Health Behaviors and Conditions of Adult New Mexicans

Results from the New Mexico Behavioral Risk Factor Surveillance System (BRFSS) 2017 Annual Report

BRFSS
Behavioral Risk Factor Surveillance System

NEW MEXICO DEPARTMENT OF HEALTH

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Acknowledgements

The New Mexico Department of Health and the Epidemiology & Response Division would like to thank the residents of New Mexico who participated in the 2017 survey of the Behavioral Risk Factor Surveillance System (BRFSS). These participants gave their time and described their health status and related behaviors to help improve the health of all New Mexicans. This report would also not be possible without the tremendous work of the team of interviewers who conducted the interviews.

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BRFSS data and supporting documentation are available at:

www.cdc.gov/brfss

Or

https://nmhealth.org/about/erd/ibeb/brfss/

Additionally, BRFSS data and copies of this report and the 2017 questionnaire can be obtained by contacting:

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Overview

What is the BRFSS?

Chronic disease, injury, substance abuse, and infectious disease are the leading causes of morbidity and mortality in the U.S. The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing, nationwide surveillance system that collects data on the prevalence of health conditions in the population and behaviors that affect risk for disease and injury. The surveillance system uses telephone survey methods to collect data in all 50 states, the District of Columbia, Guam, and Puerto Rico. Individuals who are 18 years of age and older, use a cell phone or live in a private residential household with landline telephone service, are eligible for the survey. Adults who do not have a cell phone for personal use and do not have access to a landline telephone are not eligible for the survey. Additionally, adults who live in college dormitories, nursing homes, or group homes and do not have a cell phone for personal use or live in institutions, such as prisons, are not eligible for the survey.

The BRFSS was initiated in the early 1980s after significant evidence had accumulated that behaviors played a major role in the risk for premature morbidity and mortality. Prior to that time, periodic national surveys were conducted to evaluate health behaviors for the entire United States, but data were not available at the state level. Because states were ultimately responsible for efforts to reduce health risk behaviors, state level data were deemed critical.

At about the same time, telephone surveys were emerging as an acceptable means of collecting prevalence data. Telephone surveys were relatively easy for states and local agencies to administer. As a result of these concurrent developments, telephone surveys were developed by the Centers for Disease Control and Prevention (CDC) to monitor state-level prevalence of the major behavioral risk factors associated with premature morbidity and mortality. Feasibility studies were conducted in the early 1980's, and the CDC established the BRFSS in 1984 with 15 states participating. New Mexico began participating in the BRFSS in 1986.

The CDC has developed a core set of questions that is included in the questionnaire of every state. Optional modules of questions on a variety of topics have been developed by the CDC and made available to the states. Additionally, states are free to include other questions that have been borrowed from other surveys or developed by the state, provided that space is available in the questionnaire and the state provides funding to cover the additional cost. Such questions are referred to as ‘state-added’ questions.

Participation in the survey is voluntary, and all data collected are confidential. The identity of the respondent is never known to the interviewer, and the last two digits of the phone number are never sent to the CDC. The CDC removes the remaining eight digits of the phone number from the data file after completing a quality assurance protocol.

The BRFSS is supported and coordinated by the Division of Population Health, Population Health Surveillance Branch, of the CDC.

The CDC has a web site dedicated to the BRFSS:

http://www.cdc.gov/brfss

This 2017 NM BRFSS report is available in .pdf format at the NM Department of Health website:

https://nmhealth.org/about/erd/ibeb/brfss/data/

Overview

2017 New Mexico BRFSS Topics

Core CDC Components (all states):
Alcohol Consumption
Arthritis
Asthma
Cancer
Cardiovascular Disease Prevalence
Chronic Obstructive Pulmonary Disease
Colorectal Cancer Screening
Depression
Diabetes
Disability
Exercise (physical activity)
Health Status
Healthy Days
Health Care Access
HIV Test History
Immunization
Kidney Disease
Tobacco Use—Current Cigarette Smoking
Fruits and Vegetables Intake
Seatbelt Use

Optional CDC Modules:
Childhood Asthma Prevalence
Industry and Occupation
Pre-Diabetes
Diabetes
Caregiving
Family Planning/Preconception Health

Demographics Section (all states):
Age
Annual Household Income
County of Residence
Current Pregnancy Status (female respondents < 45)
Education
Employment Status
Gender
Height
Housing (Own or Rent)
Marital Status
Number of Children in Household
Number of Residential Telephone Numbers
Race/Ethnicity
Telephone Coverage
Veteran Status
Weight
Zip Code of Residence

State-added Questions on the following topics were included:
Chronic Pain
Sexual & Intimate Partner Violence
Suicide
Gender Identity
Sexual Orientation
Tribal Affiliation

Limitations and Strengths

Individuals without cellular telephones for personal use and who do not belong to a household with a landline telephone are not eligible to participate in the BRFSS survey. Data collected by the Bureau of the Census under contract with the Federal Communications Commission (FCC) indicate that unemployed persons and lower income households are less likely than other residents to have telephones. Consequently, the BRFSS sample is likely to include a greater proportion of higher income households and employed persons than the population of the state as a whole.

In recent years, a rapidly growing portion of the adult population has been moving to exclusive use of cellular telephones. This shift is most pronounced among younger adults but has been accelerating and has included all age groups in recent years. For a decade, the Centers for Disease Control has been actively studying the issues related to inclusion of cellular telephones in the BRFSS and other telephone surveys. The information gathered through these studies has been used to prepare for the inclusion of cell phone numbers in the BRFSS. Beginning with the 2011 BRFSS, cellular telephones were included as a formal part of the sampling process and in 2017 cellular telephone interviews were included in the data analyzed for this report.

The BRFSS relies on adults to provide information on their own health behaviors and conditions. Respondents may be reluctant to report behaviors that are considered undesirable such as drinking and driving. Respondents may also have trouble remembering details about past behaviors or may remember them incorrectly. Consequently, the prevalence of these behaviors may be underestimated by the survey.

Telephone interviews have a number of advantages over other sampling methods such as face-to-face interviews and self-administered questionnaires. The lower cost of telephone interviews makes it possible to include a larger number of adults in the survey than would be possible if a face-to-face survey were conducted. Telephone surveys are also easier to monitor for quality assurance purposes than are face-to-face surveys. Telephone interviews are administered by a trained interviewer while self-administered mail-out surveys may be affected by the literacy of the selected respondents and could be completed by family members other than the one selected, which may affect the accuracy of the information collected.

Overview

Limitations and Strengths

Response Rates

The measures of response presented here were designed to summarize the quality of the 2017 BRFSS survey data. The Response Rate, Cooperation Rate, and Refusal Rate for the 2017 BRFSS were calculated using standards set by the American Association of Public Opinion Research (AAPOR). The Cooperation Rate presents the percentage of complete and partially completed interviews among contacted and eligible respondents. The Refusal Rate presents the percentage of refusals among all eligible and likely eligible phone numbers in the sample. Separate cooperation and refusal rates were calculated for landline and cellular telephone samples. The Response Rate is a measure meant to provide an overall summary of survey administration and response. Separate response rates are calculated for landline and cellular telephone samples, then a combined summary Response Rate is calculated by combining the individual rates, weighted to the respective size of the two samples.

Response Rates, New Mexico and U.S., 2017						
	Landline		**Cellular**		**Combined Landline & Cellular**	
Rate	**NM**	**US**	**NM**	**US**	**NM**	**US**
Response Rate	47.3%	44.2%	50.9%	45.8%	48.4%	44.9%
Cooperation	57.9%	63.8%	82.6%	82.5%	*	*
Refusal	22.1%	15.5%	9.4%	7.3%	*	*

*Unavailable in 2017.

Overview

Data Presentation

The data in this report are presented in either tables or graphs, and are the estimated population percentages of adults with a particular condition, risk factor, or behavior. Like any estimate produced from population surveys, the estimates produced from the BRFSS are subject to error . Two related measures of error are the standard error (SE) and the 95% confidence interval. Stata/MP 14.2 was used to estimate SE and to produce the corresponding 95% confidence interval estimates presented in this report. Stata/MP 14.2 is statistical analysis software that considers the complex sample design of the BRFSS to calculate appropriate SE and 95% confidence intervals.

In the tables presented throughout this report, the weighted population estimates along with the 95% confidence intervals are shown. By BRFSS convention and the NMDOH Small Numbers Rule, when a particular estimate is based on less than 50 respondents, the weighted percentage, and associated 95% confidence intervals are not presented because estimates based on small sample sizes are considered unreliable. Bar graphs included in this report include the 95% confidence interval corresponding to the relevant point estimate.

Five race/ethnicity categories are presented. American Indian (presented as AIAN), Asian or Native Hawaiian or Other Pacific Islander (presented as Asian/NHOPI), Black or African American (presented as Black/AA), Hispanic, and White (which refers to non-Hispanic White). Asian and Native Hawaiian or Other Pacific Islander are grouped together, which is a common convention when the sample size of Asian and/or NHOPI respondents is too small to present as a distinct group. Respondents reporting Hispanic ethnicity were coded to Hispanic regardless of self-reported race.

In general, population estimates with smaller standard errors (SE) are more precise and reliable than population estimates with larger SE. Sample size influences the magnitude of an estimate's probability of error and so affects the likely precision of the estimate. This issue is particularly relevant to some estimates presented by race/ethnicity where the number of AIAN, Black/AAs, and Asian/NHOPI sampled was small, resulting in large SE and estimates that were unreliable. Discerning possible differences between rates of conditions or risk factors in these smaller populations and the larger White, non-Hispanic and Hispanic populations was often difficult. This issue is relevant to estimates for any small population group, such as a narrowly defined age group, a small number of respondents with a particular health condition, or a small demographic group such as adults who were retired.

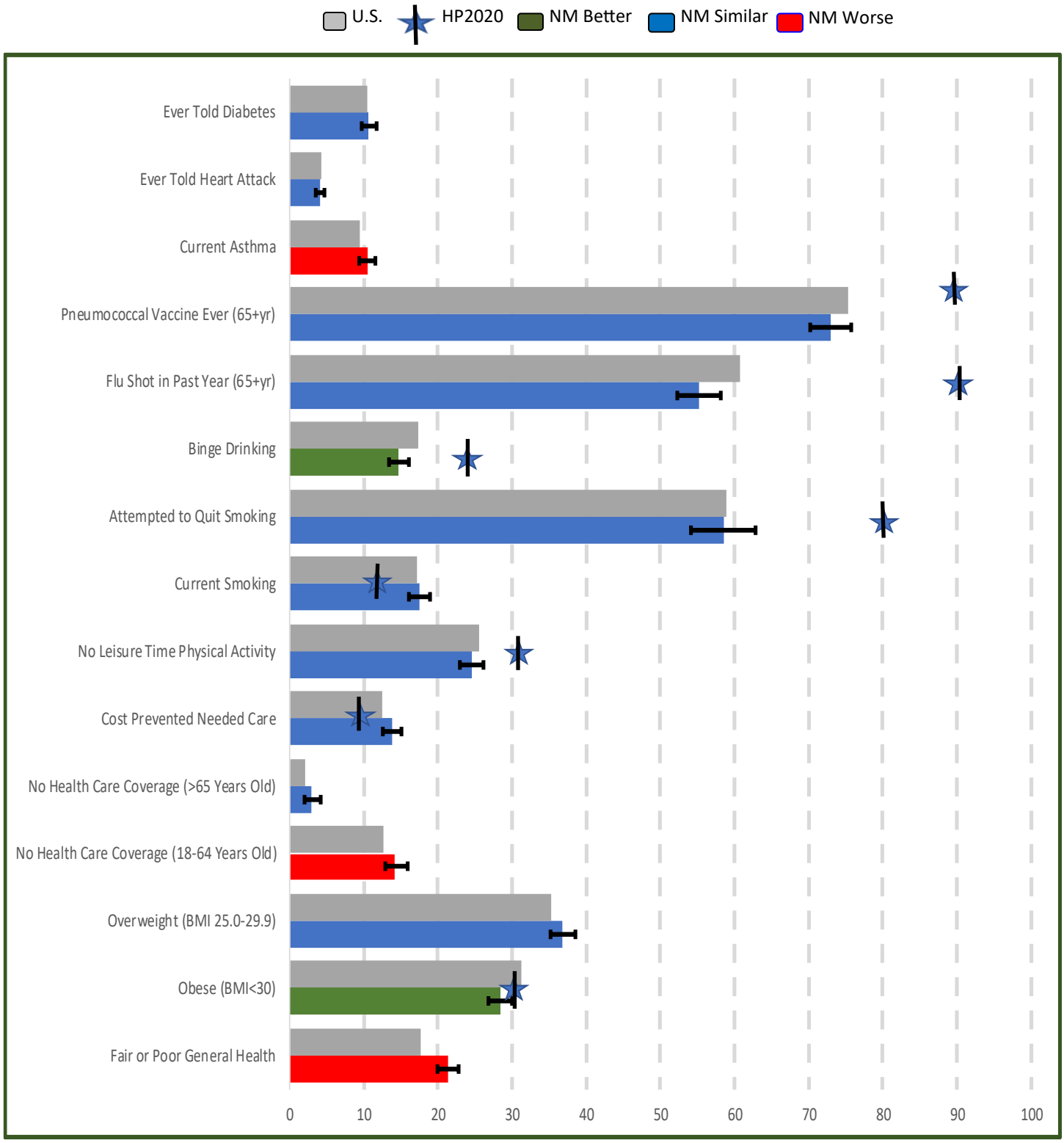
With respect to certain conditions and risk factors, particularly those addressed by core BRFSS questions that were asked of respondents in every state, estimates for the state of New Mexico (NM) were compared to estimates for the U.S. as a whole (U.S. = all 50 states, plus the District of Columbia). These charts are in the form of a trend chart.

Trend charts are presented with a break in the trend lines between data years 2010 and 2011. Beginning in 2011, cellular telephones were included in the sample and over 55% of 2017 interviews were conducted with adults on cellular telephones. Additionally, significant changes were made to the process of weighting BRFSS data beginning with the 2011 data set. These two very important and significant changes to the BRFSS preclude the comparison of 2011 and later estimates to those of earlier years, hence the break presented in trend lines in this report.

Summary

NM Health Risk Factors and Preventive Health Care

This chart summarizes the prevalence of health care access, preventive health care, and behavioral indicators among adult New Mexicans in 2017, compared to the U.S. NM estimates are presented as being either **better** than, **worse** than, or **similar** to the U.S. rate. Healthy People 2020 objectives are also shown where available.



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Demographics of the 2017 New Mexico Sample

Demographic Characteristics	2017 BRFSS Data			2017 ACS Pop. Estimates¥
	Number in Sample*	Unweighted Percent (%)	Weighted Percent(%)	
Total	6,538	100.0	100.0	
Age				
18-44	1,733	26.8	45.9	45.4
45-64	2,355	36.1	32.1	32.5
65+	2,405	37.1	22.0	22.0
Gender				
Male	2,885	44.2	49.1	49.1
Female	3,650	55.8	50.9	50.9
Race/Ethnicity				
AIAN	726	11.5	8.4	8.6
Asian or NHOPI	53	0.8	1.4	1.8
Black/AA	72	1.1	1.6	2.1
Hispanic	2,056	32.4	46.4	45.3
White	3,441	54.2	42.2	42.2
Sexual Orientation				
Straight	5,967	96.5	95.6	NA
LGB/Other	216	3.5	4.4	NA
Household Income				
< $15,000	838	15.0	14.9	NA
$15,000-$24,999	1,201	21.5	24.1	NA
$25,000-$49,999	1,407	25.2	25.3	NA
$50,000-$74,999	796	14.3	12.9	NA
> $75,000	1,337	24.0	22.7	NA
Geographic Region				
Northwest	1,691	25.9	9.7	10.3
Northeast	1,140	17.4	14.9	14.8
Metropolitan	1,654	25.3	44.4	44.0
Southeast	982	15.0	13.5	13.4
Southwest	1,071	16.4	17.5	17.6
Education Level				
<HS	744	11.4	16.1	NA
HS Grad/GED	1,848	28.3	26.9	NA
Some College	1,763	27.0	33.6	NA
College Grad.	2,171	33.3	23.4	NA
Employment Status				
Employed	2,867	44.1	51.2	NA
Unemployed/Unable to work	906	14.0	15.0	NA
Homemaker/Student	671	10.3	14.4	NA
Retired	2,054	31.6	19.4	NA
Urban/Rural Designation				
Metro	1,594	25.2	44.0	44.0
Small/Metro	1,965	31.0	23.0	23.5
Mixed Urban/Rural	2,381	37.6	27.5	27.9
Rural	393	6.2	5.5	4.7

*Respondents who answered "don't know not sure" or who refused to answer were excluded. Consequently, the sample sizes across categories for some variables may not add to the total.

¥ ACS: American Community Survey. Source: U.S. Bureau of the Census. NA indicates that Inter-Censal data were not available for this category.

General Health Status

Question:

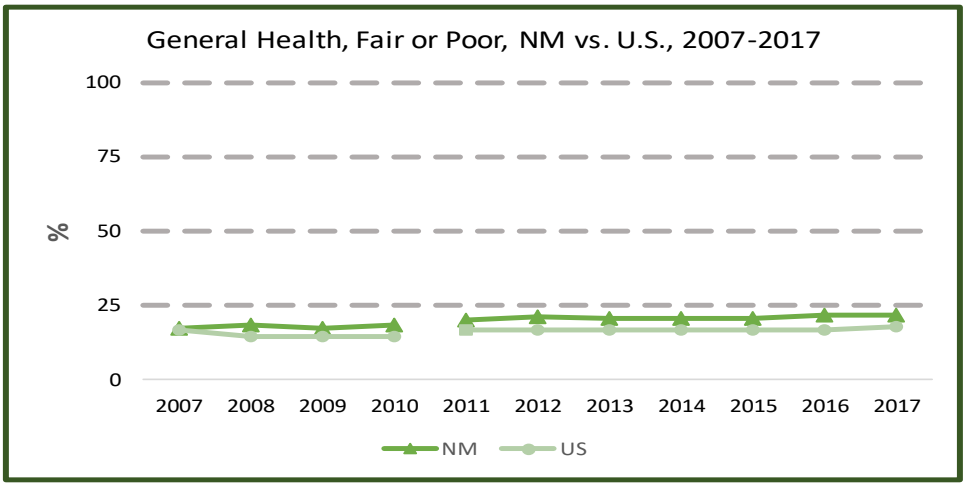
"Would you say that in general, your health is: Excellent, Very good, Good, Fair, or Poor?

Self-reported health status is how a person perceives their own health, is a very important indicator of health among different populations, and allows for broad comparisons across various health conditions.[1]

- In 2017, 21.4% of New Mexico adults reported that their general health was either fair or poor.
- Fair or poor general health increased with age and decreased with increasing household income.
- The prevalence of fair or poor general health status was similar among geographic regions.
- White adults (17.5%) reported a significantly lower prevalence of fair or poor health than AIAN (24.2%) and Hispanic(24.9%) adults.
- In 2017, the prevalence of fair or poor general health among NM adults (21.4%) was higher than that of the U.S. median prevalence (17.6%).

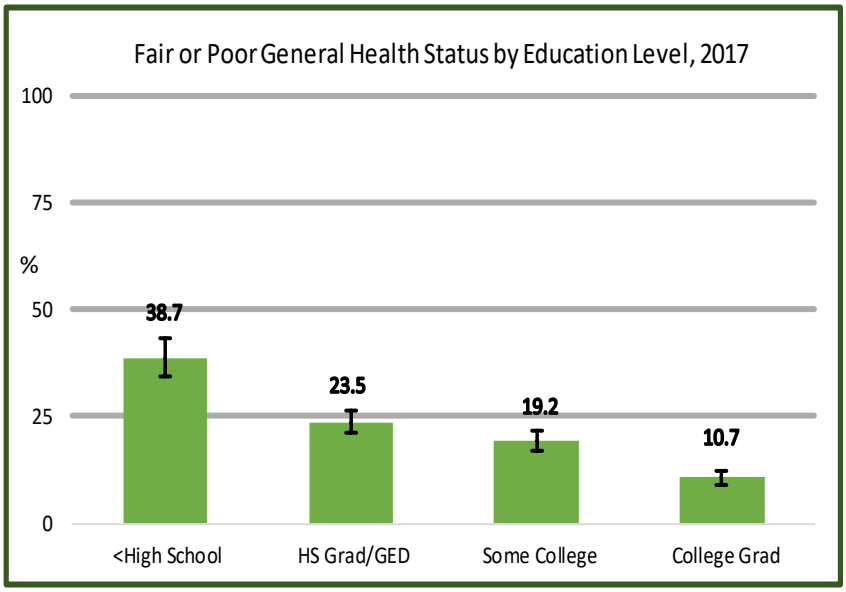
Demographic Characteristics	General Health, Fair or Poor[a] %	(95% Confidence Interval)
Total	**21.4**	**(20.1-22.9)**
Age		
18-44	14.6	(12.5-16.9)
45-64	26.7	(24.3-29.3)
65+	28.3	(25.8-31.0)
Gender		
Male	19.9	(17.9-22.0)
Female	23.0	(21.1-25.0)
Race/Ethnicity		
AIAN	24.2	(19.6-29.5)
Asian or NHOPI	15.0	(5.8-33.7)
Black/AA	21.8	(12.4-35.5)
Hispanic	24.9	(22.6-27.4)
White	17.5	(15.8-19.4)
Sexual Orientation		
Straight	21.4	(19.9-22.9)
LGB/Other	26.4	(19.2-35.1)
Household Income		
< $15,000	43.8	(39.0-48.7)
$15,000-$24,999	26.5	(23.1-30.2)
$25,000-$49,999	19.1	(16.4-22.1)
$50,000-$74,999	12.5	(9.7-15.9)
> $75,000	7.9	(6.2-10.1)
Geographic Region		
Northwest	23.2	(20.4-26.2)
Northeast	23.5	(20.2-27.2)
Metropolitan	19.2	(16.9-21.8)
Southeast	23.9	(20.9-27.1)
Southwest	22.5	(19.6-25.7)

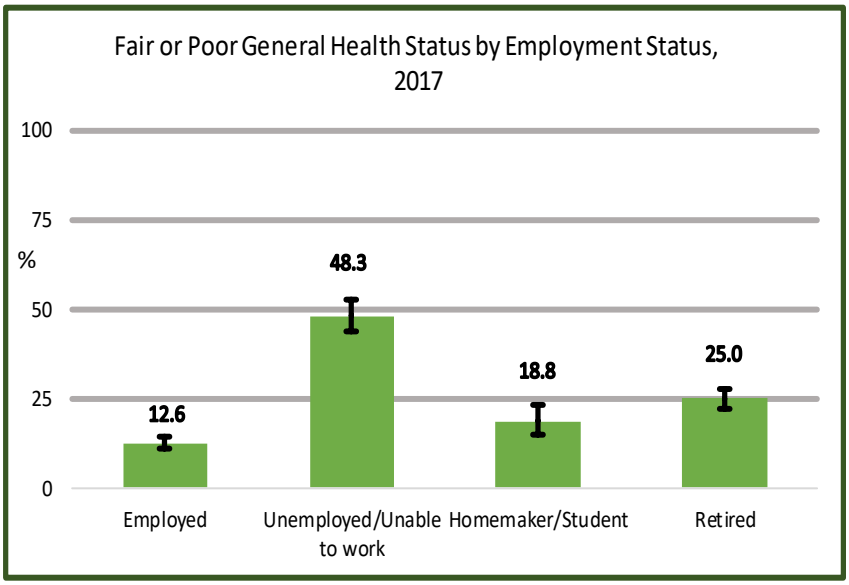
[a] Among all adults, the proportion reporting that their health, in general was either fair or poor.

