grant funds CHR takes to medical need/appts Harm reduction at Public Health offices Pax Games SB3 Behavior Health passed Teen court Compostela	Traditional Healing Services is provided Navajo Behavioral Health Services. Cibola County Community Health Council Acoma Behavioral Health Services Community Health Center Indian Health Services	
What resources does our community need to address Behavioral Health?		
AA, NA, Al-Anon Address some of the underlying racial and ethnic tensions, such as directly dealing with the plaza in Santa Fe Affordable housing; housing for those in recovery Awareness for elders Buddy systems for people who are socially isolated Community needs to jump on board with having Integration of medical, mental and behavioral healthcare services under one roof. Community resilient support, and training community-based interventions	Parenting Funding for McKinley County Access to transportation (Acoma/Cibola) Training for peer support (for students and adults) Appointments with a shorter wait period More behavioral health providers (Cibola County) Prevention activities Culturally based prevention and healing More youth access/providers BH/MH Provider Shortage - NW Region	We have to find a way to overcome the stigma of mental health so the residents are more willing to reach out for help. Organizations to provide listed MCO benefits We do have an El Centro Clinic 2 days a week in Roy but currently they are not offering mental health services here. support groups for individuals and families Waitlists Guadalupe - BH need more providers/transportation to appointments, training for first responders

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Creation of a public transport route that is centered on linking people to treatment programs - rather than creating one off approaches to transportation services. DOH harm reduction training for schools ? Early intervention Easier access to Narcan vending machines. Education for parents and caretakers Education for seniors/older generations Education/tuition assistance for folks going into the field. Events concentrated downtown Expanded student loan forgiveness Expansion of stabilization centers Fed/national/private NM priority but then denied funding Free, accessible transportation ! Funding Health care hubs in all areas of our communities with assistance from hospitals and clinics, etc. Housing for those in recovery Implementation of BH programs into non-treatment spaces - like libraries, buses Indigenous healers/traditional counselors Lack of MH providers Lak of referrals for services Leadership support Linguistically appropriate services Low population and denied Mental Health outreach More community training More homeless shelters that have behavior health workers (counselors provider) . With outpatient treatment support National Private funders Non-law enforcement crisis management teams Normalization of MH/BH and treatment - maybe more messaging, folks sharing from the community to the community Normalization of traditional healing practices in BH services	Affordable insurance and access to quality healthcare (Cibola) 988 connect locally and not nationally or outside of our region Youth treatment - adolescent treatment centers Eating Disorder Treatment - youth and adults Safe healthy outdoor spaces Self Development for all ages. I think if we can assist one's built on their own positive self esteem n self respect, they will have the tools to combat issues. Funding/health insurance coverage for alternative treatment options (holistic, etc.) Increase Liquor Access Tax Changing norms encouraging others to be open minded with mental health Continued support for universal meals in schools Access to funding sources that allow for Tribal government-BHS applicants Narcan training on reservation Trauma informed supports Reduce stigma in all cultures	medication assisted treatment stigma Physical Health (including chronic and infectious disease, healthy eating/active living)