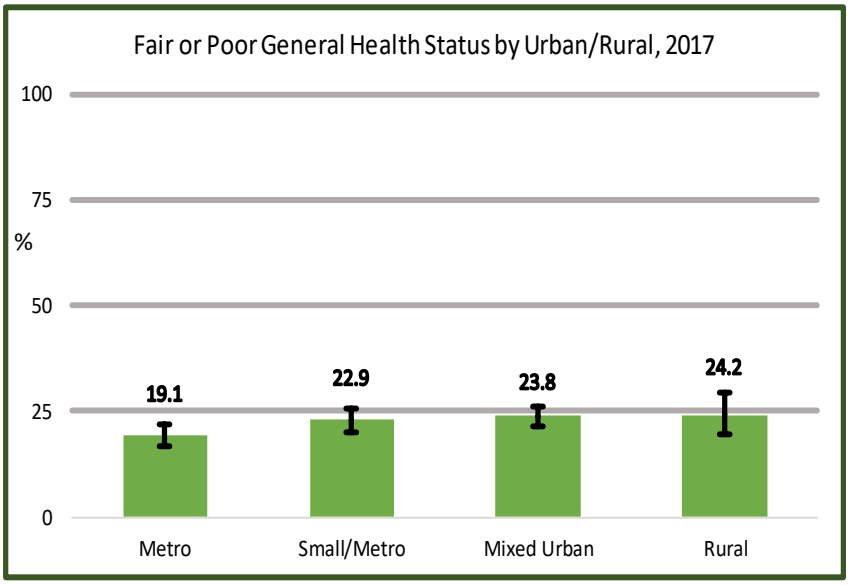


General Health Status

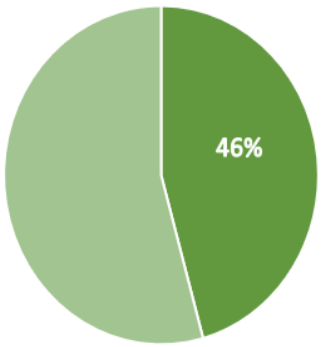
- NM adults with less than a high school education (38.7%) reported a significantly higher prevalence of fair or poor general health than adults with a high school diploma/GED, some college, and college graduates.
- Adults who reported they were unable to work/unemployed (48.3%) reported a significantly higher prevalence of fair or poor health than employed adults (12.6%).
- The prevalence of fair or poor general health was similar among counties designated as metropolitan, small metro, mixed urban/rural, and rural.



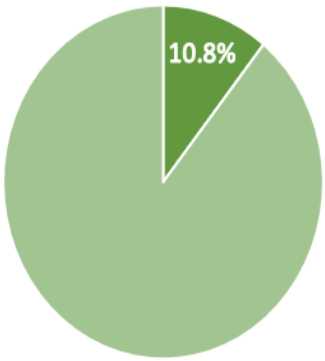




Percent with Fair/Poor Health with at least one disability



Percent with Fair/Poor Health with no disabilities



Quality of Life

Question:

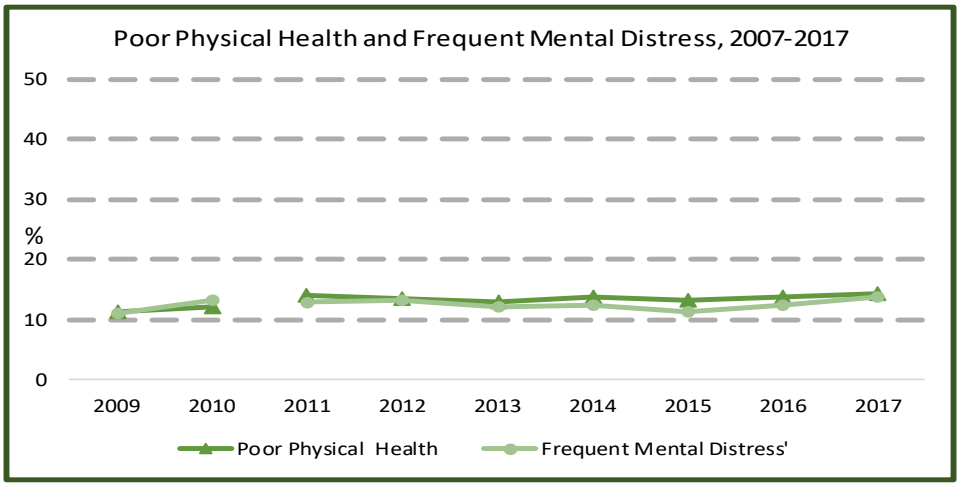
"Now thinking about your physical/ mental health...for how many days during the past 30 days was your physical/mental health not good?

The Centers for Disease Control and Prevention has defined health-related quality of life as "an individual's or group's perceived physical and mental health over time".[2]

- In 2017, 14.8% of New Mexico adults reported poor physical health and 13.8% reported frequent mental distress.
- Poor physical health increased with age while frequent mental distress decreased.
- Both poor physical health and frequent mental distress decreased as household income increased.
- Females (16.3%) reported a higher prevalence of frequent mental distress than males (11.3%).
- LGB/Other adults (23.3%) had a significantly higher prevalence of frequent mental distress than Straight adults (13.7%).

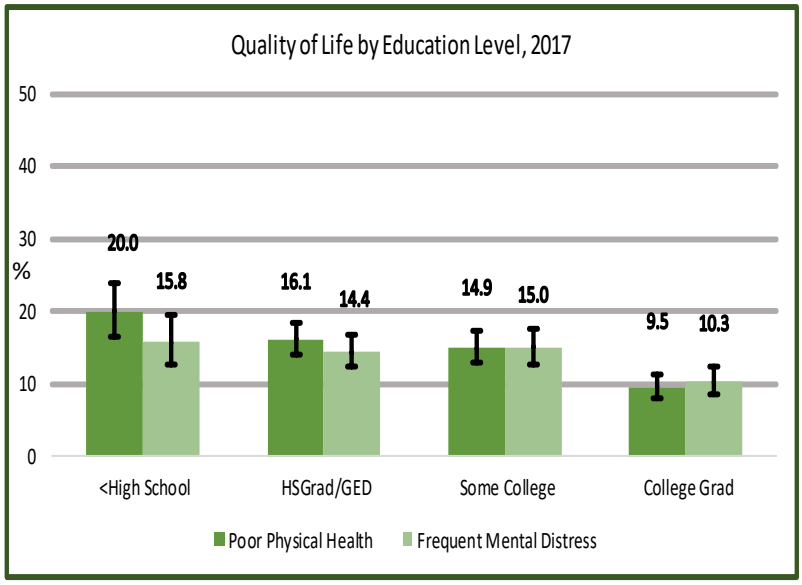
Demographic Characteristics	Poor Physical Health[a] %	Poor Physical Health[a] (95% Confidence Interval)	Frequent Mental Distress[b] %	Frequent Mental Distress[b] (95% Confidence Interval)
Total	**14.8**	**(13.6-16.0)**	**13.8**	**(12.7-15.1)**
Age				
18-44	9.2	(7.6-11.0)	14.8	(12.8-17.0)
45-64	18.6	(16.5-20.9)	15.9	(13.9-18.1)
65+	21.2	(18.9-23.7)	9.1	(7.7-10.9)
Gender				
Male	13.1	(11.6-14.8)	11.3	(9.8-13.0)
Female	16.4	(14.7-18.2)	16.3	(14.6-18.2)
Race/Ethnicity				
AIAN	13.0	(9.8-17.0)	11.7	(8.8-15.5)
Asian or NHOPI	10.2	(3.6-25.8)	12.7	(5.0-28.6)
Black/AA	11.5	(5.7-21.7)	19.2	(9.4-35.3)
Hispanic	15.2	(13.4-17.3)	14.8	(12.9-17.0)
White	14.8	(13.2-16.6)	13.2	(11.6-15.0)
Sexual Orientation				
Straight	14.7	(13.5-16.0)	13.7	(12.4-15.0)
LGB/Other	19.1	(13.1-26.9)	23.3	(16.6-31.6)
Household Income				
< $15,000	30.5	(26.3-35.0)	26.8	(22.8-31.3)
$15,000-$24,999	17.8	(15.1-20.8)	15.5	(12.7-18.7)
$25,000-$49,999	12.5	(10.2-15.3)	12.7	(10.4-15.4)
$50,000-$74,999	9.1	(6.6-12.5)	7.9	(5.8-10.8)
> $75,000	7.7	(5.9-9.9)	8.9	(6.8-11.6)
Geographic Region				
Northwest	15.6	(13.4-18.0)	13.8	(11.5-16.4)
Northeast	16.4	(13.8-19.3)	12.5	(10.3-15.1)
Metropolitan	13.4	(11.5-15.5)	14.7	(12.6-17.0)
Southeast	15.2	(12.8-18.0)	15.4	(12.7-18.6)
Southwest	16.1	(13.5-19.1)	11.7	(9.5-14.3)

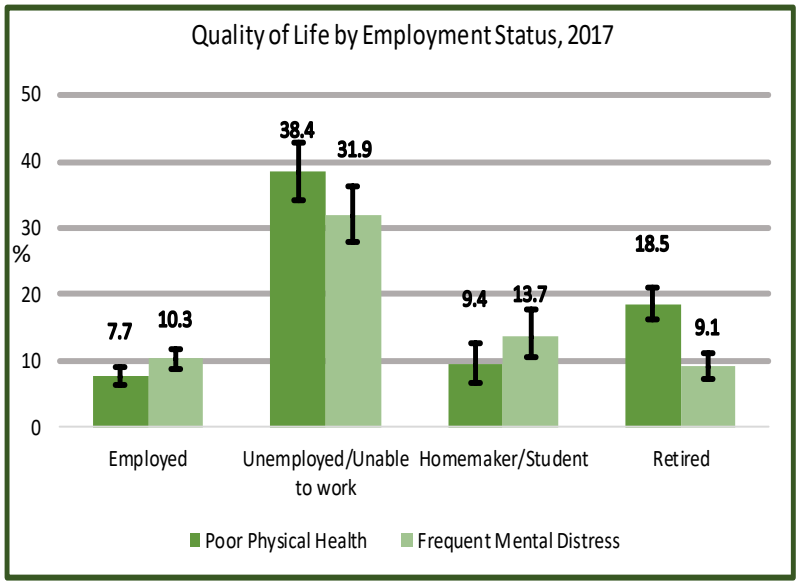
[a] Among all adults, the proportion reporting 14 or more days of poor health. [b] Among all adults, the proportion reporting 14 or more days of poor mental health.

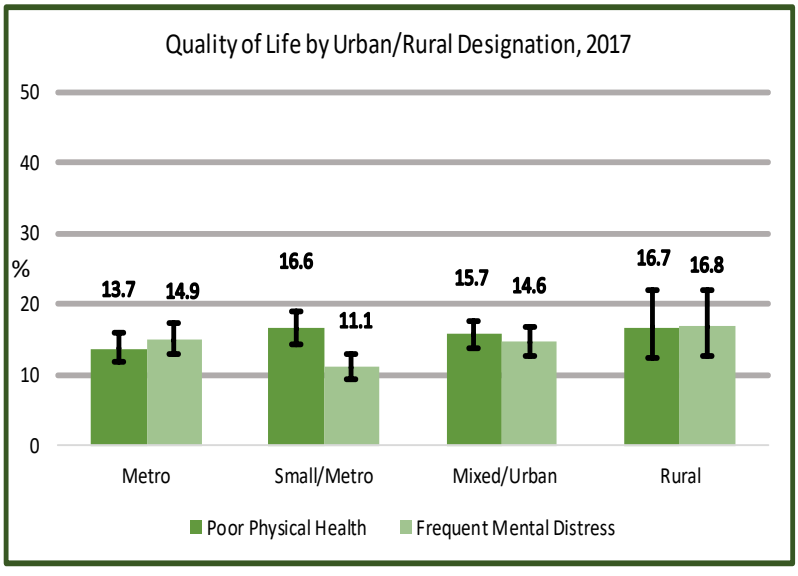


Quality of Life

- Among NM adults, the prevalence of both poor physical health and frequent mental distress decreased with higher education level.
- Both poor physical health and frequent mental distress were reported significantly higher among NM adults who were unemployed or unable to work.
- The prevalence of poor physical health and frequent mental distress was similar across Urban/Rural county designation.
- Adults with disabilities (35.6% and 37.1%) were more likely to have both poor physical health and frequent mental distress than adults without disabilities (5.8% and 5.7%, respectively).







Disability

Question:

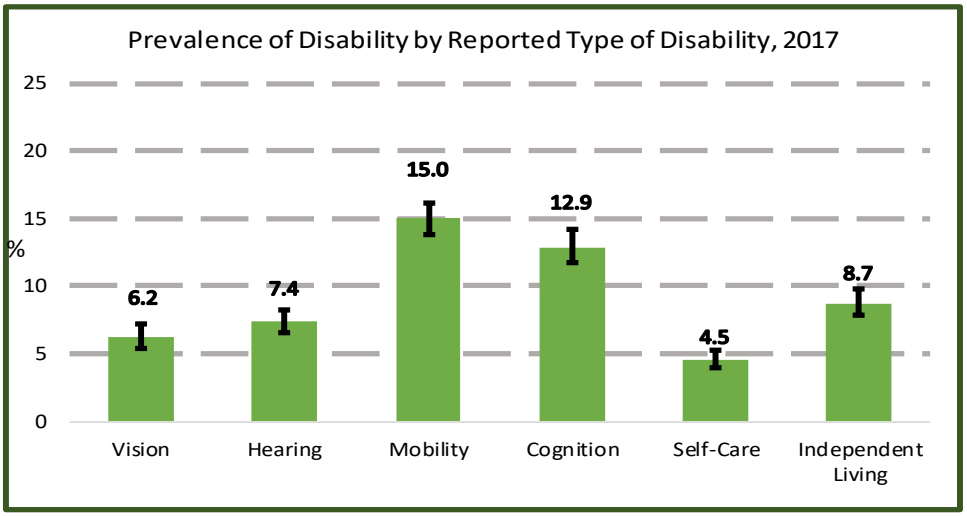
"The following questions are about health problems and impairments you may have? Such as difficulty seeing, hearing, walking, and independent living.

In the Americans with Disabilities Act, an individual with a disability is defined as a person who is substantially limited in one or more major life activities by a physical or mental impairment, a person who has a history of such an impairment, or a person who is perceived by others as having such an impairment.[3]

- In 2017, an estimated 29.6% of New Mexico adults reported at least one disability.
- The prevalence of at least one disability increased with age.
- The prevalence of having at least one disability decreased with increasing household income.
- LGB/Other adults (37.0%) were more likely to have at least one disability than straight adults (29.2%). This was not statistically significant.
- The most prevalent disability was difficulty walking (15.0%). The highest prevalence of difficulty walking was among adults over 65 years of age (27.1%).

Demographic Characteristics	Total Disability[a] %	Total Disability[a] (95% Confidence Interval)
Total	**29.6**	**(28.0-31.2)**
Age		
18-44	21.7	(19.2-24.4)
45-64	31.6	(29.0-34.3)
65+	42.8	(39.9-45.8)
Gender		
Male	27.9	(25.7-30.3)
Female	31.2	(29.0-33.5)
Race/Ethnicity		
AIAN	28.2	(23.2-33.8)
Asian or NHOPI	17.9	(7.7-36.2)
Black/AA	17.5	(9.0-31.2)
Hispanic	31.8	(29.2-34.6)
White	27.9	(25.8-30.1)
Sexual Orientation		
Straight	29.2	(27.5-30.9)
LGB/Other	37.0	(28.3-46.7)
Household Income		
< $15,000	54.5	(49.4-59.5)
$15,000-$24,999	37.3	(33.3-41.5)
$25,000-$49,999	24.8	(21.8-28.2)
$50,000-$74,999	20.1	(16.5-24.2)
> $75,000	16.1	(13.5-19.2)
Geographic Region		
Northwest	30.9	(27.6-34.5)
Northeast	30.0	(26.3-33.8)
Metropolitan	27.9	(25.2-30.9)
Southeast	33.4	(29.9-37.2)
Southwest	29.8	(26.5-33.4)

[a]Among all adults, those who said yes to at least one disability; difficulty seeing, hearing, walking, remembering, dressing/bathing and mobility to run errands.



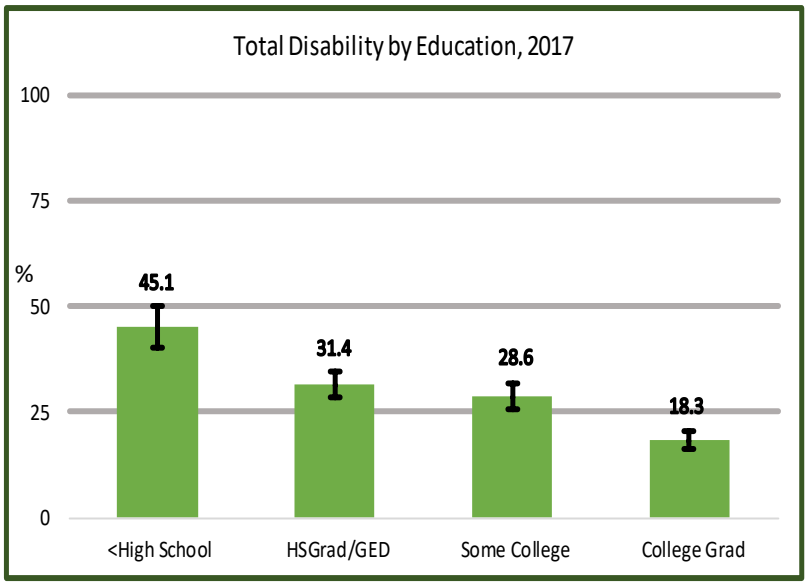
Disability

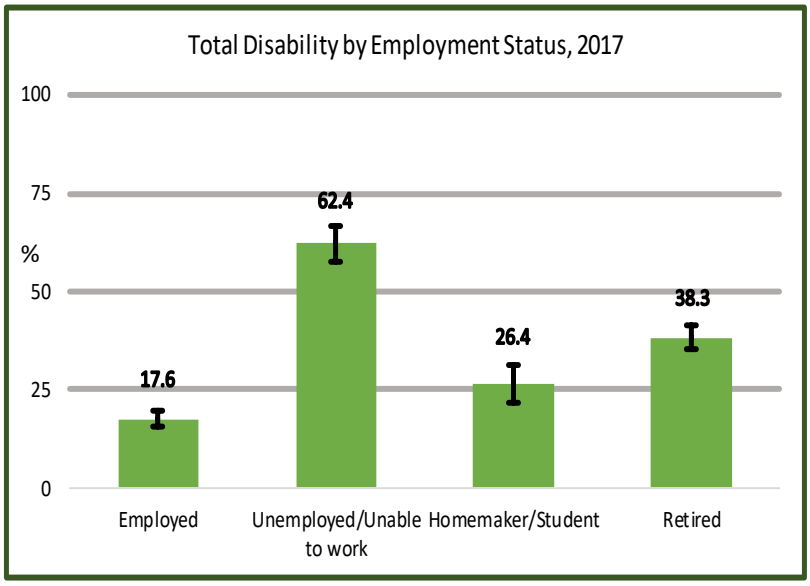
- Among NM adults, the prevalence of at least one disability decreased with increasing education level. NM adults with less than a high school diploma/GED had a significantly higher prevalence of at least one disability (45.1%) than adults with a college degree (18.3%).

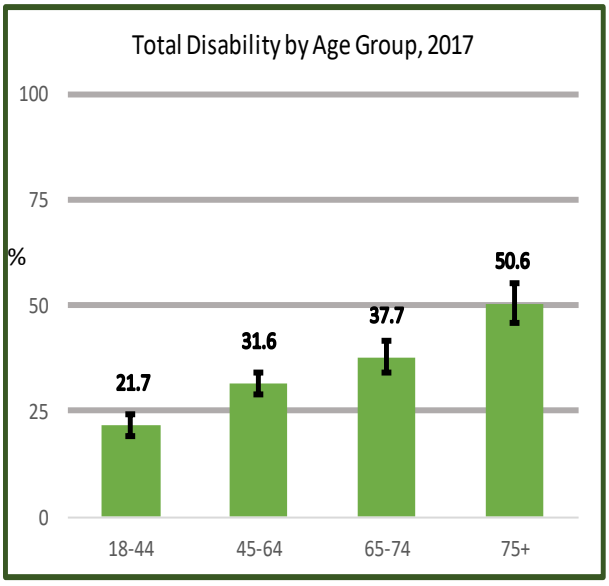
- NM adults who were either unemployed and/or unable to work had a significantly higher prevalence of having at least one disability (62.4%) than employed adults (17.6%).

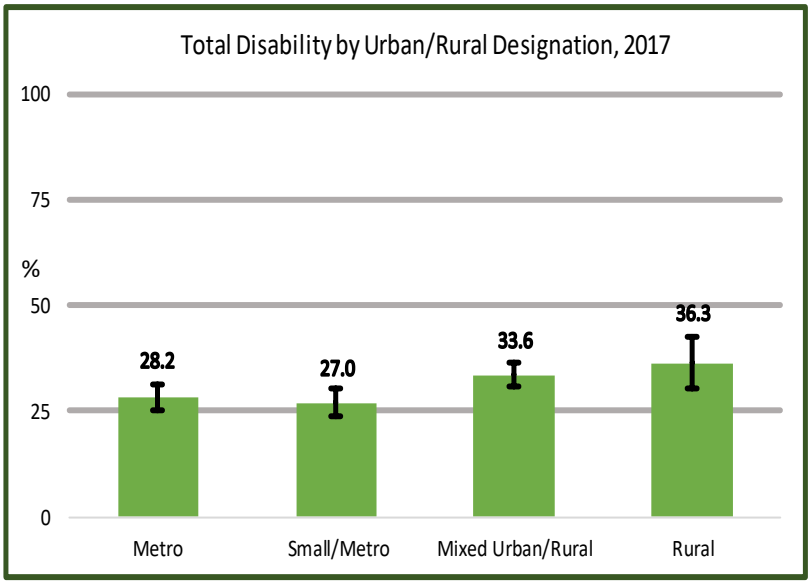
- The prevalence of at least one disability was similar among Urban/Rural county designation.

- The prevalence of disability increased with age, over 50 percent of adults over 75 years of age had at least one disability.









Weight Status

Questions:

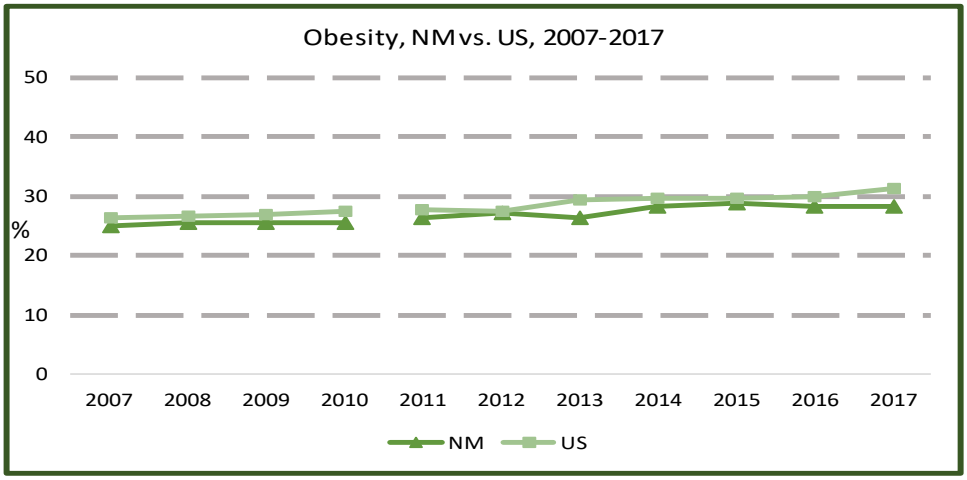
"About how much do you weight without shoes? About how tall are you?"

Overweight and obesity have been proven to increase the risk of diseases and health conditions such as high blood pressure, diabetes, coronary heart disease, stroke, gallbladder disease, high cholesterol, and some forms of cancer.[4] Overweight is defined as having a body mass index (BMI) between 25.0 and 29.9, and obesity is defined as a BMI greater than or equal to 30.0.

- In 2017, 28.4% of New Mexico adults were obese. The prevalence of obesity in New Mexico was lower than the U.S. median prevalence (31.3%).
- Adults in the middle age range had a higher prevalence of obesity (34.0%) than adults aged 65 and older (21.7%) and adults 18-44 (27.9%).
- There was no measurable difference in obesity by gender.
- AIAN adults had a significantly higher prevalence of obesity (38.8%) than all other races/ethnicities.
- Adults in the lowest household income category had a significantly higher prevalence of obesity (35.9%) compared to adults in the highest category (27.3%).
- Adults in the Northwest region had the highest prevalence of obesity (35.3%) while those in the Northeast region had the lowest (23.2%).

	Obese[a]	
Demographic Characteristics	**%**	**(95% Confidence Interval)**
Total	**28.4**	**(26.8-30.0)**
Age		
18-44	27.9	(25.2-30.8)
45-64	34.0	(31.3-36.8)
65+	21.7	(19.5-24.1)
Gender		
Male	27.4	(25.2-29.8)
Female	29.4	(27.1-31.7)
Race/Ethnicity		
AIAN	38.8	(33.0-44.8)
Asian or NHOPI	**	**
Black/AA	25.2	(14.8-39.5)
Hispanic	30.9	(28.2-33.7)
White	24.9	(22.8-27.1)
Sexual Orientation		
Straight	28.2	(26.6-30.0)
LGB/Other	32.4	(24.2-42.0)
Household Income		
< $15,000	35.9	(31.2-40.9)
$15,000-$24,999	28.6	(25.0-32.5)
$25,000-$49,999	27.8	(24.4-31.4)
$50,000-$74,999	28.5	(24.2-33.1)
> $75,000	27.3	(24.1-30.7)
Geographic Region		
Northwest	35.3	(31.8-39.0)
Northeast	23.2	(19.7-27.2)
Metropolitan	26.9	(24.1-29.8)
Southeast	33.4	(29.9-37.2)
Southwest	29.0	(25.7-32.5)

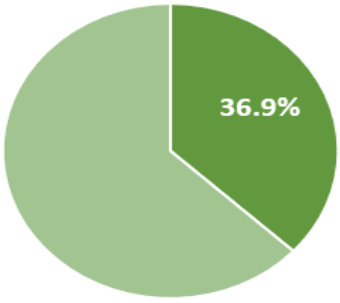
[a]Among all adults, the proportion of respondents whose BMI was greater than or equal to 30.0.
Note: BMI, body mass index, is defined as weight (in kg) divided by height (in meters) squared. Weight and height are self-reported. Pregnant women were excluded. ** Suppressed due to a denominator <50.



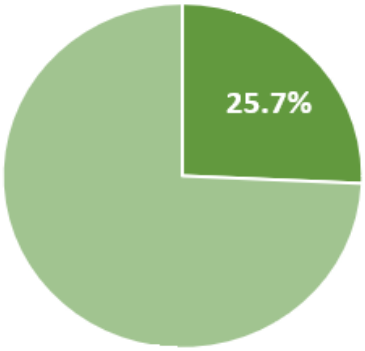
Weight Status

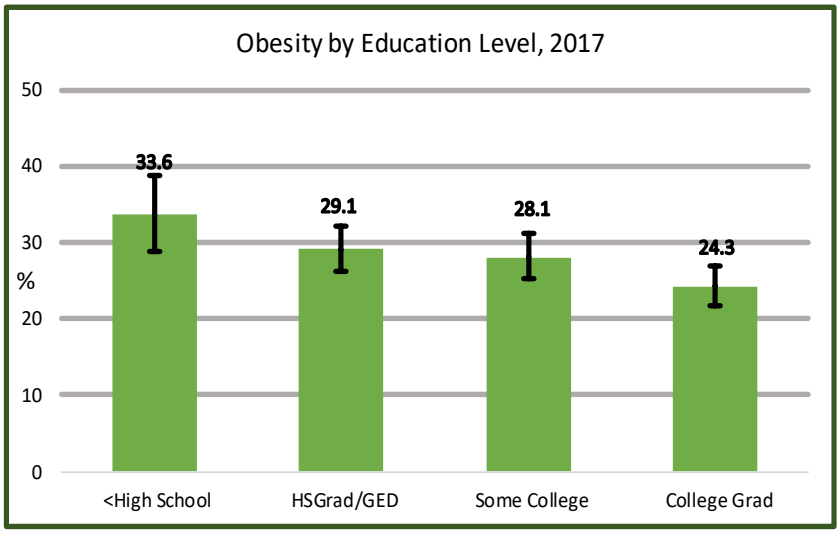
- The Healthy People (HP) 2020 goal for obesity among adults is 30.5%. The prevalence of obesity among NM adults in 2017 was 28.4%, 2.1 percentage points lower than the HP2020 goal.[5]
- College graduates had a significantly lower prevalence of obesity that those with less than a high school education.
- NM adults who were unemployed/unable to work reported a higher prevalence of obesity (34.6%) compared to retired adults (22.1%).
- The prevalence of obesity was similar by Urban/Rural county designation.
- Adults who reported exercising (leisure-time physical activity) had significantly less obesity than adults who reported no exercise.

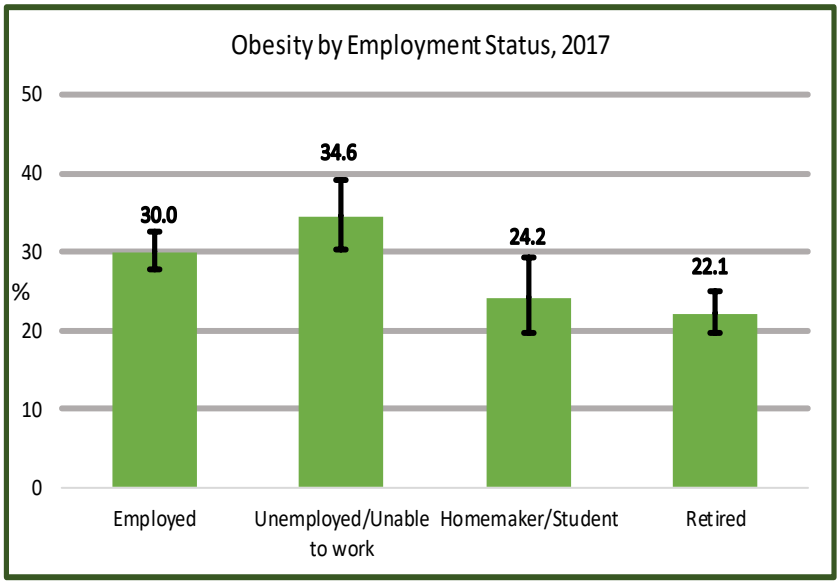
NM adults who report no Leisure-Time Physical activity who are Obese

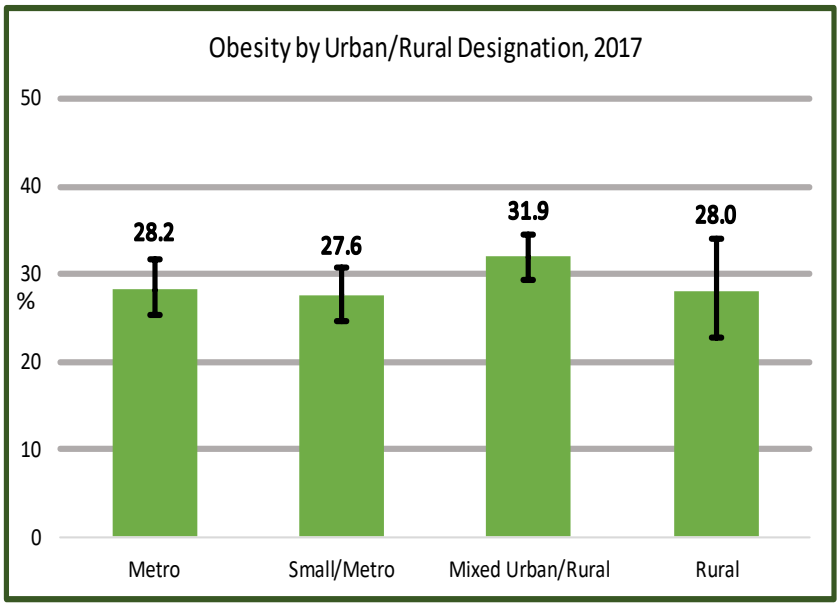


NM adults who report Leisure-Time Physical activity who are Obese









Lack of Health Care Coverage (Adults 18-64)

Question:

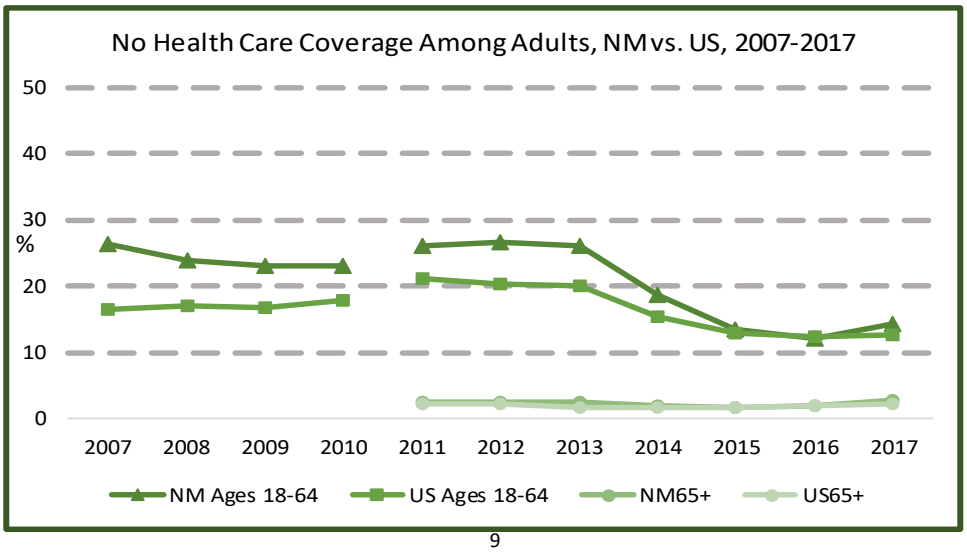
Do you have any kind of health care coverage...?

Lack of health care coverage has been associated with delayed access to health care and clinical preventive services that could lead to early diagnosis of chronic disease and to decrease mortality.[6] Uninsured adults are more likely to develop preventable illnesses, more likely to suffer complications from those illnesses, and are more likely to die prematurely.[6,7]

- In 2017, 14.3% of New Mexico adults reported having no health care coverage. The prevalence of no health care coverage among NM adults 18-64 was higher than the U.S. median prevalence (12.7%).
- The prevalence of no health care coverage decreased with age.
- There was a gradient in lack of health care coverage by level of household income. Those reporting household income more than $75,000 per year had the lowest prevalence of no health care coverage (3.4%), and those at $15,000-$24,999 income level had the highest (22.6%).
- Males (16.6%) reported a higher prevalence of no health care than females (12.1%). White adults (8.5%) reported a significantly lower prevalence than Hispanic adults (19.2%).

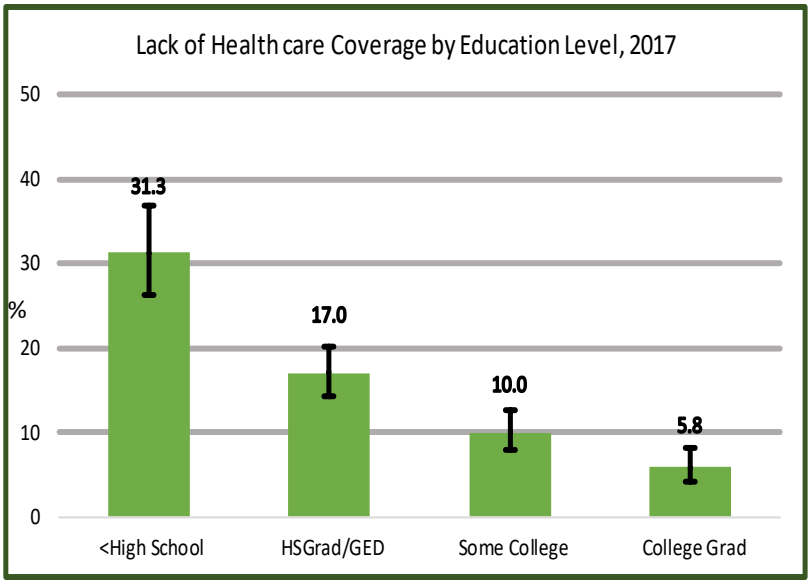
	No Health Care Coverage Among Adults 18-64[a]	
Demographic Characteristics	**%**	**(95% Confidence Interval)**
Total	**14.3**	**(12.9-15.9)**
Age		
18-44	16.8	(14.7-19.2)
45-64	10.8	(9.1-12.7)
Gender		
Male	16.6	(14.4-19.0)
Female	12.1	(10.3-14.2)
Race/Ethnicity		
AIAN	13.3	(9.4-18.4)
Asian or NHOPI	**	**
Black/AA	13.5	(5.4-30.2)
Hispanic	19.2	(16.8-21.9)
White	8.5	(6.8-10.5)
Sexual Orientation		
Straight	14.9	(13.3-16.6)
LGB/Other	8.1	(4.0-15.6)
Household Income		
< $15,000	16.2	(12.5-20.8)
$15,000-$24,999	22.6	(18.8-26.9)
$25,000-$49,999	16.6	(13.2-20.5)
$50,000-$74,999	7.4	(5.1-10.7)
> $75,000	3.4	(2.2-5.4)
Geographic Region		
Northwest	15.8	(12.7-19.6)
Northeast	16.9	(13.5-20.9)
Metropolitan	13.9	(11.5-16.8)
Southeast	14.8	(11.9-18.3)
Southwest	12.0	(9.1-15.7)

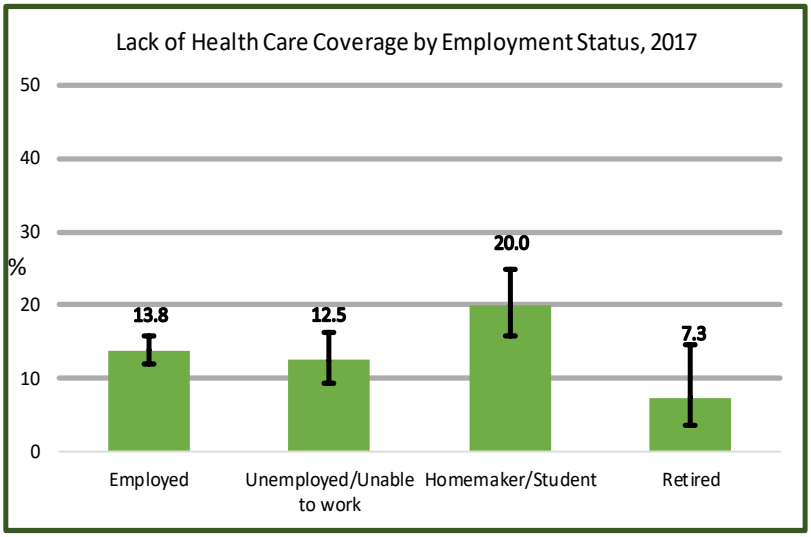
[a]Among adults aged 18-64 years, the proportion who reported having no health care coverage, including health insurance, prepaid plans such as HMO's, or government plans, such as Medicaid or Indian Health Services. ** Suppressed due to a denominator <50.

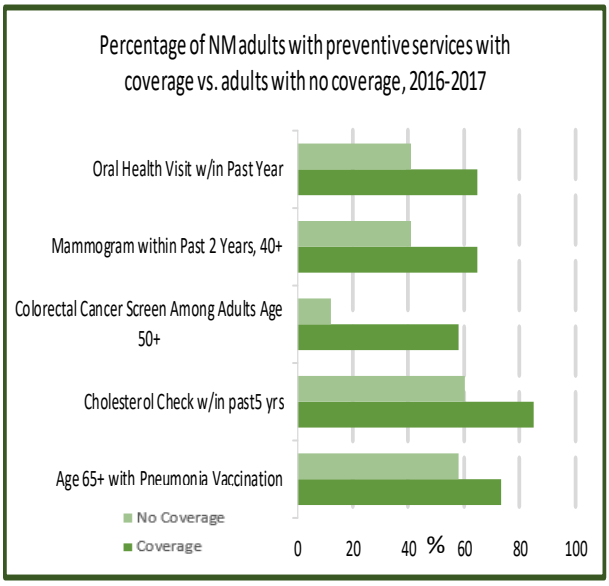


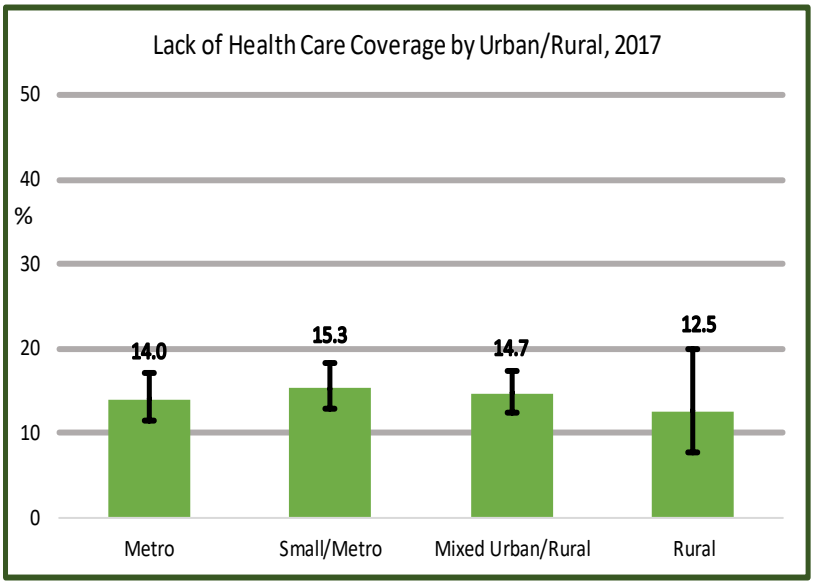
Lack of Health Care Coverage (Adults 18-64)

- The HP 2020 target is to have 100% of adults insured by 2020. Since the prevalence of no health care coverage among New Mexico adults is currently 14.3%, this prevalence would have to decrease by 4.7 percentage points each year to meet this goal.
- The prevalence of no health care coverage decreased with increasing education level.
- Homemakers/students reported a higher prevalence of no health care coverage compared to retired adults.
- The prevalence of no health care coverage was similar across geographic regions.
- Adults without health care coverage were significantly less likely to receive any of five preventative health care services than were adults with coverage.