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Peer recovery specialists Prevention Providers, strengthening of family systems, accountability in public institutions like public schools Referrals Safe use sites. Social workers at the unhoused encampments Strategies to address loneliness Substance use/Narcan request from school Transportation, broadband, and a separate focus on RURAL Trauma informed care and services Wage gap in rural areas We need all levels of care for Addx Treatment - to include more inpatient and outpatient services We need health care hubs that offer health care on all levels.		
What assets exist in the community to address Social Drivers of Health?		
Chaves Center – a city-run community center, but there's a fee to use it 100% initiatives Adelante program at Santa Fe Public schools Beinvenidos BIA Built environment Care Coordination Services Churches/faith leaders City City and County Home Delivered Meal Programs Commodities Program Community foundations (NMF, TCF, SFCF, LVNMCF, LACF) , 100% initiatives Community gardens Community Resource guide Comprehensive transportation system CYFD SKY and APS reports for child/adult abuse/neglect Early childhood and after school programs EarthCare Employees ENIPC-commodities Esperanza	McKinley Community Health Alliance (health council) Acoma Food Distribution Program number of retailers accepting SNAP benefits Navajo Special Diabetes Program Navajo Chapters Acoma Community Health Office Tooh Holtsooi Community Center in Sheepsprings Acoma Social Services Care Coordinators, Community Health Workers, Peer Support Workers Navajo Health Education & Navajo HIV Prevention Program Senior Centers "Senior Center-DALTCs- The Division of Aging and Long-Term Care Support" Acoma BHS Prevention Team CHRs CHW Echo Food Bank NMED surface, drinking, and potable water monitoring	TFD has been the only food security provider in a few areas Harding County has a very strong Health Council as a driving force. We have settled transportation to and from health care for all residents, vaccinations, health fairs, etc... but mental health is underserved. Food Depot also handles Harding County. San Miguel Early Childhood Coalition: Working with Northern Roots with Presbyterian Health Plan giving families a meal bag each Friday for 16 weeks. Drug Court NMSU community garden and kids cooking Food depot serving multiple counties, but existing as a singular org - supporting these different locations San Miguel county, specific san Miguel rural area has right now access to 2 different food

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Farmers Market Nutrition Program Federally qualified health centers Food banks Food distributions Food in Medicine Services and Programs Foundations/ Philanthropy Free Flow NM Health Councils Health Policy Planning Commission (city/county, needs to be engaged) Homewise Housing Community Housing Specialists w/in MCOs Interfaith community shelter Kitchen angels Many Mothers MCOs Meals on Wheels Men's groups Mobile farmers market thru SFe farmers market. Mobile shower programs. Mutual aid programs Narcan Newly developed (or developing?) – Housing Trust NM DOH-Public Health Offices NM DV Resource Center NM Housing Coalition NMDOH Public Health Offices NNM has a robust network of cbos and healthcare working together Nutritionist Police/Law Enforcement Pres' Health Equity Training series Pres' SDOH Wheel Presbyterian Produce rx programs Resource guides Reunity Resources RX, Needle disposal Santa Fe Connect Santa Fe Mountain Center Senior centers Senior Centers, City Parks SF Farmers' Market Institute SNAP/DUFB Soup kitchens	NM Social Justice Equity Institute - Gallup Gallup Community Pantry School districts McKinney Vento programs Gallup Solar Community Pantry (Gallup) NMSU Extension Office Senior farmers market McKinley Recycling Haak'u Learning Center - Family Education nights and Father Education nights DigDeep (water access - new site coming to Thoreau) Navajo Nation Institutional Review Board More funding Strong Father program by John Hopkins MCOs Cibola General Hospital and their expanding network in Cibola County Bernalillo County Jail and NM State Detention Centers Political will is needed. Have to activate our people! Silver Sneakers Programs IHS Northern Navajo Medical Center Shiprock Health Promotion/Disease Prevention	pantries and libraries. Working on getting more food programs. Working with land grant to educate on local culture. Working with our local school to also allow more access to the food provided through the food depot along with sanitary and hygiene products as well. We do have an El Centro Clinic 2 days a week in Roy but currently they are not offering mental health services here.