Arthritis

Question:

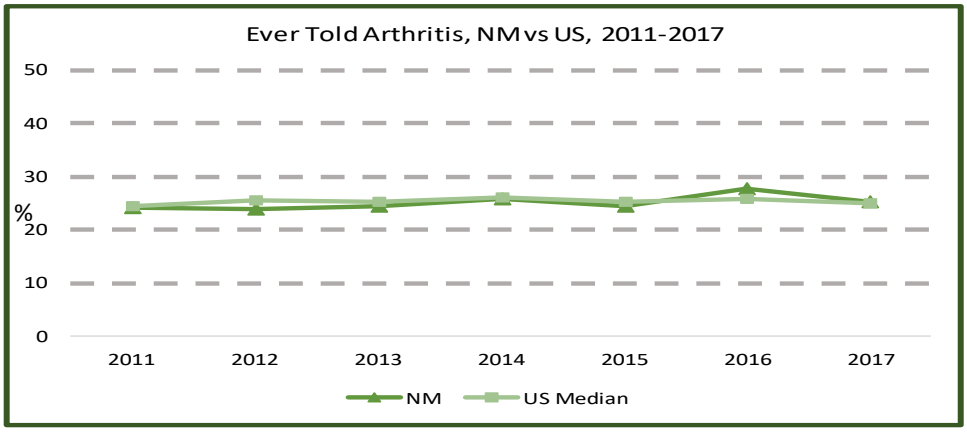
"Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?"

There are over 100 forms of rheumatic disease commonly referred to as arthritis, including osteoarthritis, rheumatoid arthritis, fibromyalgia, and gout. Arthritis is the most common cause of disability in the U.S.[8]

- In 2017, 25.4% of New Mexico adults had been diagnosed with some form of arthritis. The prevalence of arthritis among NM adults was slightly higher than the U.S. median prevalence (24.9%).
- The percentage of women with diagnosed arthritis (29.6%) was higher than that of adult men (21.0%). This association between arthritis and gender has been consistent over time.
- Arthritis is strongly associated with age, the prevalence among adults over 65 years was 46.5%.
- The percentage of adults with diagnosed arthritis was higher among White adults than among AIAN and Hispanic adults.
- Among adults living in households with an annual income of $75,000 or more, the prevalence of diagnosed arthritis was lower than those of income categories of less than $15,000.

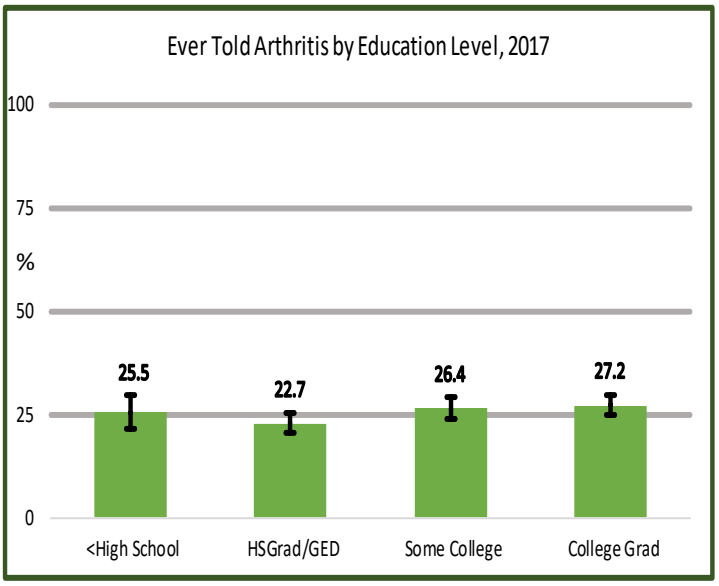
	Ever Told Arthritis[a]	
Demographic Characteristics	**%**	**(95% Confidence Interval)**
Total	**25.4**	**(24.0-26.8)**
Age		
18-44	9.9	(8.2-11.8)
45-64	33.0	(30.4-35.6)
65+	46.5	(43.7-49.4)
Gender		
Male	21.0	(19.1-23.0)
Female	29.6	(27.6-31.7)
Race/Ethnicity		
AIAN	16.6	(12.7-21.3)
Asian or NHOPI	19.5	(9.5-36.1)
Black/AA	23.7	(14.2-37.0)
Hispanic	21.9	(19.7-24.1)
White	31.7	(29.6-33.8)
Sexual Orientation		
Straight	25.9	(24.4-27.4)
LGB/Other	21.1	(15.5-28.5)
Household Income		
< $15,000	34.9	(30.6-39.5)
$15,000-$24,999	25.6	(22.3-29.2)
$25,000-$49,999	23.2	(20.5-26.2)
$50,000-$74,999	23.5	(19.2-27.6)
> $75,000	22.8	(20.1-25.8)
Geographic Region		
Northwest	21.1	(18.5-24.1)
Northeast	26.9	(23.8-30.3)
Metropolitan	25.6	(23.2-28.2)
Southeast	25.2	(22.3-28.2)
Southwest	26.1	(23.1-29.2)

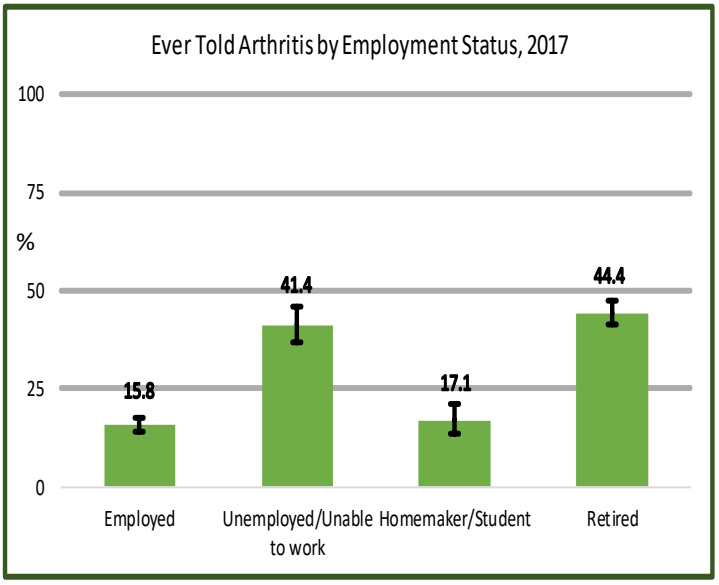
[a]Among all adults , the proportion who reporting ever been told by a doctor that they had some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia.

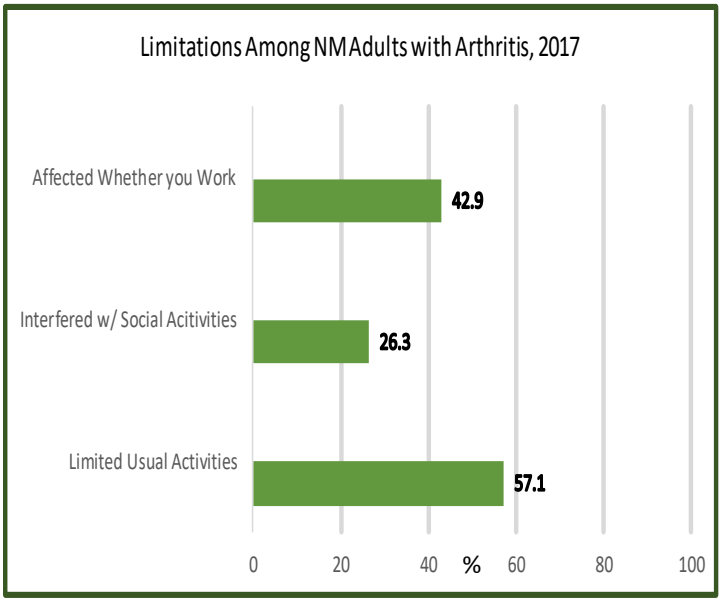


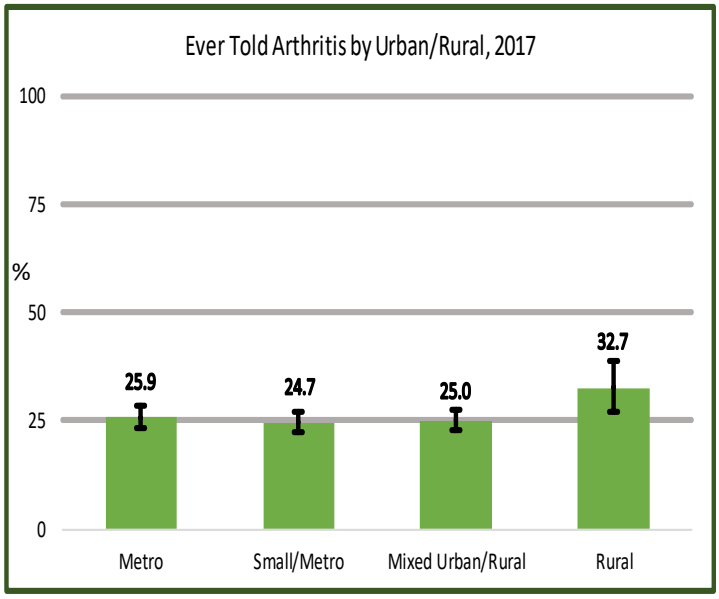
Arthritis

- The prevalence of diagnosed arthritis did not vary by sexual orientation or education level.
- Among NM adults with an employment status of retired or unemployed/unable to work, the prevalence of diagnosed arthritis was significantly higher than employed or homemaker/student adults.
- The prevalence of diagnosed arthritis was slightly lower among adult residents of the Northwest region compared to the other regions.
- Adults with diagnosed arthritis were more likely to have fair or poor health (41.0% and 14.7%), to have diabetes(18.7% and 7.8%), cardiovascular disease (16.4% and 4.2%), to be obese (33.5% and 26.6%), or have a disability (55.3% and 20.8%).
- 57.1% of adults with arthritis reported that arthritis limited their usual activities.









Asthma

Questions:

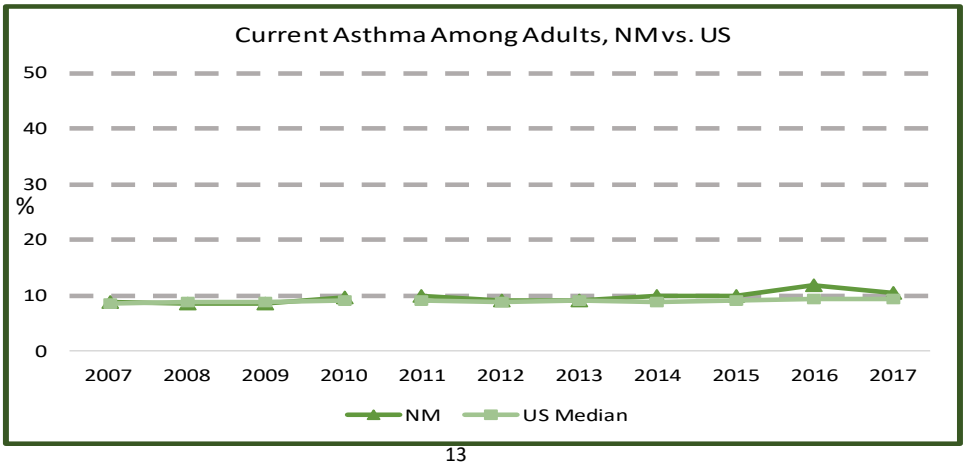
"(Ever told) you had asthma?
Do you still have asthma?"

Asthma is a chronic respiratory disease characterized by episodes or attacks of inflammation and narrowing of small airways. Asthma attacks can vary from mild to life threatening. Symptoms can include shortness of breath, cough, wheezing, and chest pain or tightness.[9]

- In 2017, 10.5% of New Mexico adults had asthma at the time of the interview. The prevalence of current asthma among NM adults was higher than the U.S. Median prevalence (9.4%).
- The percentage of women who currently had asthma (13.6%) was significantly higher than that of men (7.3%).
- The prevalence of current asthma among LGB/other was higher than among straight adults, 15.6% and 10.4%, respectively. This was not statistically significant.
- Low income adults (<$15,000) were more likely to report asthma than other income categories.
- The prevalence of current asthma did not vary significantly by age.

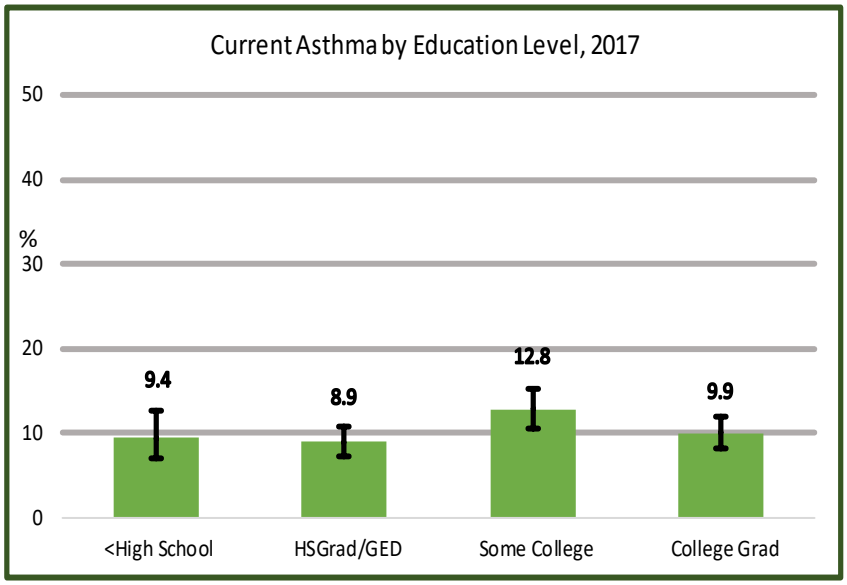
Demographic Characteristics	Current Asthma[a] %	Current Asthma[a] (95% Confidence Interval)
Total	**10.5**	**(9.4-11.6)**
Age		
18-44	11.5	(9.7-13.6)
45-64	10.6	(9.1-12.4)
65+	8.3	(6.9-10.0)
Gender		
Male	7.3	(6.1-8.7)
Female	13.6	(12.0-15.4)
Race/Ethnicity		
AIAN	10.3	(7.6-13.8)
Asian or NHOPI	11.5	(3.7-30.4)
Black/AA	7.1	(2.5-18.4)
Hispanic	9.8	(8.2-11.7)
White	11.7	(10.2-13.5)
Sexual Orientation		
Straight	10.4	(9.3-11.6)
LGB/Other	15.6	(10.1-23.2)
Household Income		
< $15,000	16.7	(13.3-20.7)
$15,000-$24,999	11.8	(9.6-14.6)
$25,000-$49,999	8.0	(6.2-10.3)
$50,000-$74,999	8.7	(6.1-12.1)
> $75,000	9.4	(7.3-12.1)
Geographic Region		
Northwest	12.4	(10.2-15.1)
Northeast	9.9	(7.7-12.6)
Metropolitan	9.9	(8.2-11.8)
Southeast	10.5	(8.4-13.1)
Southwest	11.4	(8.8-14.5)

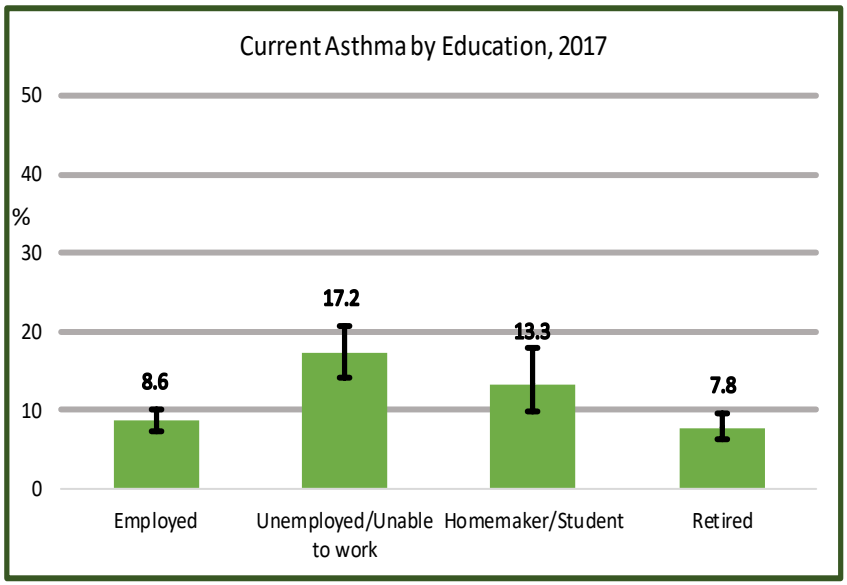
[a] Among all adults, the proportion reporting that they were ever told by a doctor, nurse, or other health care professional that had asthma and report that they still have asthma.

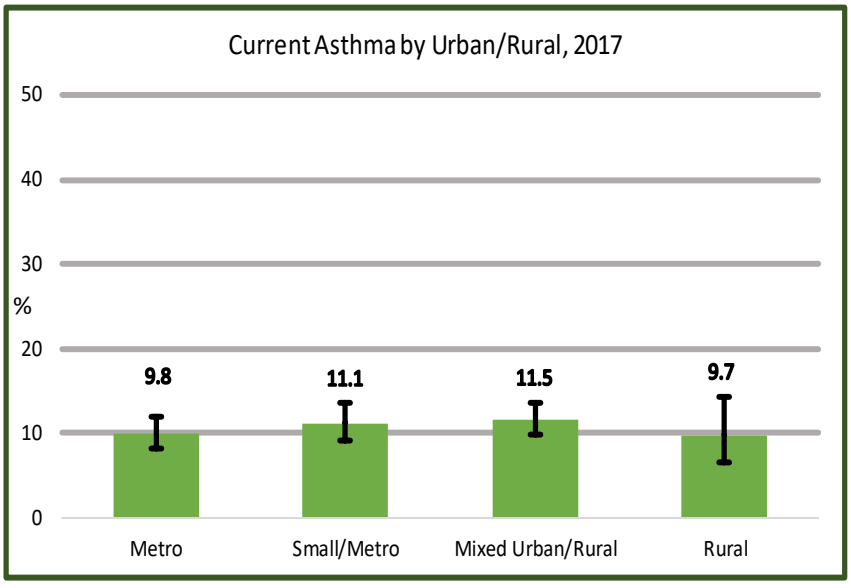


Asthma

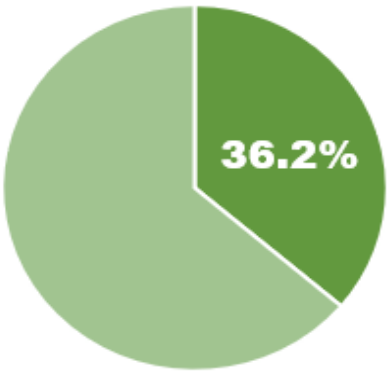
- The prevalence of current asthma did not vary significantly by education level.
- Adults who were unemployed/unable to work were more likely to report current asthma, (17.2%) than those who were retired (7.8%), employed (8.6%), or a homemaker or student (13.3%).
- The prevalence of current diagnosed asthma did not vary significantly by Urban/ Rural county designation.
- Adults with current asthma were more likely to report disability/activity limitation (38.7%) compared to those without current asthma (21.5%).



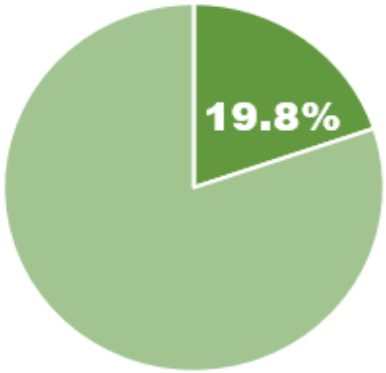




Fair/Poor Health with Asthma, 2017



Fair/Poor Health without Asthma, 2017



Cancer

Question:

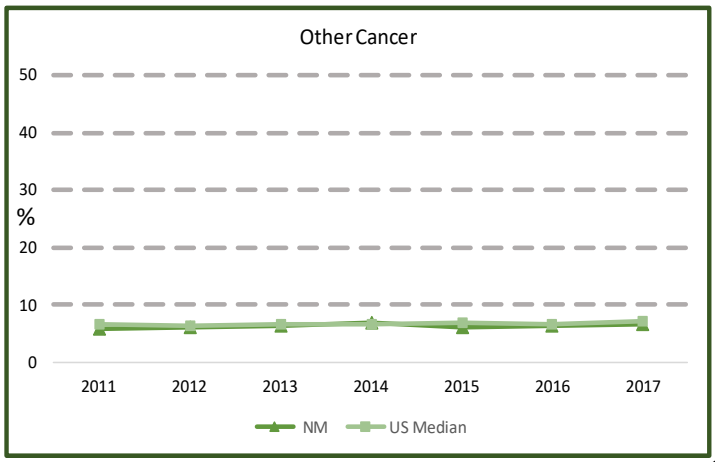
"(Ever told) you had skin cancer, any other types of cancer?"

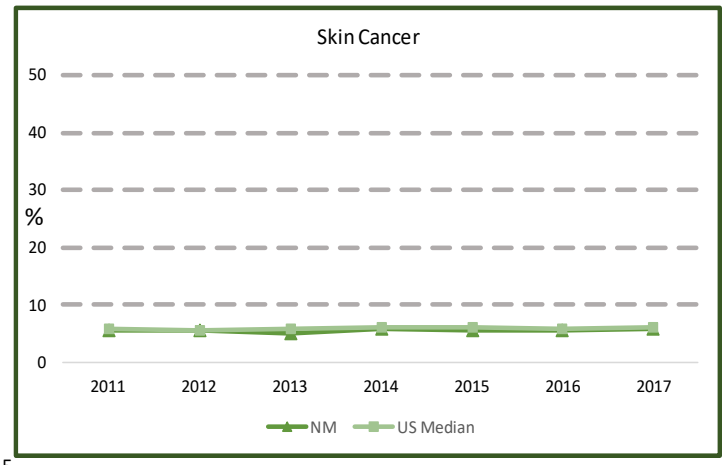
Cancer is a term used for diseases in which abnormal cells divide without control and are able to invade other tissues. There are over 100 different types of cancer.[10]

- In 2017, an estimated 11.6% of adults had a history of any type of cancer, 6.8% had a history of cancer other than skin cancer, and 5.9% had a history of skin cancer. There was no significant difference between NM and the U.S.
- There was a strong association with age, older adults being much more likely to have a history of cancer.
- For history of all types of cancer and any other type of cancer, the prevalence was higher among women (13.8% and 8.8%) than men (9.4% and 4.7%).
- History of any cancer was higher among White adults (18.4%) than all other racial/ethnic groups and history of non-skin cancer was higher among White adults (8.3%) than among AIAN and Hispanic adults.

Demographic Characteristics	Ever Told Skin Cancer[a] %	(95% Confidence Interval)	Ever Told Any Other Types of Cancer[b] %	(95% Confidence Interval)	Ever Told Cancer[c] %	(95% Confidence Interval)
Total	**5.9**	**(5.3-6.6)**	**6.8**	**(6.1-7.6)**	**11.6**	**(10.7-12.6)**
Age						
18-44	0.6	(0.3-1.2)	2.4	(1.7-3.5)	2.9	(2.1-4.0)
45-64	6.3	(5.1-7.8)	6.9	(5.7-8.3)	12.4	(10.7-14.2)
65+	16.7	(14.7-18.8)	15.6	(13.7-17.7)	28.8	(26.4-31.5)
Gender						
Male	5.8	(5.0-6.9)	4.7	(3.9-5.5)	9.4	(8.3-10.7)
Female	6.0	(5.1-7.0)	8.8	(7.7-10.1)	13.8	(12.4-15.4)
Race/Ethnicity						
AIAN	0.3	(0.1-0.8)	4.5	(2.9-6.9)	4.8	(3.2-7.1)
Asian or NHOPI	0.0	(.-.)	2.5	(0.5-12.2)	2.5	(0.5-12.2)
Black/AA	0.0	(.-.)	6.1	(2.2-15.5)	6.1	(2.2-15.5)
Hispanic	1.5	(1.0-2.2)	5.9	(4.8-7.3)	7.3	(6.0-8.7)
White	12.4	(11.1-14.0)	8.3	(7.3-9.5)	18.4	(16.8-20.1)
Sexual Orientation						
Straight	6.0	(5.4-6.8)	6.9	(6.1-7.7)	11.8	(10.8-12.9)
LGB/Other	4.5	(2.3-8.6)	5.9	(3.1-10.8)	9.9	(6.1-15.5)
Household Income						
< $15,000	2.9	(1.9-4.5)	9.5	(7.2-12.5)	11.4	(8.9-14.5)
$15,000-$24,999	4.1	(3.0-5.8)	5.8	(4.5-7.5)	9.4	(7.6-11.6)
$25,000-$49,999	4.8	(3.8-6.1)	6.5	(5.2-8.1)	10.4	(8.7-12.3)
$50,000-$74,999	7.9	(6.0-10.3)	7.0	(5.1-9.5)	13.1	(10.5-16.2)
> $75,000	9.6	(7.8-11.7)	6.0	(4.4-7.9)	14.2	(12.0-16.8)
Geographic Region						
Northwest	3.3	(2.6-4.1)	5.6	(4.4-7.2)	8.3	(6.9-10.0)
Northeast	7.5	(5.9-9.4)	7.6	(6.1-9.4)	13.7	(11.6-16.2)
Metropolitan	6.5	(5.4-7.8)	6.6	(5.4-8.0)	12.0	(10.4-13.8)
Southeast	5.9	(4.6-7.4)	7.0	(5.5-8.8)	11.8	(9.9-14.0)
Southwest	4.7	(3.7-5.9)	7.1	(5.6-8.9)	10.7	(9.0-12.8)

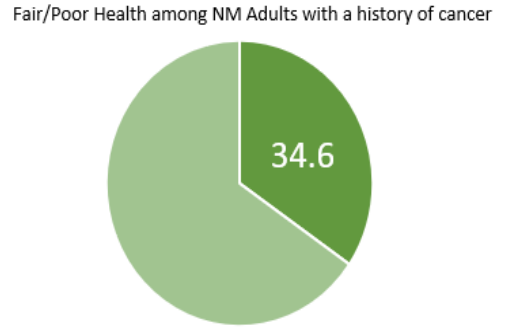
Among all adults, the proportion ever told by a doctor that: [a]they had skin cancer, [b]they had a form of cancer other than skin cancer, or [c]they had skin cancer or any other type of cancer.

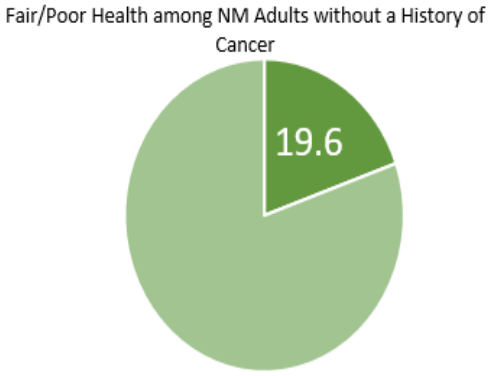


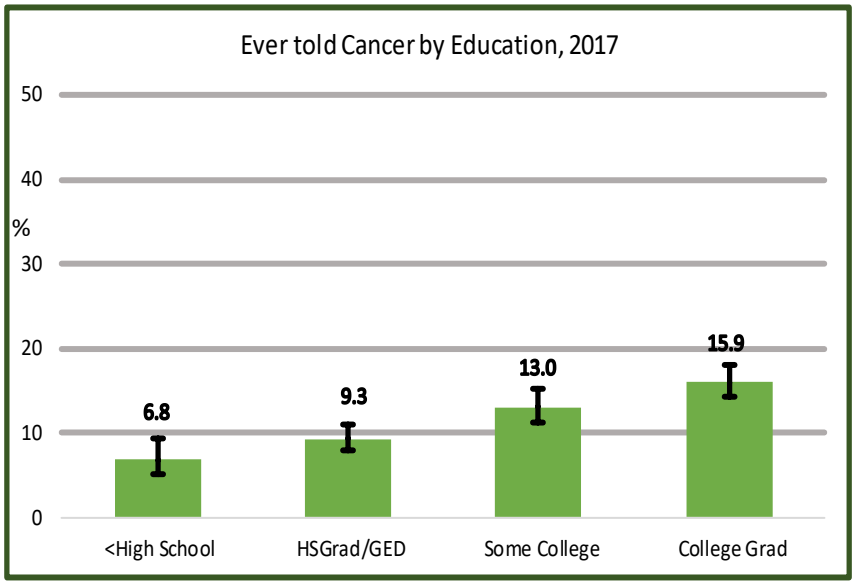


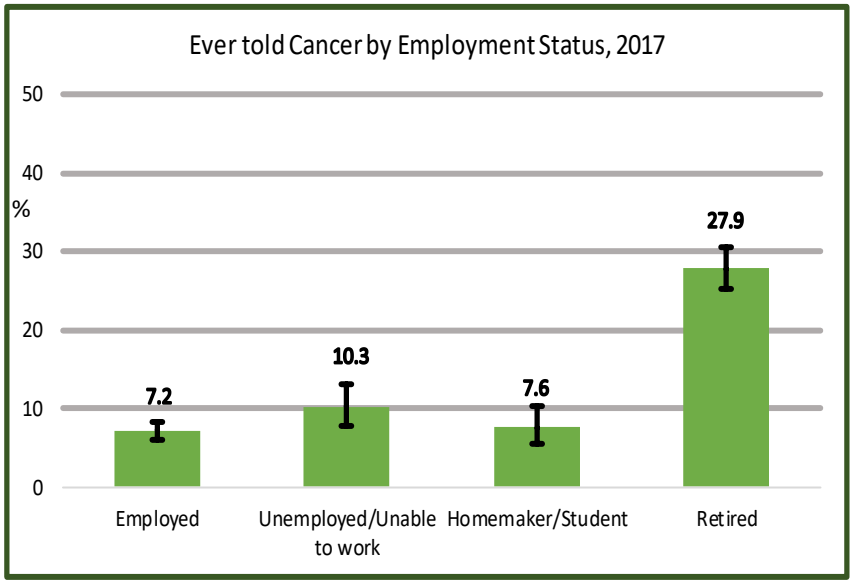
Cancer

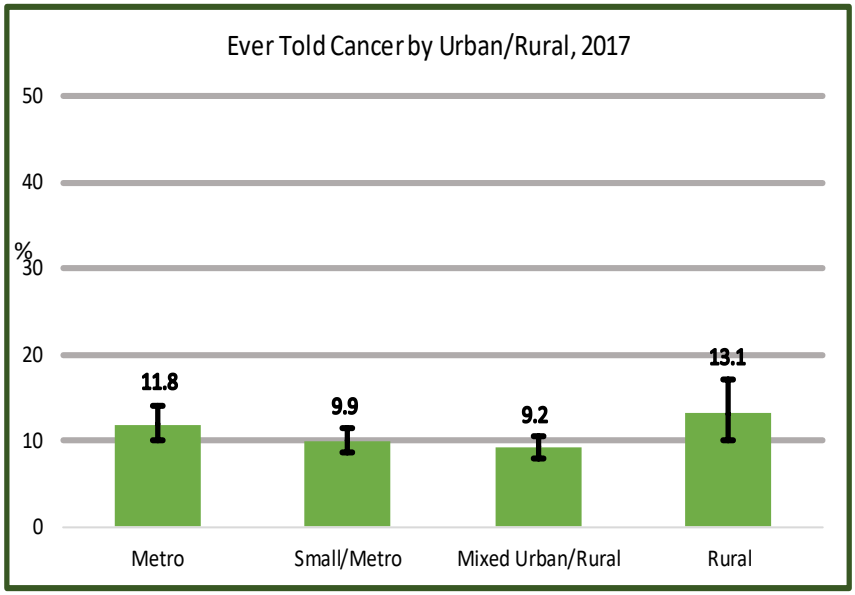
- History of skin cancer was higher among adults with higher education levels.
- Adults who were retired or unable to work were more likely to have a history of skin or other type of cancer. Adjustment for age eliminated the difference between retired and categories other than unable to work.
- There was no statistically significant difference in the prevalence of any type of cancer or any cancer except skin cancer by geographic region or urban/rural county designation.
- Adults with history of cancer were more likely to currently have fair or poor general health status, 34.6% versus 19.6%.











Cardiovascular Disease

Question:

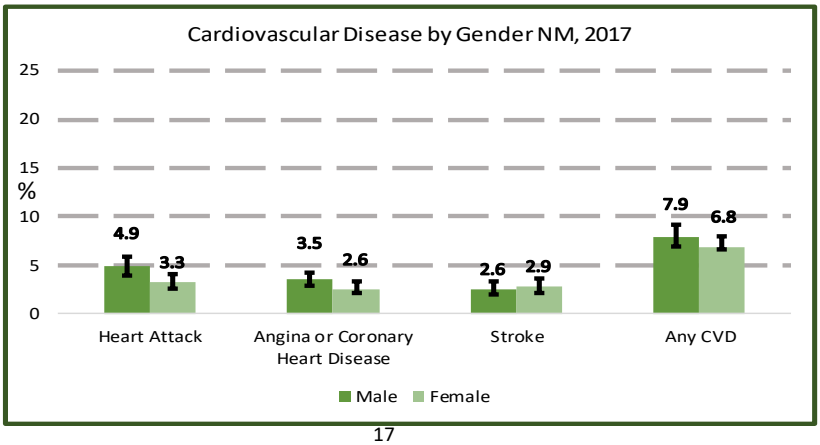
"(Ever told) you had angina or coronary heart disease, stroke, or heart attack?"

Heart disease is the leading cause of death for both men and women in the U.S.[11] It is also one of the leading causes of disability in the U.S. Stroke is the third leading cause of death in the US.[11]

- In 2017, 4.1% of New Mexico adults had ever been told they had angina or coronary heart disease, 2.7% had ever been told they had a stroke, and 3.1% they had a heart attack.
- When combining all three measures into one indicator, an estimated 7.4% of New Mexico adults had ever been told by a doctor that they had some form of cardiovascular disease.
- The prevalence of all three diseases increased with age and decreased with increasing household income level.

Demographic Characteristics	Ever Told Angina or Coronary Heart Disease[a] %	(95% Confidence Interval)	Ever Told Stroke[b] %	(95% Confidence Interval)	Ever Told Heart Attack[c] %	(95% Confidence Interval)
Total	**4.1**	**(3.5-4.7)**	**2.7**	**(2.3-3.3)**	**3.1**	**(2.6-3.5)**
Age						
18-44	1.0	(0.6-1.7)	0.7	(0.4-1.3)	0.5	(0.2-1.0)
45-64	3.8	(2.8-5.0)	3.7	(2.8-4.8)	3.6	(2.8-4.6)
65+	10.8	(9.2-12.7)	5.4	(4.2-6.9)	7.7	(6.4-9.1)
Gender						
Male	4.9	(4.0-5.9)	2.6	(2.0-3.3)	3.5	(2.9-4.3)
Female	3.3	(2.6-4.1)	2.9	(2.2-3.7)	2.6	(2.1-3.3)
Race/Ethnicity						
AIAN	3.8	(2.0-7.0)	2.4	(1.2-4.6)	2.0	(1.1-3.6)
Asian or NHOPI	4.4	(0.6-25.0)	0.6	(0.1-4.1)	5.3	(1.0-23.2)
Black/AA	7.2	(2.3-20.0)	2.7	(0.8-8.7)	4.3	(1.3-13.2)
Hispanic	3.2	(2.5-4.2)	2.2	(1.6-3.0)	1.8	(1.4-2.4)
White	4.9	(4.1-5.9)	3.4	(2.6-4.3)	4.5	(3.8-5.4)
Sexual Orientation						
Straight	4.1	(3.5-4.8)	2.9	(2.4-3.4)	3.1	(2.7-3.6)
LGB/Other	5.0	(2.4-10.2)	0.7	(0.2-2.5)	1.9	(0.9-4.3)
Household Income						
< $15,000	6.5	(4.4-9.6)	4.8	(3.2-7.1)	4.1	(2.8-5.9)
$15,000-$24,999	4.9	(3.7-6.4)	3.8	(2.7-5.2)	4.1	(3.0-5.6)
$25,000-$49,999	3.9	(2.9-5.2)	2.2	(1.5-3.2)	2.3	(1.6-3.1)
$50,000-$74,999	3.0	(1.7-5.2)	2.4	(1.2-4.9)	2.5	(1.5-4.0)
> $75,000	2.0	(1.4-2.9)	1.2	(0.6-2.4)	2.6	(1.9-3.7)
Geographic Region						
Northwest	3.8	(2.7-5.3)	4.2	(3.0-5.8)	2.9	(2.1-4.1)
Northeast	4.3	(3.1-5.9)	2.5	(1.7-3.6)	2.9	(2.0-4.1)
Metropolitan	3.8	(2.9-4.9)	2.3	(1.6-3.3)	2.5	(1.8-3.3)
Southeast	5.2	(3.9-6.7)	3.1	(2.1-4.4)	4.3	(3.2-5.8)
Southwest	4.0	(2.9-5.5)	3.0	(2.0-4.5)	3.7	(2.8-4.9)

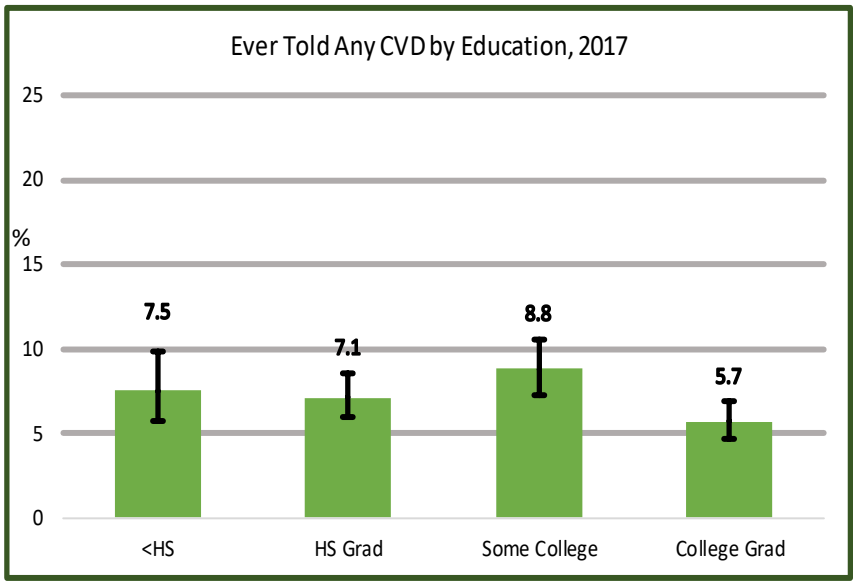
Among all adults, the proportion ever told by a doctor that: [a] they had angina or coronary heart disease, [b]they had a stroke, or [c]they had a heart attack or myocardial infarction.

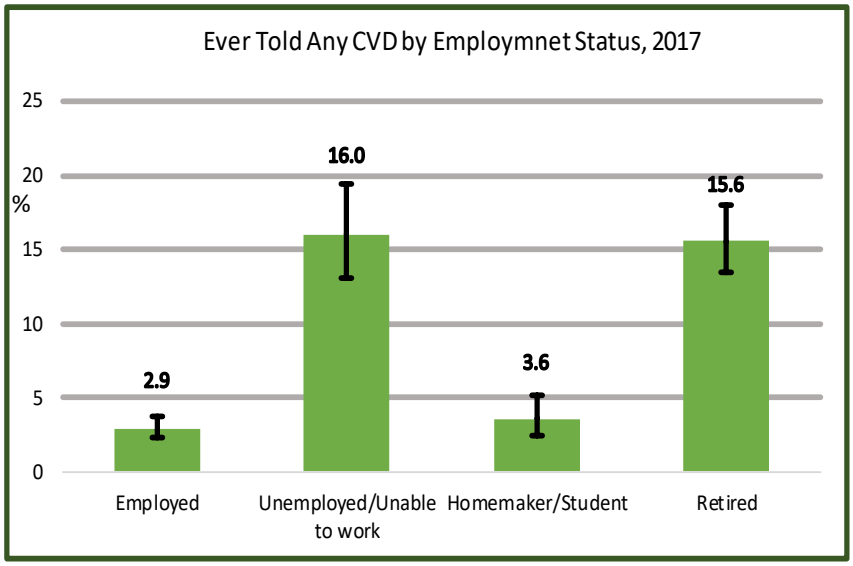


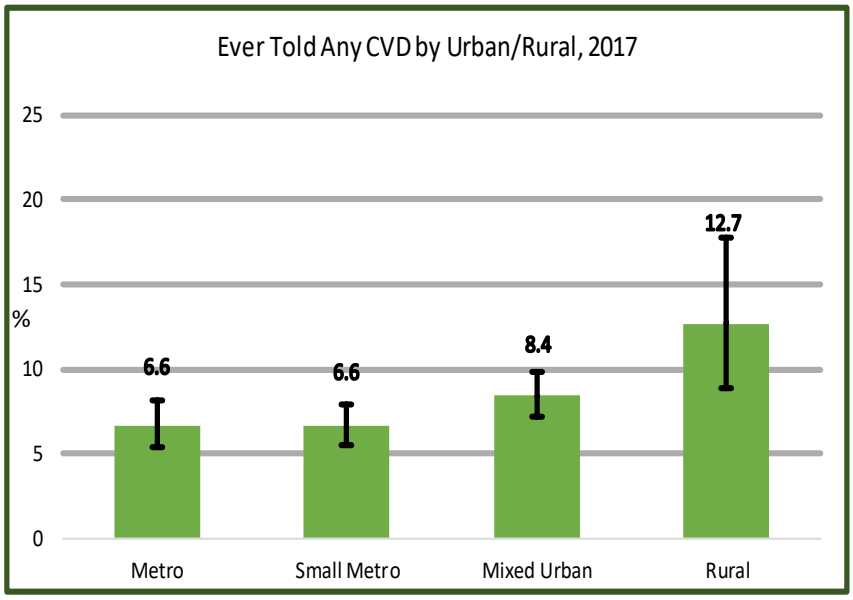
Cardiovascular Disease

Health conditions such as high blood cholesterol levels, high blood pressure, obesity, and diabetes mellitus can increase the risk of cardiovascular disease (CVD). Behavioral factors, including tobacco and alcohol use, diets high in saturated fat and cholesterol, and physical inactivity, may also increase the risk of development of cardiovascular disease.[11]

- There was no statistically measurable difference by race/ethnicity.
- Males were more likely than women to have a history of coronary heart disease and myocardial infarction (4.9% and 3.5%), than females (3.3% and 2.6%), but these difference were not statistically significant.
- Adults with less education or lower annual household income were more likely to have a history of CVD.
- Adults who were unemployed/unable to work were much more likely to have a history of CVD than those who were employed. Adjustment for age nearly eliminated the difference between retired and other employment categories.
- Former smokers were more likely to have a history of any CVD (10.9%) compared to adults who had never smoked (5.2%).