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State government Taos, Housing Partnership, Dream Tree Project Nest, Blue bus, Community Against Violence, volunteers, Tewa Roots (therapy) Tewa women United The Food Depot The Mountain Center Transportation Tribal Government UNM Vital spaces, a new nonprofit Well trained people who are paid well enough so they stay WIC program		
What resources does our community need to address Social Drivers of Health?		
Funds; $ More housing ; affordable/income based housing More affordable housing. More outreach Better transportation options A Consistent Healthy Food Source Transportation Permanent Supportive Housing (PSH) Well trained people who are paid well enough so that they stay Higher wage that reflects cost of living Administrative support: to keep websites updated, to make and print handouts, etc Connected communities Employees Tribal voice/input More individuals working in these fields who are kind and supportive Local government, regional collaborations, communication, legislative changes, (and to NOT duplicate) Resources Center that are one stop shopping to get connected to resources Acceptance of issues Vocational and workforce development programs that enable paths to healthcare and social care jobs Food transportation, aggregation and distribution network, esp. for rural and frontier communities	Crystal, NM-EMS/Fire Station Access to reliable internet on rural - Tribal lands More funding More food pantries to administer federal programs like the Emergency Food Assistance Program and Food Distribution Program on Indian Reservations Universal Income! more community interaction Out of the Box funding for SDOH Linkage to services provided. Approved legislation Safer and well-lit walking/biking/hiking paths (Cibola) More connection - lots of screenings and good work out there, but would be great to generate more power together. Closed loop referrals. Ensure connection to resource was able to be made. Navajo Nation participation/inclusion/invitation in San Juan county-wide initiatives More prioritization from local governments to fund healthy built environments – bike lanes, green space, sharps disposal Increased funding for mobile food distributions to Tribal communities	Accessible, reliable transportation Senior community engagement activities Youth mentorship & apprenticeship opportunities SDHealth: housing shortage, food desert - transportation for specialty health care A reliable and fully functioning water treatment plant and updated water lines alternative transportation outside 8-5 hours transportation to county seat from more distant villages Sidewalks, crosswalks centralized social service location Education (very low proficiency in reading, math, science)

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Support for small business to diversify local economies Team approach How do we make it easier for healthcare and community providers to live here - higher wage, housing. for the communities that are more remote, maybe a bus that visits those communities intermittently to share resource information Digital literacy support in addition to internet access Collaboration between organizations. CBOs and non profits support/empathy SF Workforce Connection City infrastructure and population growth Lack of willingness to embrace the future Firearm Violence Start in schools – talk about firearm access and operation – address that knowledge. Build resiliency and mental health Road Violence/rage/anger PDAs to address road violence and anger, encouraging people to eat local, healthy, and traditional. Messages need to be community-centered and built. Can include daytime TV distributions, and messaging for all interventions should have a positive spin, highlight the public good. Can also use Spotify because people listen and there's no scroll-by like on social media. Age range to focus on 18-25 for many interventions Vandalism -source? Anger, hopelessness, despair, boredom, inebriation How do we address? Build resiliency, especially with younger people Build compassion and empathy, community pride? For kids age 11-12, engagement and resources disappear – they are unwanted in spaces, lack of accessible spaces to exist in a space where they're	Food sovereignty initiatives Development of NM County and Tribal Think Tanks - to implement solutions increased support and access to harm reduction interventions Solar powered trails Adventure Gallup	

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too old for after school programs, but too young for independence (i.e. malls) Southside needs a community center Build a teen center? Housing crisis Tax the Rich – many homes in SF are peoples' second or third homes or AirBnBs – increasing taxes on these types of homes could provide more funds to reinvest in community. Shelters are needed for unhoused people, but the wealthy are fighting placement of those houses – trying to push them out of town instead of supporting programs to support people experiencing homelessness. There's a big wealth gap. Additional crises include sanitation – we need free and accessible public restrooms and sanitation stations to address human waste and information campaigns/places to get tent cities out of arroyos. Reservations experience food insecurities. Lack of access to CDSM programs in rural areas. Could focus on cooking and grocery shopping education. Education should include interpretation and cultural appropriateness around food, counseling, and meds. Could include food suggestions in appropriate language and to the culture Need more understanding of health in languages and cultures – interpretive services, health literacy of providers		
What assets exist in the community to address Physical Health?		
Recurring funding for exercise & nutrition community activities Health council network in counties and tribes Wellness- monthly health challenges staff/community Ages 18-24 to utilize the center and participate in events Silver sneaker program for seniors Mobile clinics Farmers markets and traditional Ag. Bridge to Health NM	Wellness Center Wellness centers Open spaces NM physical education requirements in schools Schools sports programs Walking/hiking trails Just Move it across the Navajo Nation Healthy Kids Healthy Communities CHW/CHR -- Diabetes & Heath Educators	Physical Health - Guadalupe county Healthy Kids Healthy communities grant focusing on healthy eating, access to food and active living Harding County has a very strong Health Council as a driving force. We have settled transportation to and from health care for all residents, vaccinations, health fairs, etc...