Chronic Obstructive Pulmonary Disease (COPD)

Question:

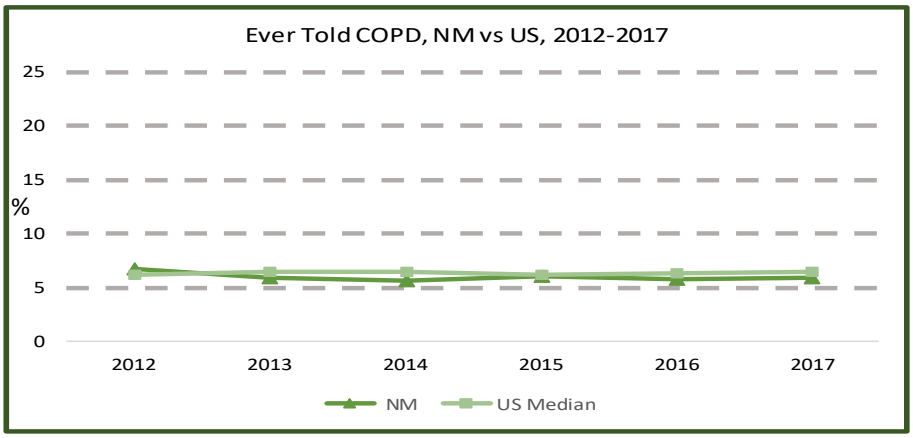
"Have you ever been told by a doctor, nurse or other health professional that you have COPD (chronic obstructive pulmonary disease), emphysema or chronic bronchitis?"

Chronic obstructive pulmonary disease, or COPD, is a serious lung disease that makes it hard to breathe and gets worse over time. COPD includes two main conditions, emphysema and chronic bronchitis.[12] Other causes include exposure to smoke caused by burning wood and worksite dusts and chemicals.[13]

- In 2017, 5.9% of New Mexico adults had been diagnosed with some form of COPD. This was lower than the U.S. median COPD prevalence, 6.5%.
- The prevalence of COPD among females (6.3%) was higher than among males (5.6%).
- The difference in the prevalence of COPD by sexual orientation was not statistically significant.
- White adults (7.8%) were more likely to have COPD than AIAN (1.9%) and Hispanic adults (5.0%).
- There was a gradient in COPD prevalence by level of household income. Those living in households with income more than $75,000 per year had a lower prevalence of COPD (3.3%), and those at the lowest income level of less than $15,000 a year had higher COPD prevalence (13.3%).

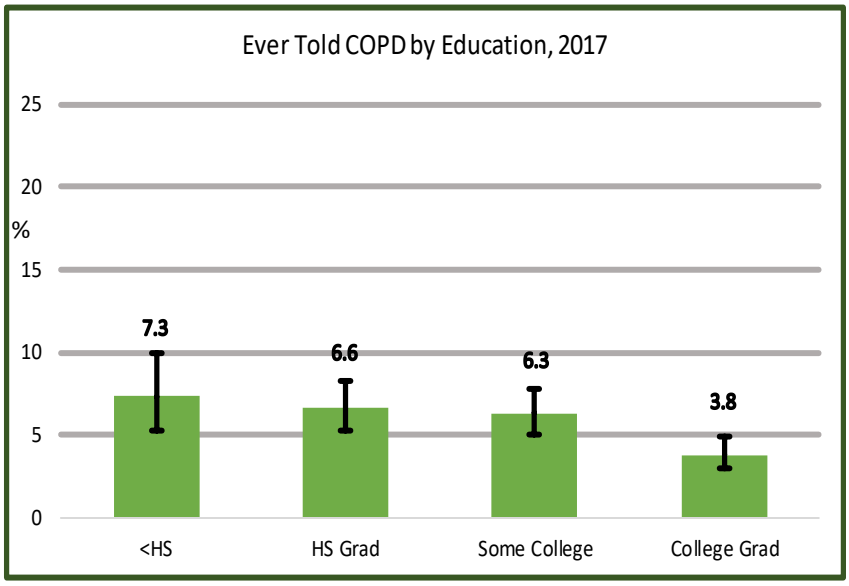
Demographic Characteristics	Ever Told COPD[a] %	Ever Told COPD[a] (95% Confidence Interval)
Total	**5.9**	**(5.2-6.7)**
Age		
18-44	2.1	(1.4-3.1)
45-64	8.4	(6.9-10.1)
65+	10.5	(8.9-12.3)
Gender		
Male	5.6	(4.6-6.8)
Female	6.3	(5.3-7.4)
Race/Ethnicity		
AIAN	1.9	(0.8-4.4)
Asian or NHOPI	7.7	(2.1-24.7)
Black/AA	8.2	(3.1-20.2)
Hispanic	5.0	(4.0-6.3)
White	7.8	(6.7-9.0)
Sexual Orientation		
Straight	6.1	(5.4-7.0)
LGB/Other	7.6	(4.3-13.1)
Household Income		
< $15,000	13.3	(10.4-16.8)
$15,000-$24,999	6.7	(5.1-8.6)
$25,000-$49,999	4.9	(3.7-6.4)
$50,000-$74,999	4.0	(2.6-6.2)
> $75,000	3.3	(2.3-4.6)
Geographic Region		
Northwest	5.0	(4.0-6.3)
Northeast	3.9	(2.9-5.2)
Metropolitan	6.2	(5.0-7.7)
Southeast	7.0	(5.4-9.1)
Southwest	6.6	(5.2-8.4)

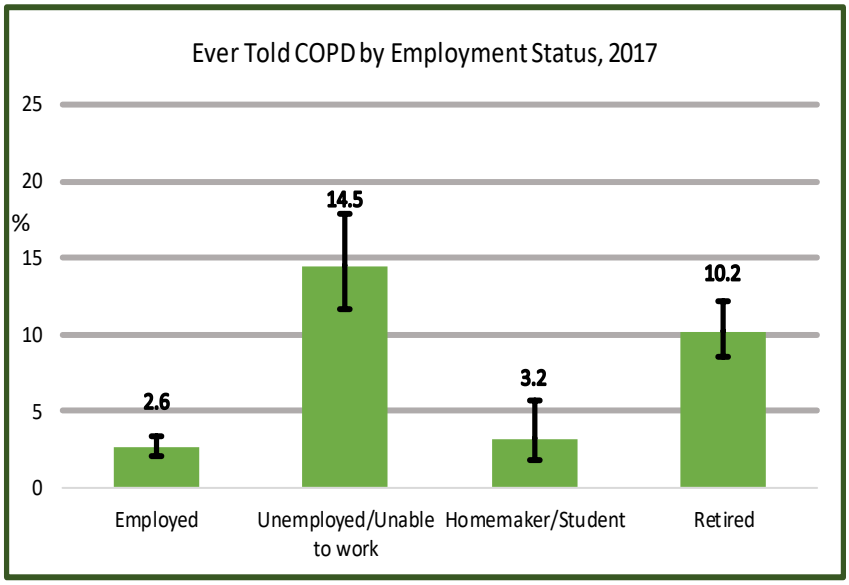
[a]Among all adults , the proportion reporting ever being told by a doctor that they had chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis.

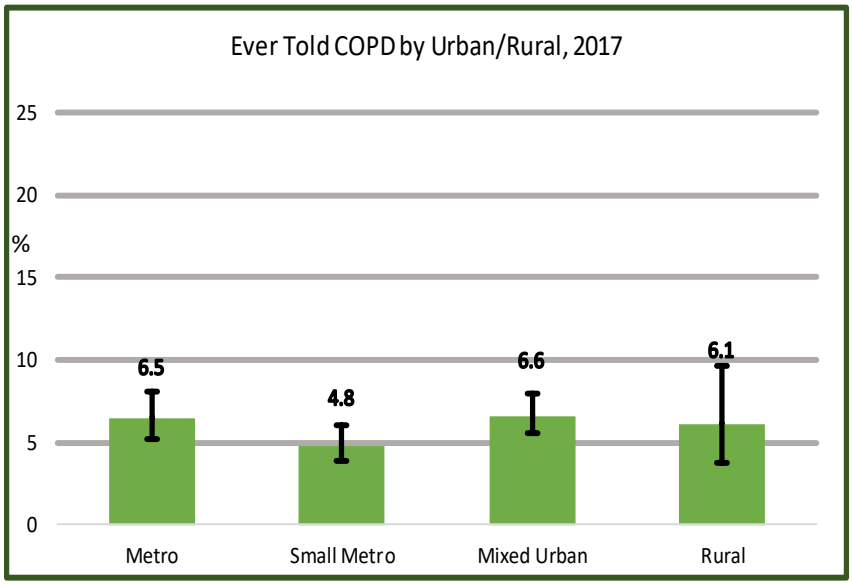


Chronic Obstructive Pulmonary Disease (COPD)

- The prevalence of history of COPD was highest in the Southeast region (7.0%) and lowest in the Northeast region (3.9%).
- The prevalence of COPD was lower among adults with a college degree or more education among all education levels.
- The prevalence of a history of COPD was more than 3 times higher among adults who were unemployed/unable to work or retired, than employed or homemaker/ student.
- The prevalence was not statistically significant different by Urban/Rural county designation.
- History of COPD was higher among current (13.2%) and former smokers (11.1%) than never smokers (2.5%).
- 56.2% of adults with COPD had fair or poor general health status, versus 19.1% of adults with no history of COPD. 66.7% of those with COPD had at least one disability, versus 27.1% of adults without COPD.







Depression

Questions:

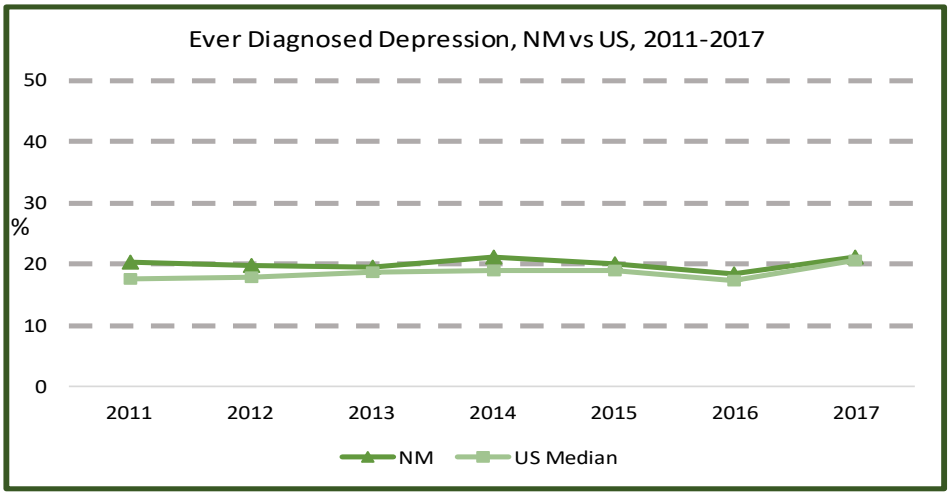
"Have you ever been told you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?"

Depression is characterized by depressed or sad mood, diminished interest in activities that used to be pleasurable, weight gain or loss, psychomotor agitation or retardation, fatigue, inappropriate guilt, difficulties concentrating, as well as recurrent thoughts of death.[15]

- In 2017, 21.2% had a history of depression meaning they had ever been told they had depression, this is slightly higher than the U.S. median (20.5%).
- Adults aged 45-64 had a higher prevalence of history of depression (24.0%) than adults over the age of 65 (17.3%).
- Females had a higher prevalence of history of depression (26.0%) than males (16.2%).
- White adults (22.9%) were more likely to have a history of depression than AIAN adults (14.2%).
- History of depression was higher among LGB/Other (40.3%), compared to Straight adults (20.5%).

Demographic Characteristics	Ever Told Depression[a] %	Ever Told Depression[a] (95% Confidence Interval)
Total	**21.2**	**(19.8-22.7)**
Age		
18-44	21.3	(19.0-23.9)
45-64	24.0	(21.7-26.4)
65+	17.3	(15.3-19.4)
Gender		
Male	16.2	(14.4-18.3)
Female	26.0	(23.9-28.1)
Race/Ethnicity		
AIAN	14.2	(10.2-19.5)
Asian or NHOPI	13.4	(6.3-26.4)
Black/AA	20.2	(10.9-34.5)
Hispanic	21.2	(19.0-23.7)
White	22.9	(21.0-25.0)
Sexual Orientation		
Straight	20.5	(19.1-22.1)
LGB/Other	40.3	(31.5-49.8)
Household Income		
< $15,000	36.4	(31.8-41.4)
$15,000-$24,999	22.9	(19.7-26.5)
$25,000-$49,999	19.9	(17.0-23.1)
$50,000-$74,999	16.8	(13.7-20.4)
> $75,000	16.1	(13.4-19.2)
Geographic Region		
Northwest	18.0	(15.4-21.0)
Northeast	20.8	(17.8-24.1)
Metropolitan	22.1	(19.6-24.8)
Southeast	21.4	(18.4-24.7)
Southwest	20.9	(18.0-24.1)

[a]The proportion reporting ever being told that they had depression by a healthcare professional.

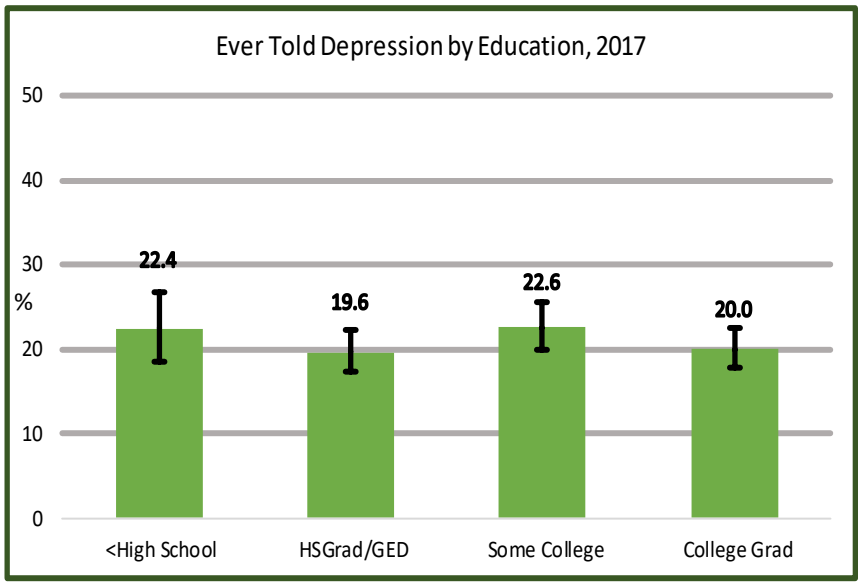


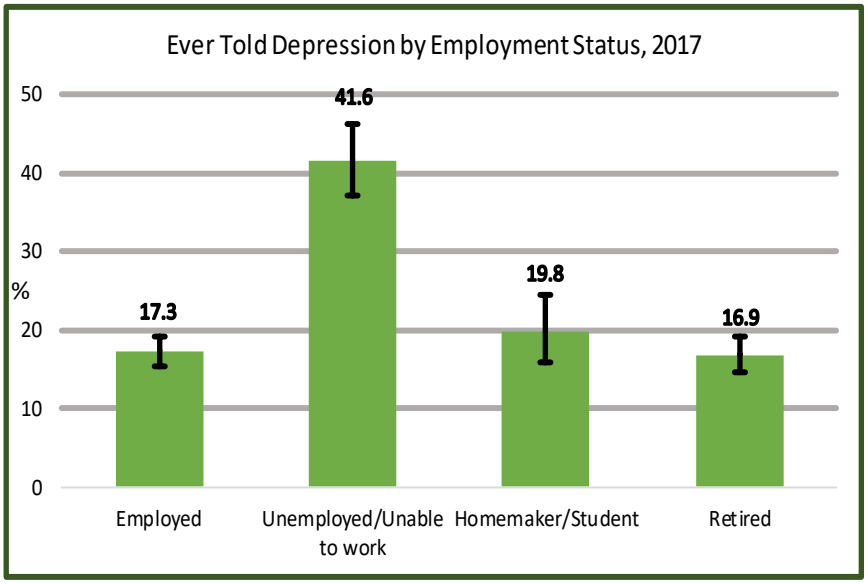
Depression

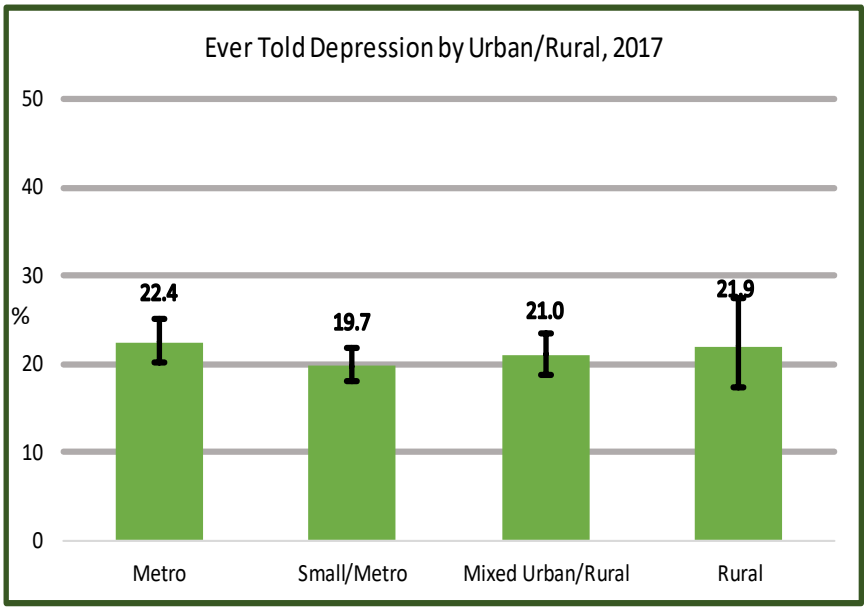
- There was a gradient in the prevalence of history of depression by level of household income. Of lower income adults, over one third (36.4%) had ever been diagnosed with a depressive disorder, decreasing to 16.1% among adults in the highest household income level.

- There was no measurable difference in current depression or history of depression by geographic region or urban/rural county designation.

- Over forty percent (41.6%) of adults who were unable to work or unemployed had a history of diagnosed depression.







Diabetes

Question:

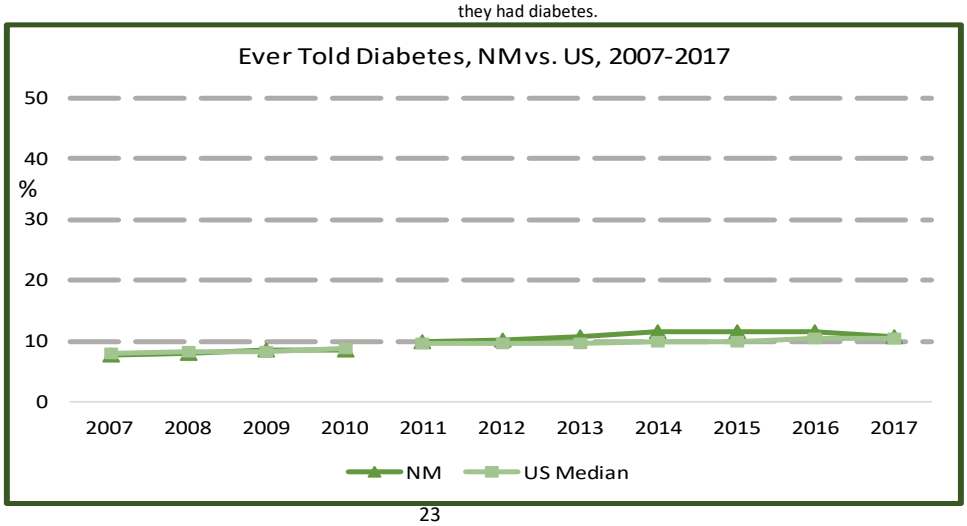
"Have you ever been told by a doctor that you have diabetes?"

Diabetes Mellitus (DM) is a group of diseases characterized by high levels of blood glucose resulting from insufficient insulin production, insulin action, or both. Diabetes can be associated with serious complications including cardiovascular disease, end-stage renal disease, blindness, amputation, and premature death, but people with diabetes can take steps to control the disease and lower the risk of complications.[16]

- In 2017, the percentage of adults in New Mexico with diagnosed diabetes was 10.7%. The NM rate was similar to the U.S. rate (10.5%). The prevalence of diagnosed diabetes has increased in recent years, both in NM and nationally.
- Diagnosed diabetes was higher among AIAN (18.6%) than among White adults (8.3%).
- There was no statistically significant difference in diabetes prevalence by gender.
- Adults with lower incomes were more likely to have been diagnosed with diabetes, 16.0% for adults with the lowest income category and 6.8% for adults with the highest income category.
- Adults in the Northwest region (15.7%) were more likely to have been diagnosed with diabetes while adults in the Metropolitan region had the lowest (9.1%).

Demographic Characteristics	Ever Told Diabetes[a] %	Ever Told Diabetes[a] (95% Confidence Interval)
Total	**10.7**	**(9.7-11.7)**
Age		
18-44	3.8	(2.7-5.3)
45-64	13.9	(12.2-16.0)
65+	20.1	(17.9-22.5)
Gender		
Male	11.6	(10.2-13.3)
Female	9.8	(8.6-11.1)
Race/Ethnicity		
AIAN	18.6	(14.7-23.2)
Asian or NHOPI	14.5	(6.0-31.1)
Black/AA	10.7	(5.1-21.2)
Hispanic	11.6	(10.0-13.4)
White	8.3	(7.2-9.5)
Sexual Orientation		
Straight	10.9	(9.9-12.0)
LGB/Other	7.4	(4.0-13.3)
Household Income		
< $15,000	16.0	(13.1-19.4)
$15,000-$24,999	12.1	(9.7-14.9)
$25,000-$49,999	9.7	(7.8-12.2)
$50,000-$74,999	9.8	(7.3-13.0)
> $75,000	6.8	(5.4-8.6)
Geographic Region		
Northwest	15.7	(13.4-18.3)
Northeast	10.3	(7.9-13.4)
Metropolitan	9.1	(7.5-10.9)
Southeast	11.4	(9.5-13.6)
Southwest	11.8	(9.9-14.1)

[a]Among all adults, the proportion reporting that they were ever told by a doctor that they had diabetes.



Diabetes

- New Mexico adults with less education were more likely to be diagnosed with diabetes; adults with less than a high school education (14.2%) had a higher prevalence than adults with a college graduate education (6.9%).

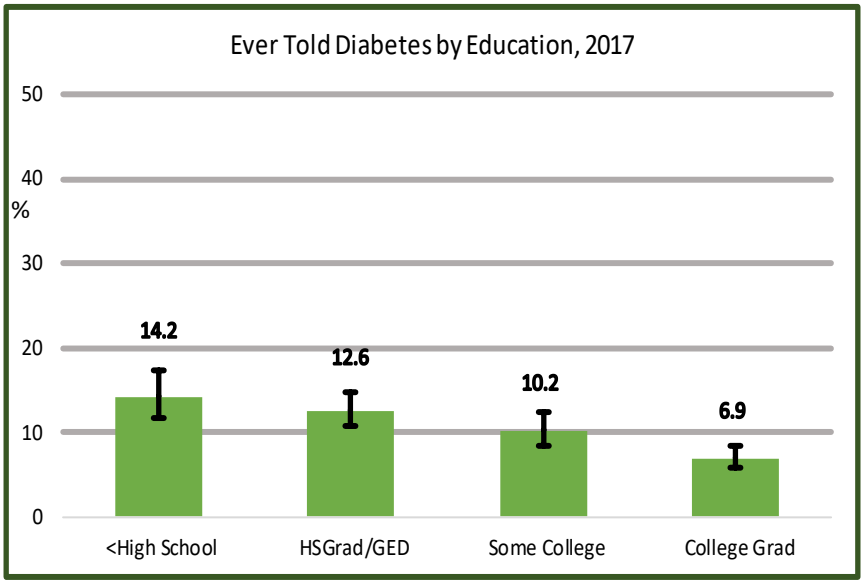
- In 2017, the prevalence of diagnosed diabetes was much higher among adults who were unemployed/unable to work (19.7%) and among retired adults (17.6%) compared to employed adults (6.2%) and homemaker/student adults (7.7%).

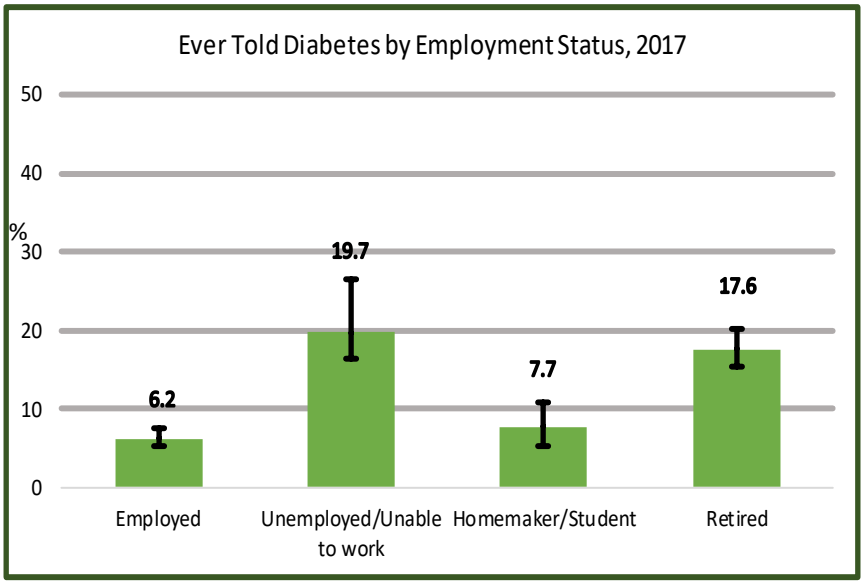
- The was no measurable difference by Urban/Rural designation.

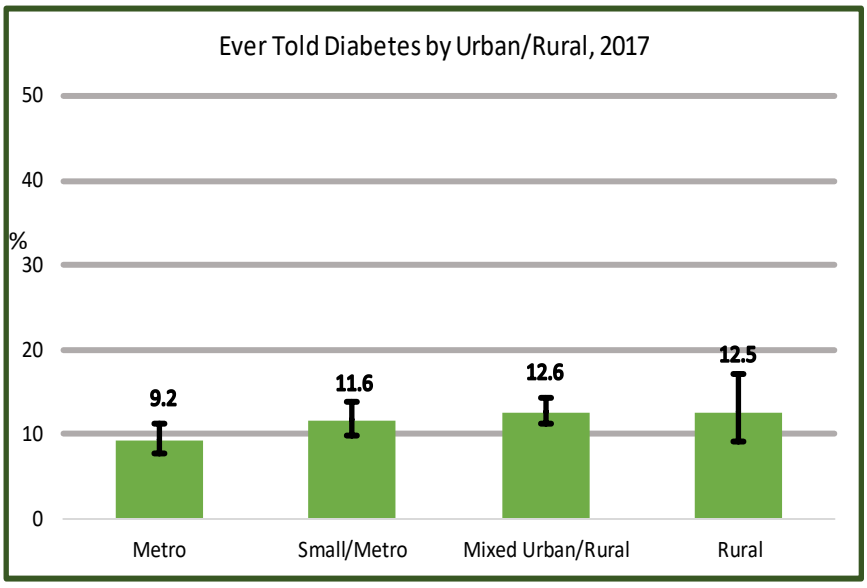
- Adults who were obese had the highest prevalence of diagnosed diabetes (19.0%) followed by overweight individuals (10.1%) and adults within the healthy weight range (5.5%).

- Over half of adults (52.4%) with diagnosed diabetes had fair or poor general health status, compared to 17.7% of adults with diagnosed diabetes.

- Over half (52.5%) of adults with diagnosed diabetes had a disability, compared to 26.8% of those without diagnosed diabetes.







Chronic Pain

Question:

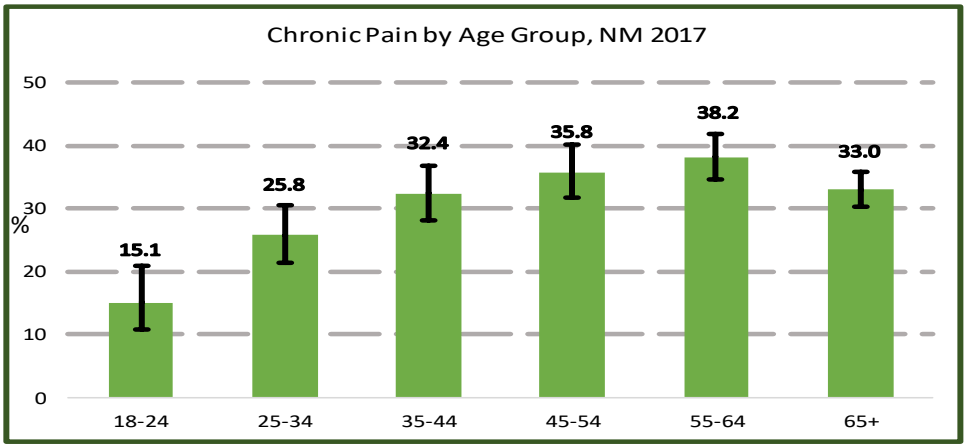
"Do you suffer from any type of chronic pain that occurs constantly or flares up….How long?"

Chronic pain is a pain that persists longer than what would be considered the normal healing time. The economic and societal burden of chronic pain due to a decrease in quality of life has made chronic pain a public health indicator of interest.[17]

- In 2017, the percentage of adults in New Mexico with chronic pain was 30.8%. Due to differences in methodology a national estimate is not available.
- Chronic pain was more prevalent among adults 45 years of age and older.
- The prevalence of chronic pain was much higher in females (34.1%) than males (27.4%).
- AIAN had a significantly lower prevalence than other race/ethnicity groups.
- Adults with lower incomes were more likely to have chronic pain, at 48.0% for adults with the lowest income category and 24.3% for adults with the highest income category.
- Adults in the Northeast region of the state had a higher prevalence of chronic pain (33.7%) compared to adults in the Northwest region (26.1%).

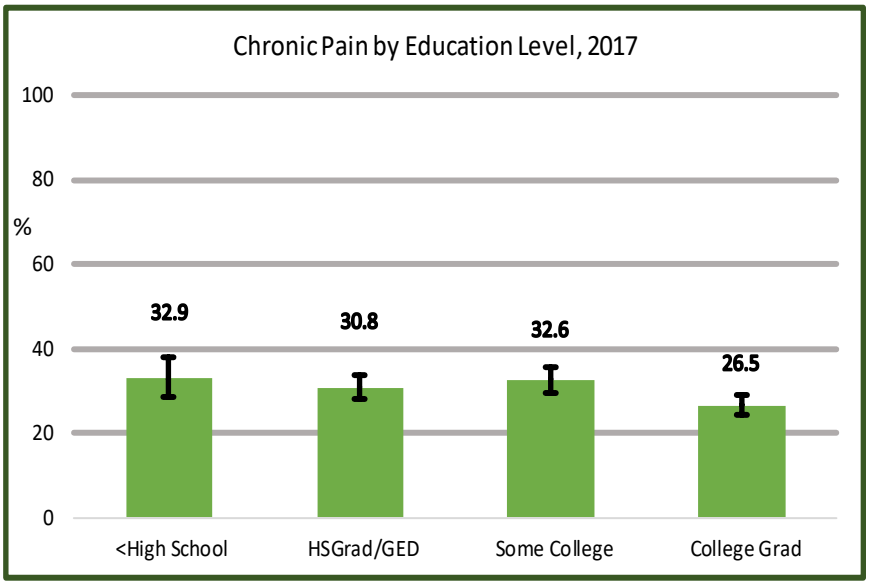
Demographic Characteristics	Chronic Pain[a] %	Chronic Pain[a] (95% Confidence Interval)
Total	**30.8**	**(29.2-32.4)**
Age		
18-44	25.1	(22.5-27.9)
45-64	37.1	(34.4-39.8)
65+	33.0	(30.4-35.8)
Gender		
Male	27.4	(25.2-29.8)
Female	34.1	(31.8-36.4)
Race/Ethnicity		
AIAN	20.2	(15.8-25.3)
Asian or NHOPI	**	**
Black/AA	34.1	(21.5-49.4)
Hispanic	30.0	(27.5-32.8)
White	33.9	(31.6-36.2)
Sexual Orientation		
Straight	30.5	(28.8-32.2)
LGB/Other	36.2	(28.1-45.1)
Household Income		
< $15,000	48.0	(43.0-53.0)
$15,000-$24,999	33.7	(29.9-37.6)
$25,000-$49,999	28.6	(25.3-32.1)
$50,000-$74,999	28.2	(24.2-32.7)
> $75,000	24.3	(21.2-27.6)
Geographic Region		
Northwest	26.1	(23.2-29.4)
Northeast	33.7	(30.1-37.5)
Metropolitan	30.8	(28.0-33.8)
Southeast	32.2	(28.8-35.8)
Southwest	29.6	(26.3-33.2)

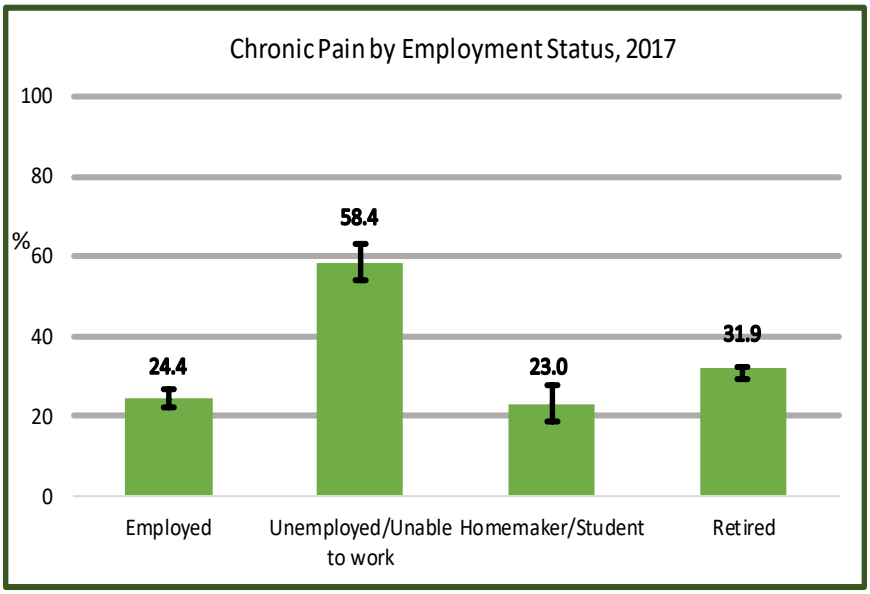
[a]Among all adults, the proportion reporting that they suffer from any type of chronic pain that occurs constantly or flares up and have experienced this type of pain for more than 3 months. ** Suppressed due to a denominator <50.

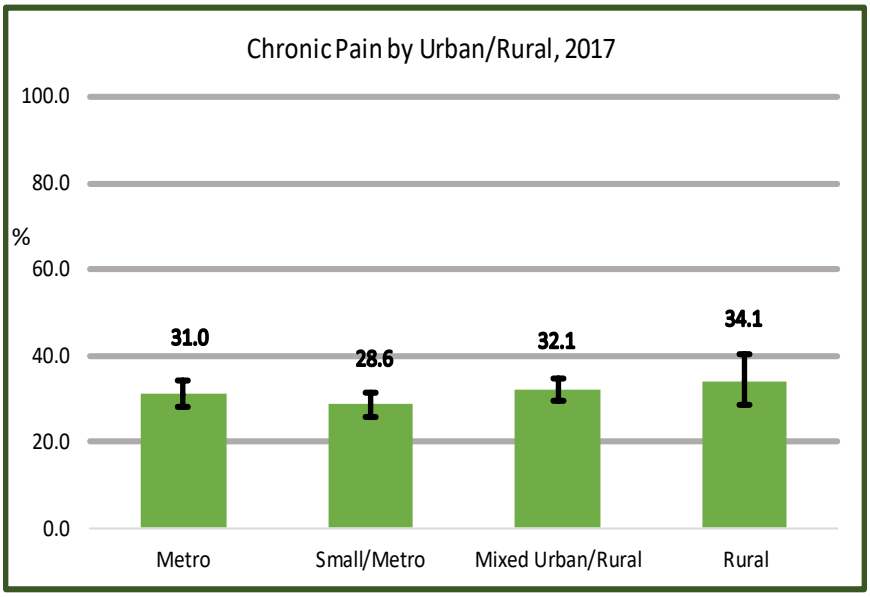


Chronic Pain

- New Mexico adults with less education were more likely to have chronic pain, adults with less than a high school education (32.9%) had a higher prevalence than adults with a college graduate education (26.5%).
- In 2017, the prevalence of chronic pain was much higher among adults who were unemployed/unable to work (58.4%) compared to all other employment categories.
- The was no measurable difference by Urban/Rural designation.
- Over half of adults (56.3%) with chronic pain had at least one disability, compared to 17.9% of adults without chronic pain.
- Adults with chronic pain were more likely to report fair/poor health (56.3%) compared to adults without chronic pain (17.9%).







Alcohol Consumption

Question:

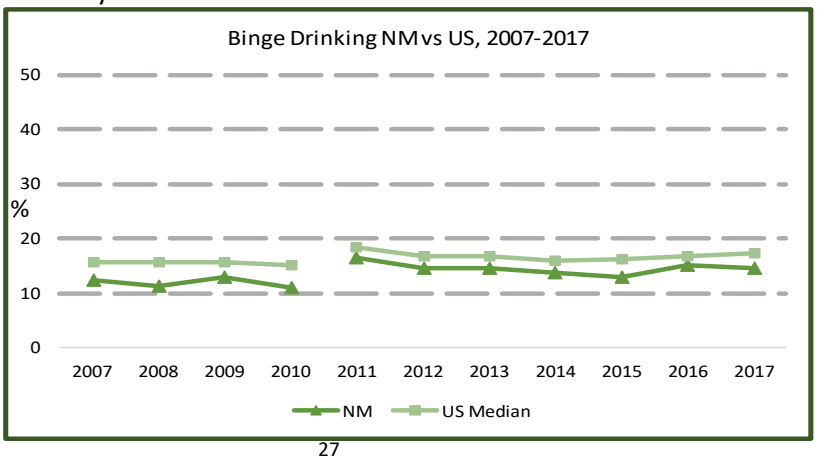
"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more (men) or 4 or more (women) drinks on a single occasion?"

Excessive alcohol consumption is a contributing factor to morbidity and mortality from many causes.[18] Acute binge drinking (defined as 5 or more drinks for males and 4 or more drinks for females on at least one occasion during the past month) is strongly associated with injuries and death from motor vehicle crashes, homicide, suicide, falls and drug overdose. Chronic 'heavy' drinking (defined as > 2 drinks per day for men and > 1 drink per day for women on average during the past month) is strongly associated with numerous alcohol-related diseases, most notably alcohol-related chronic liver disease.[18]

- In 2017, the prevalence of binge drinking was 14.7%, lower than the U.S. median of 17.4%. 5.5% of New Mexico adults were heavy drinkers. Although the rates of binge drinking were lower in NM than the U.S., over the past 20 years, New Mexico has consistently had among the highest alcohol-related death rates in the U.S.[18]
- Binge drinking was more prevalent among the younger age groups, but was relatively uncommon in the older age groups, ranging from a high of 21.1% in those 18-44 years of age to 4.8% in those 65+. Heavy drinking was more evenly distributed across age groups.

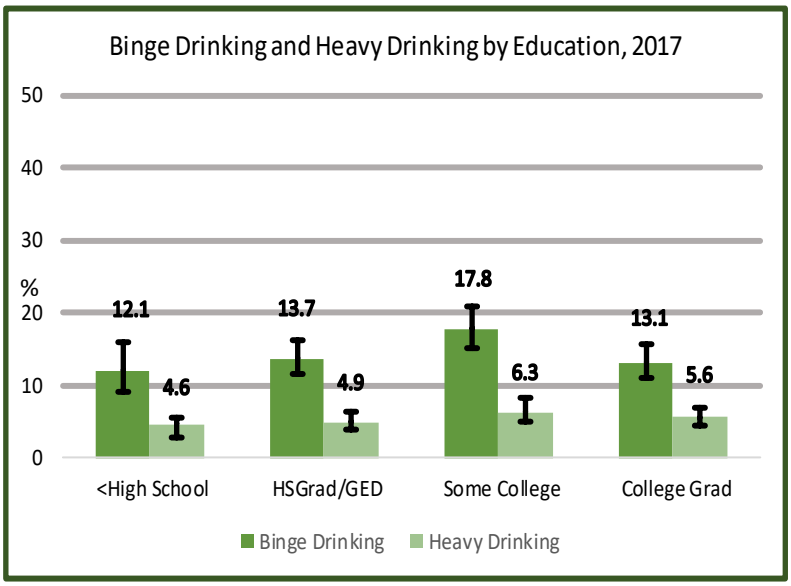
Demographic Characteristics	Binge Drinking[a] %	Binge Drinking[a] (95% Confidence Interval)	Heavy Drinking[b] %	Heavy Drinking[b] (95% Confidence Interval)
Total	**14.7**	**(13.4-16.1)**	**5.5**	**(4.8-6.4)**
Age				
18-44	21.1	(18.6-23.8)	5.7	(4.5-7.2)
45-64	12.7	(10.9-14.8)	5.8	(4.6-7.3)
65+	4.8	(3.8-6.1)	4.7	(3.6-6.2)
Gender				
Male	19.3	(17.2-21.5)	6.2	(5.1-7.5)
Female	10.3	(8.7-12.2)	4.9	(3.9-6.1)
Race/Ethnicity				
AIAN	16.3	(12.0-21.8)	4.8	(3.1-7.5)
Asian or NHOPI	21.2	(9.2-41.7)	0.0	(.)
Black/AA	16.4	(6.4-35.7)	7.4	(2.1-22.6)
Hispanic	15.8	(13.7-18.2)	4.4	(3.3-5.7)
White	13.2	(11.5-15.1)	7.1	(5.9-8.4)
Sexual Orientation				
Straight	14.0	(12.7-15.5)	5.2	(4.5-6.0)
LGB/Other	23.0	(15.3-33.0)	7.5	(3.7-14.4)
Household Income				
< $15,000	12.6	(9.8-16.1)	4.1	(2.6-6.4)
$15,000-$24,999	16.4	(13.2-20.1)	6.0	(4.3-8.5)
$25,000-$49,999	16.2	(13.4-19.5)	5.9	(4.5-7.8)
$50,000-$74,999	13.2	(10.0-17.1)	5.2	(3.7-7.4)
> $75,000	17.3	(14.3-20.7)	6.5	(5.0-8.6)
Geographic Region				
Northwest	13.9	(11.2-17.1)	4.8	(3.5-6.6)
Northeast	13.9	(11.2-17.3)	7.3	(5.2-10.1)
Metropolitan	14.3	(12.1-16.8)	4.6	(3.5-6.0)
Southeast	14.6	(11.9-17.7)	5.6	(5.0-8.9)
Southwest	16.8	(13.8-20.2)	6.7	(4.8-6.4)

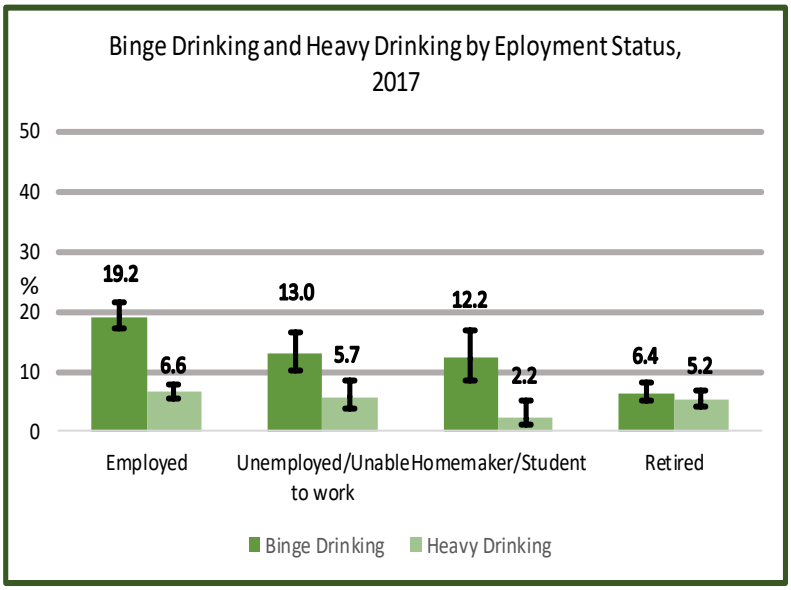
[a]Among all adults, the proportion reporting consuming five or more drinks per occasion (males) or four or more drinks (females) at least once in the past month or [b]reporting consuming seven or more drinks per week.