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Diabetes program Medical and Dental Clinics Food Depot NMDOH-Public Health Offices Healthy kids program Rec departments Presbyterian Healthcare services YMCA PE teachers Girls Inc. Senior program Many of the same stakeholders are trying to address all of these issues at the same time. Teen Centers (YMCA) Mamas ROAMS Grandmamas Holy Cross and other Health Systems Medical providers Family members and support systems are the larger population of healthcare caregivers - all of which are rarely compensated CHR/CHW Rio Arriba Adult Literacy Program HCA MAS communidad, IHS, Holy cross hospital, Taos Whole health, SBHC, Centralized systems and care lines to make access smoother and easier DOH programs Oral health Paths to Health NUPAC 988 line Who should be at the table? Housing department Seniors Physical activity classes Safety Program – housing (i.e. fire stove safety) Young adults and youth Environmental Depts Waste dept. Recycle dept. Housing dept. Food dept./prog	Navajo Nation programs Boys & Girls Club Silver Sneakers Programs Senior Centers Adaptive Sports Programs NMDOH Mobile Vaccine Unit Team HIV educational specialist _ Fannie Jackson Acoma Senior Center - Wood distribution program La Vida Felicidad Early Childhood Education Program - Cibola County Gallup Silver Stallion Bicycle Ft. Defiance Medical Center-Mobile Unit Shiprock Health Promotion program (IHS) Free gym memberships to elders. Increase education on mobility MCO tribal liaisons CHR/CHW Ft. Defiance Indian Medical Center-Wellness team Health Educator Fitness specialist from Navajo Special Diabetes Program Acoma Parks & Recreation Team - certified personal trainers Boys n girls club in ft defiance PMS	but mental health is underserved. We do have an El Centro Clinic 2 days a week in Roy but currently they are not offering mental health services here. TFD is working with MCOs to promote & implement the Food As Medicine statewide initiative Alta Vista, Sunrise Clinic, school based health centers Colgate offers kits for prek to 1st grade teachers to provide for their classes. Pepsi has a recycling program for schools as well. El Centro Family Health is a federally qualified health system with several locations, one is in Las Vegas Highlands U., Luna Community College, Recreation center, little leagues, gymnastics, dance, cheer, riverwalk, hiking at Las Vegas National Wildlife Refuge

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What resources does our community need to address Physical Health?		
Employees More providers Healthcare workers Affordable Cancer/radiation treatment Free healthcare for all Education Bilingual providers Better schools to keep providers with families here Safe, high-quality affordable primary care for all Wellness Policy Funding Establishing trust in the health care system so patients seek care they need Affordable healthcare Billing More medical specialists in the state; plus transportation to get there Personal accountability to do what we can to keep our bodies healthy Removal of co-pays More training on person-centered/ whole-person care Fewer fast food chains Extreme weather and emergency systems with prevention, warning, and response Access to more nutritious food. Trails, Nutrition, Transportation, access to nutritional food, Access to preventative screenings and care Strong community, wide of vaccination access, and equity "Free/ cost effective Internet services for connectivity for telemedicine" Telehealth Transportation Early intervention FIT More access to STI testing More rapid test for more STI Fresh produce is lacking Cannabis- increased growers and water consumption for it Built environment	Mobile cancer screening More community access to wellness centers More fitness/wellness centers for those at high risk of diabetes and other chronic illnesses/diseases Chapter officials to open up the local gym at the chapter or wellness center. Access to healthy affordable foods More access to walking trails Evening events for families SAFE walking trails with LIGHT At home exercise programs Peer coaches for support Solar powered trails Access to basketball courts, playgrounds, volleyball courts, trails, etc. Community access to Wellness Funding at Chapter level to develop wellness center, walking trails, etc. Safer/paved biking-walking paths (New Laguna has a great dedicated side path situated away from the main drive road) Land access	Organizations to provide listed MCO benefits FREE recreation Safe access to outdoor spaces Reliable gym hours, lifeguards, staffing access to variety of produce and encouragement to use the farmers markets San Miguel county, specific san Miguel rural area has right now access to 2 different food pantries and libraries. Working on getting more food programs. Working with land grant to educate on local culture. Working with our local school to also allow more access to the food provided through the food depot along with sanitary and hygiene products as well. Intramural teams for adults

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Sidewalks or safe walking Powerlines (electric) Internet access Community programs- engaging youth in a more on going/involved way – but how exactly?		
What assets exist in the community to address Access to Care?		
CHRs/CHWs La Familia Senior Centers NM DOH-Public Health Offices PMS Libraries Transportation policy Community Health Workers and navigators Telehealth Connect BH/Social Services Smartphones Ride United for elders and low income who need transportation to their appts, etc. The two low-cost Dental clinics Internet HCA Community College Education Programs Partnerships with NM Oral Health Required High school health classes, which vary inequality PROSA Institute, Mobil Mexican Consulate for health literacy Health Care Authority Compostela - CHW/ CHR education High school health classes which vary in quality Presbyterian Food Depot Outreach Diabetes intervention Food Depot in Nambe- more volunteers to help from the community Santa Fe Connect Harm Reduction Mountain Center Needle exchange Testing Blue Bus	Health care organizations Indian Health Services in Region MCO Tribal Liaisons San Juan Regional Medical Center Navajo Department of Health IHS Public Health Nurse CHR/CHW at the local chapters on Navajo Nation-who advocate for community members NMDOH Public Health Office Community Health Centers Navajo Nation CHR/CHW across navajo nation and part of hopi	First Born of Northern New Mexico Home Visiting Program with access to breastfeeding information, developmental milestones, and bonding and attachment. West Las Vegas Head Start/ Early Head Start Nurse promoting access to care for families and children including a health fair in June with onsite dental care for children. WIC for families to access nutrition and breastfeeding resources. Harding County has a very strong Health Council as a driving force. We have settled transportation to and from health care for all residents, vaccinations, health fairs, etc... but mental health is underserved. early childhood network El Centro - El Centro Family Health is a federally qualified health system with several locations, one is in Las Vegas Drug Court Alta Vista, Sunrise Clinic, school based health centers

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People can boo rides for anything North regional transport services $1 each way People need to be aware. It's underutilized Espanola, Tesuque, Chimayo Can use for anything! MyBlue Community Health Funders Alliance Christus Anchorum NM commission for the deaf and heard of hearing The DOH id s good asset Coming Home Connection Serving older adults OPRE listserv Rooted in community Help build an effective coalition CHR/CHW Transportation for Nambe tribal members CHR/CHW All healthcare systems are continuously work on this issue CHW and Peers CONNECT Presbyterian Health & Human Services FQHC's NM DOH- Public Health Offices Navigators, 100 %, hospital, MAS comunidad Social services division Health Councils How do we strategize funding cuts due to current administration		
What resources does our community need to address Access to Care?		
More Spanish speaking providers Healthy foods and transportation to be clinics and Drs appts Funding Shorter wait times which I think is related to shortage of medical workers Centralized systems and carelines that serve as one stop shops for linkage to care. And these lines need to be managed by people not technology	transportation Education around resource availability Need providers Transportation More awareness of currently available resources More providers Make access to care affordable more exposure to health careers for students	Statewide provider shortages Waitlists Guadalupe - BH need more providers/transportation to appointments, training for first responders SDHealth: housing shortage, food desert - transportation for specialty health care

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We need to tools that help with visualizing capacity management and availability of services More tailored resources across the lifecycle People need to read flyers, resource guides, newspaper, etc. There is a lot of information out there they people don't slow down enough to actually read Bilingual navigators Mobile health clinics, trainings, etc for RURAL. Transportation system, such as Golden Spread. Mobile health literacy, schools Affordable or no cost health care insurance More support groups like the dementia caregiver support groups Health care, food, financial literacy hubs as a one stop "shopping" place for access to support NM DOH- Public Health Offices The Human Rights Alliance Not childcare Not enough Transportation Early intervention and FIT Up north esp- a lot of people may not have access to electricity/internet Language equity- bilingual people Missing from the table- Deaf/Hard of hearing community (Commission, NMSD)	Health literacy for providers including translation services and how to communicate with patients Housing to attract providers Grow our own providers More media output in the Navajo Language BeWell NM advocates for community sign-up/education on health insurance options	Physician shortage (especially specialties, [OB/GYN, surgeons, cardiology]) Organizations to provide listed MCO benefits Education (very low proficiency in reading, math, science)
What assets exist in the community to address Health Equity?		
Transgender Resource Center Rural OB Telehealth and Support Services- ROAMS UNM and Office of Community Health trainings. I will out URL in chat Presbyterian has an extensive HE team Vaccine clinics FQHCs NM DOH- Public Health Offices cross training of health employees Medical centers The Human Rights Alliance UNM's Office for Community Health Training Opportunities Dashboard more staff	Gallup PRIDE is active! Equity NM Transgender resource center of NM Local healthy food sources Translators outreach programs First nations community healthsource	El Centro TFD is working with MCOs to promote & implement the Food As Medicine statewide initiative; initially focused on gestational folk & seniors These areas have great, active health councils Alta Vista, Sunrise Clinic, school based health centers

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Funding Positive deviance Unhoused outreach- coalition and community building before the intervention is implemented to ensure buy-in and success instead stigma Food Depot- FIM SDOH Initiative Birthing people- gestational diabetes/seniors Bilingual/immigrant communities- accessibility and specific dietary needs UNM CHR/CHW Presbyterian Community Health NMAHC Compostela/ PROSA Institute NMDOH Still working on collaborations and comings together. 100% Rio Arriba Initiative- Bridge to Health is the only one I know here in Rio Arriba.. Better alignment across community efforts and initiatives NMDOH-Public Health Offices Development of Community-based HE dashboards - similar to some of the visualizations that they are doing for opioid reparation funds. 100 Taos, MAS Interfaith/housing- transport route for health needs around town (NCRTD)- social service ambassador Trauma informed care, small rural communities Elders don't believe in internet- secluded Esp program teniors- teens helping seniors with IT NCRTD- veterans/peer and comfort with speaking together Peer support, partnership with VFW and American Legion Outreach to pull in more partners		
What resources does our community need to address Health Equity?		
Healthcare Hubs Stable funding Providers	Two Spirit Collective of community members and professionals in NW NM region to collaborate More indigenous doctors	Statewide provider shortages, esp. for diverse & traditional communities Physician shortage

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Many programs are grant and episodic based which makes continued progress difficult more staff State funding Multi-lingual resources, providers, etc. Rural OB Telehealth and Support Services Expand trainings to roles you might not think "need" it - increase the messaging on a large scale. Family stability/early childhood focus Language in equity- barriers or lactation (rare bilingual IBCLC) and other related services Prenatal à pre-K à as you get older fewer services available (except early intervention) Entering school w/o assessments and who to refer to when shortage of providers Rural RA (TA area) complete absence United Health approached to expand to AM and RA – didn't fund because of lower population density reflected in data Time and $ to meet gaps in rural NM Inequity of relying on traditional sources of data for understanding and responding to tribal needs Ongoing issues for Toas County (diverse NE communities) – Services based on data for entire county but actual services in town of Toas but not accessible to highest need rural communities with highest need- should require physical access points- no other access options (no transportation & expensive) so many people go w/o services Get creatives- priority for resource distribution Job access, nutrition security (seniors too, telehealth access and access solutions) Birthing people- lack of specialties and often lack of OBGYN- have to travel to Toas Hospital, OED, SF Ppl dying trying to travel to delivery	Local healthy food sources Hospital systems are still oppressive. - need more training and hiring best practices Prevention and wellness screenings More programs like Safe Rides Meetings with community leaders to find out what the need , instead of making recommendations with their input Education / Training for Tribal Administrations on how to show up and advocate	stigma

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More cost effective to concentrate services in higher density pop areas Need solutions- rural clinics/rotating specialists in hub-and-spoke model Nambe/NA- go to IHS but to go our have to get approval to go to other healthcare- comfort barrier Barriers with electronics Hearing impaired vets- communicate through test to help navigate- Esp VA hard to reach and not many services Transportation to ABQ/services- vets, seniors Solution for vets, traveling together for social support (esp. Toas)		

APPENDIX E: ADDITIONAL PEOPLE WITH INPUT INTO THE COMMUNITY HEALTH ASSESSMENTS AND COMMUNITY HEALTH IMPLEMENTATION PLANS

We work together with our staff, our governing boards, the New Mexico Shared Community Health Needs Assessment Collaborative (NM-SCHNA), our community partners and other coalitions to invite feedback from:

- People with special knowledge of or expertise in public health
- Federal, tribal, regional, state, or local health or other departments or agencies with current data or other information relevant to the health needs of the community served by the hospital facility.
- Leaders, representatives or members of medically underserved, low-income and minority populations, and populations with chronic disease needs, in the community served by the hospital.
- Business and economic development professionals, and non-profit leaders

Community members, patients, insurance plan members, staff, network providers, and others are invited and encouraged to contact the Presbyterian Community Health Department *CommunityHealthTeam@phs.org*, at any time with any additional comments and input.

In addition to the direct feedback we received from participants at the community conversations, many others give input into these assessments and plans.

Presbyterian Community Health Maintains its own Advisory Committee which plays an essential role in guiding and sharing the vision of Community Health by bringing expertise and diverse stakeholders together to invest in improved health in the community.

Presbyterian Community Health Advisory Committee Members	
Helen Wertheim Board Member Presbyterian Healthcare Services	Barbara Balik Ed.D. Faculty, Institute for Healthcare Improvement Board Member, Presbyterian Healthcare Services
William Wiese, MD, MPH Associate Director and Senior Fellow for the Robert Wood Johnson Foundation Center for Health Policy University of New Mexico	Revathi Davidson, MA, MPH Retired Healthcare Administrator
Caitlin Chestnut, MD Family Practice Clinician and Medical Director Presbyterian Healthcare Services	Shelley Man – Lev, MPH, Certified Prevention Specialist Executive Director Healthy Climate New Mexico
John Bell President and Chief Strategist NextNow Digital Board Member, Presbyterian Healthcare Services Board Member, Explora Science Center	Melissa Toledo-Ontiveros MA, MCJ, MPA Special Operations Coordinator Community Action Agency of Southern New Mexico
Jessica Tsabetsaye, MS Physician Assistant and Medical Director of Practice Operations Presbyterian Healthcare Services	Kenneth Thompson, CFRE Vice President, Major & Planned Giving Presbyterian Healthcare Foundation

Santa Fe Medical Center is governed by a volunteer Board of Trustees made up of members of the community who represent different backgrounds and sectors including business, health, and many others. These board members give invaluable input and approval for the finalization of these assessments and plans.

Presbyterian Santa Fe Medical Center Board Members	
Christine Cassell, MD	V. Sue Cleveland
Brian Fantl	Angelina Flores-Montya
Monique Garcia	Tracy Hartzler
Christopher Loucks, MD	Janice Lucero
Eric Magaña, MD	Thao Marquez, MD
Scottie Pierce	Mary Romero Hart
Jessica Tsabetsaye, PA-C	John Van Drimmelen
Walter Voigt, MD	