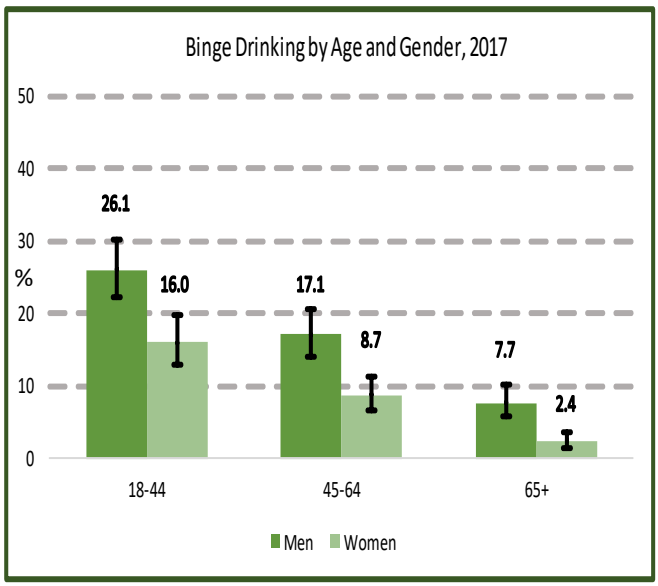


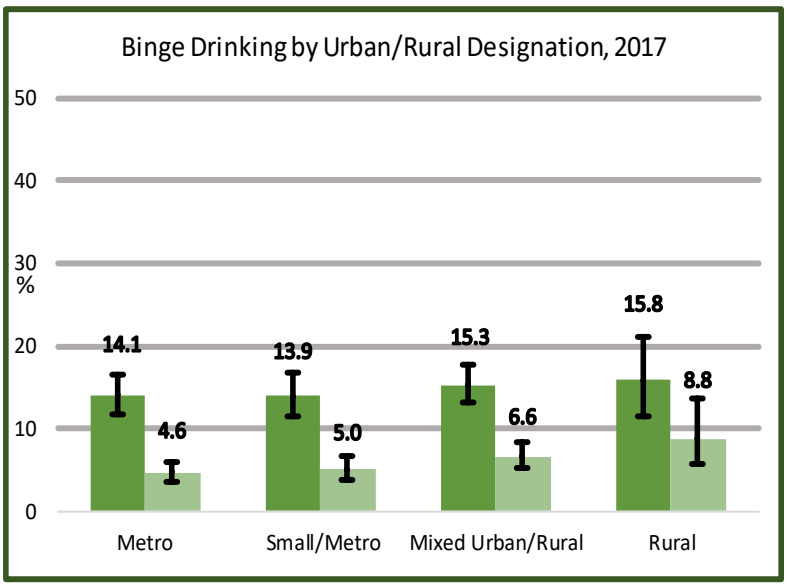
Alcohol Consumption

- Binge drinking was statistically significantly higher among adult males (19.3%) than among adult females (10.3%).
- There was no measurable difference in binge drinking or heavy drinking by race/ethnicity.
- There was no statistically significant difference in binge drinking or heavy drinking by income level or sexual orientation.
- Adults with some college had a higher prevalence of binge drinking (17.8%) compared to adults with less than an high school education (12.1%).
- Employed adults had a significantly higher prevalence of binge drinking (19.2%) than retired adults (6.4%).
- There was no measurable difference for binge drinking by Urban/Rural county designation.









Immunizations Among Adults 65+

Question:

"During the past 12 months have you had either a flu shot or flu vaccine?

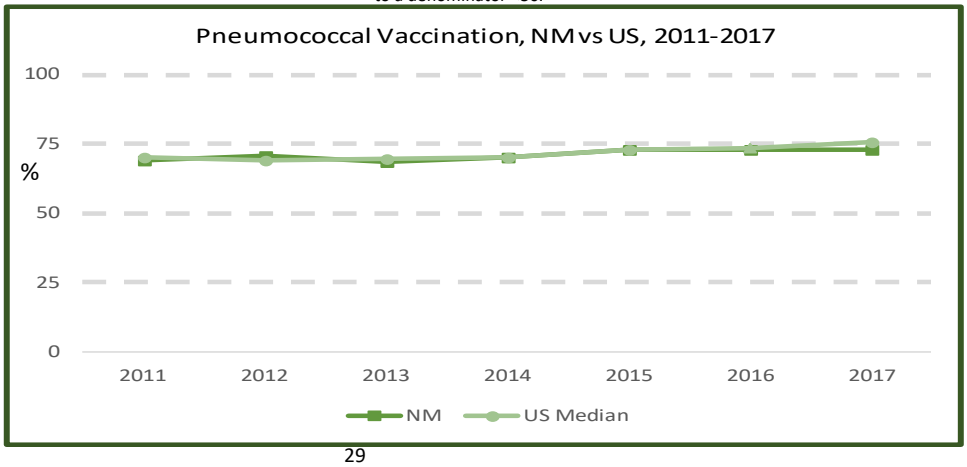
Have you ever had a pneumonia shot?"

People 65 years and older are at a greater risk of serious complications from the flu and from pneumonia. Monitoring adult immunizations against influenza and pneumococcal disease is an important indicator within public health to assess the morbidity and mortality associated with both of these diseases. [19]

- In New Mexico in 2017, 55.2% of New Mexico adults 65 and older received a flu vaccine and 73.0% report that they have ever had a pneumonia shot.
- A greater percentage of White adults had a flu shot in the past year and have ever had a pneumonia shot (56.9% and 76.8%) compared to all other race/ethnicities.
- The prevalence of both having a flu vaccine in the past year and ever having a pneumonia vaccine was similar by gender.
- There was not a statistically significant difference in the prevalence of either having a flu vaccine the past year or ever having the pneumonia vaccine by household income or geographic region.

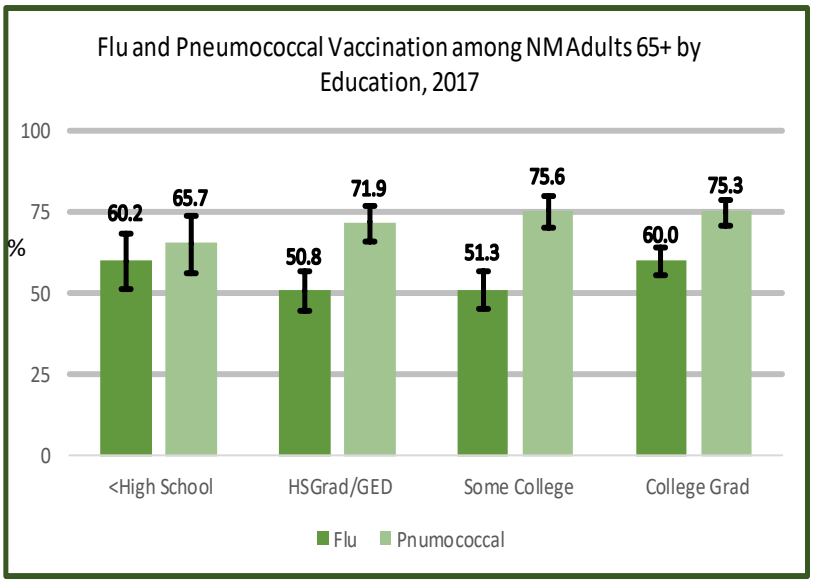
	Flu Vaccine[a]		Pneumonia Vaccine[b]	
Demographic Characteristics	%	(95% Confidence Interval)	%	(95% Confidence Interval)
Total	**55.2**	**(52.2-58.1)**	**73.0**	**(70.2-75.7)**
Age				
65-74	53.1	(49.2-56.9)	68.4	(64.6-71.9)
75+	58.4	(53.5-63.1)	80.3	(75.9-84.1)
Gender				
Male	54.0	(49.5-58.5)	69.7	(65.3-73.7)
Female	56.1	(52.1-60.1)	75.8	(72.1-79.2)
Race/Ethnicity				
AIAN	52.8	(39.5-65.8)	67.5	(53.9-78.7)
Asian or NHOPI	**	**	**	**
Black/AA	**	**	**	**
Hispanic	53.1	(46.9-59.1)	67.1	(61.0-72.7)
White	56.9	(53.4-60.3)	76.8	(73.7-79.7)
Sexual Orientation				
Straight	55.8	(52.7-58.8)	73.3	(70.4-76.0)
LGB/Other	**	**	**	**
Household Income				
< $15,000	57.6	(48.4-66.2)	70.8	(62.3-78.0)
$15,000-$24,999	54.7	(47.2-62.1)	72.3	(65.1-78.6)
$25,000-$49,999	48.0	(42.1-53.9)	70.7	(64.9-75.8)
$50,000-$74,999	56.0	(47.3-64.4)	78.8	(71.0-84.9)
> $75,000	59.5	(52.8-65.8)	75.4	(68.5-81.1)
Geographic Region				
Northwest	56.0	(50.0-61.8)	70.7	(64.8-76.0)
Northeast	53.3	(46.6-59.3)	70.5	(63.9-76.3)
Metropolitan	58.9	(53.4-64.2)	76.5	(71.3-81.0)
Southeast	48.3	(41.8-54.9)	65.9	(59.5-71.7)
Southwest	52.7	(52.2-58.1)	73.2	(67.4-78.3)

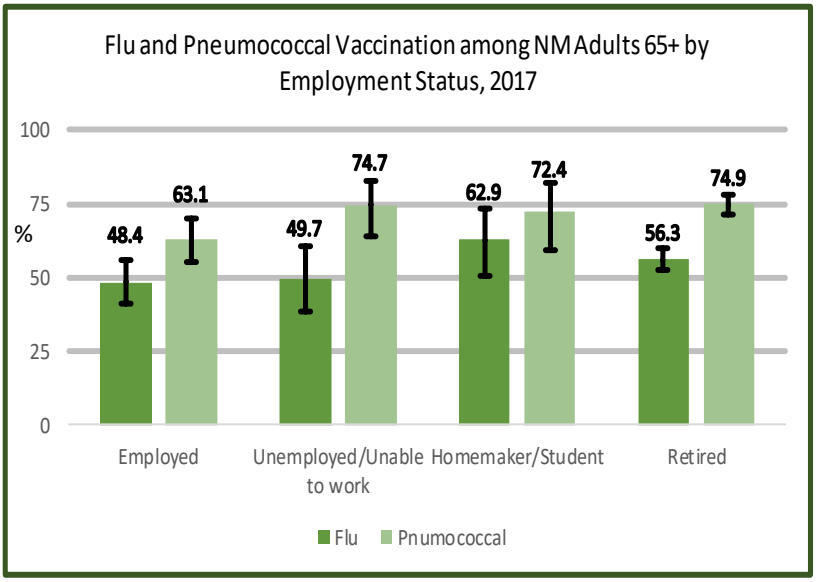
[a]Among adults aged 65 years and older, the proportion reporting that they had a flu vaccine, either by injection or sprayed in the nose in the past 12 months. [b]Among adults 65 years and older, the proportion reporting that they ever had pneumococcal vaccine. ** Suppressed due to a denominator <50.

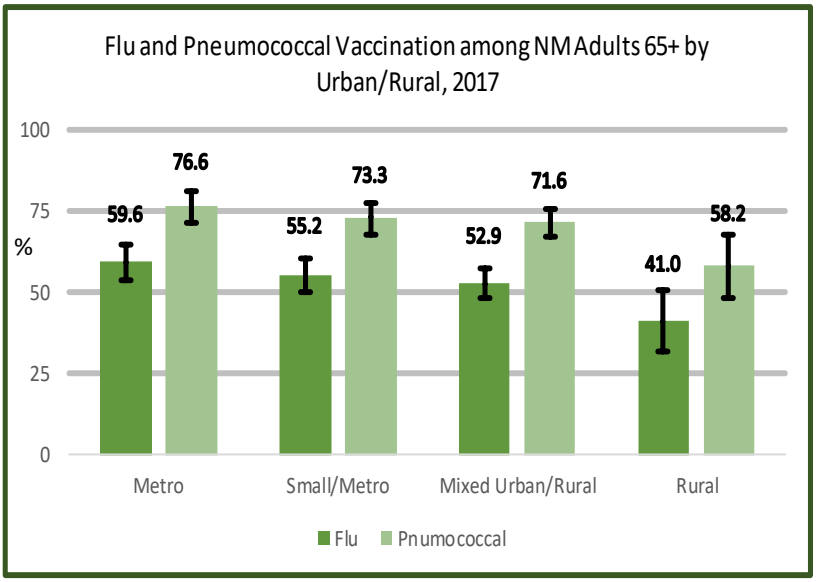


Immunizations Among Adults 65+

- There was no statistically significant difference in the prevalence of either having a flu vaccine the past year or ever having the pneumonia vaccine by education.
- Adults over 65 years of age who were retired had a significantly higher prevalence of ever having the pneumonia vaccine than employed adults over 65 years of age. There was no measurable difference in flu vaccine in the past year by employment status.
- Adults over 65 years of age residing in rural counties have a much lower prevalence of both having the flu vaccine in the past year (41.0%) and ever having the pneumonia vaccine (58.2%) compared to adults over 65 years of age who reside in metropolitan counties (59.5% and 76.6 %, respectively).







Leisure-Time Physical Activity

Question:

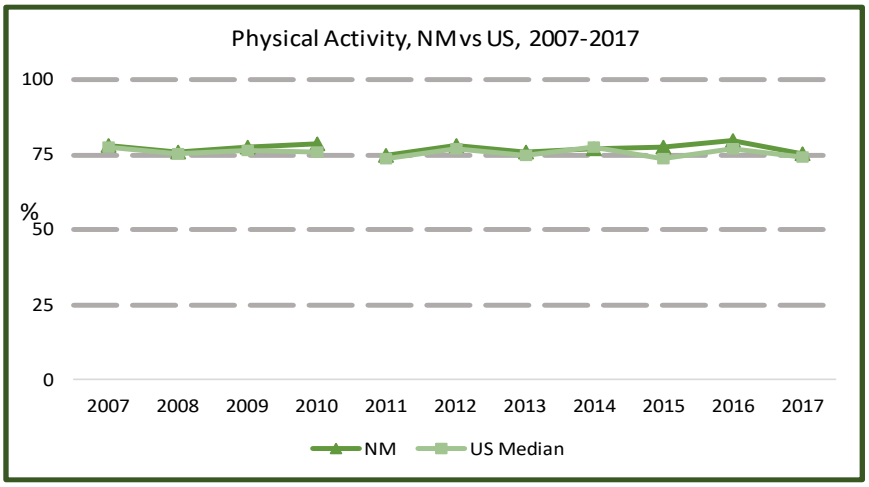
"During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Among the health benefits of regular physical activity are reduced risk of coronary heart disease, lower heart rate and blood pressure, reduced weight, lower serum triglyceride levels, increased "good" cholesterol, reduced risk of osteoporosis, boosting of immune function, beneficial effect on clotting mechanisms and improved psychological well-being and quality of life. [20]

- In New Mexico, 75.5% of adults reported participating in any form of leisure-time physical activity. This percentage was slightly higher than the U.S. median (74.4%).
- Adults 18-44 were significantly more likely to participate in any form of leisure-time physical activity (79.8%) than adults over 65 years of age (68.9%).
- Adults males (77.8%) were more likely to have some form of leisure-time physical activity than were females (73.3%).
- There was no measurable difference in leisure-time physical activity by race/ethnicity.

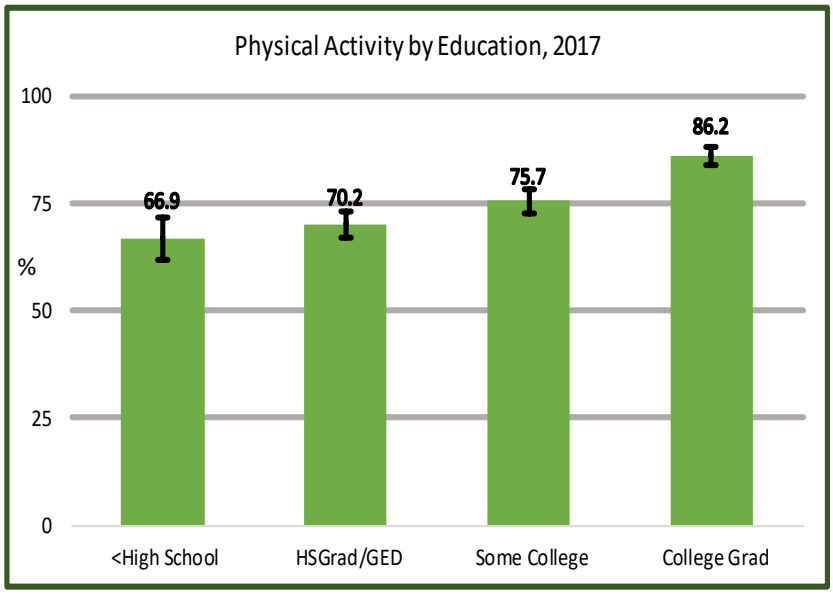
Demographic Characteristics	Leisure-Time Physical Activity[a] %	Leisure-Time Physical Activity[a] (95% Confidence Interval)
Total	**75.5**	**(73.9-77.0)**
Age		
18-44	79.8	(77.2-82.2)
45-64	73.8	(71.2-76.4)
65+	68.9	(66.0-71.7)
Gender		
Male	77.8	(75.5-79.9)
Female	73.3	(71.1-75.5)
Race/Ethnicity		
AIAN	78.0	(73.2-82.2)
Asian or NHOPI	67.2	(47.7-82.1)
Black/AA	77.1	(60.7-87.9)
Hispanic	73.6	(70.9-76.1)
White	77.0	(74.9-79.0)
Sexual Orientation		
Straight	74.9	(73.3-76.6)
LGB/Other	81.4	(73.4-87.4)
Household Income		
< $15,000	66.9	(61.9-71.5)
$15,000-$24,999	72.6	(68.8-76.1)
$25,000-$49,999	74.7	(71.0-78.0)
$50,000-$74,999	80.9	(76.7-84.4)
> $75,000	83.5	(80.5-86.1)
Geographic Region		
Northwest	73.2	(69.7-76.5)
Northeast	78.8	(75.4-82.0)
Metropolitan	77.6	(74.8-80.2)
Southeast	66.4	(62.5-70.0)
Southwest	75.3	(71.8-78.5)

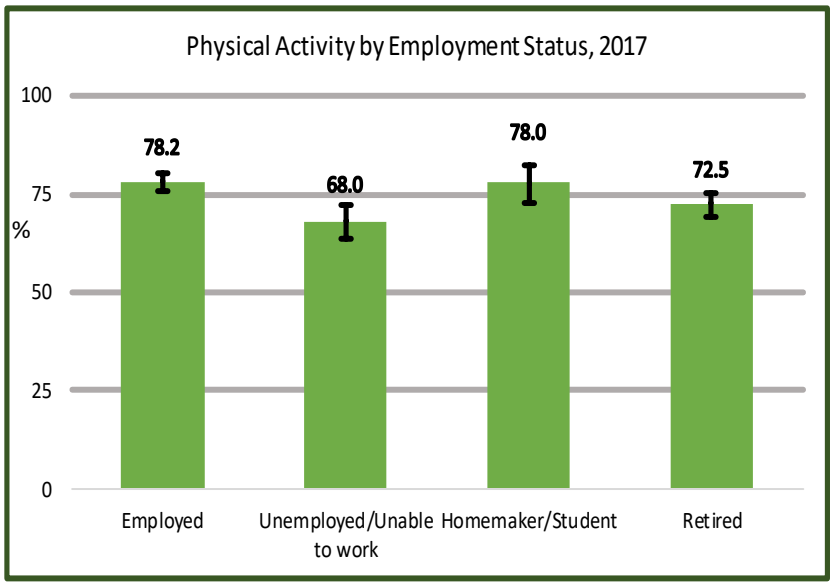
[a]Among all adults , the proportion reporting they had participated in leisure-time physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise in the past month.

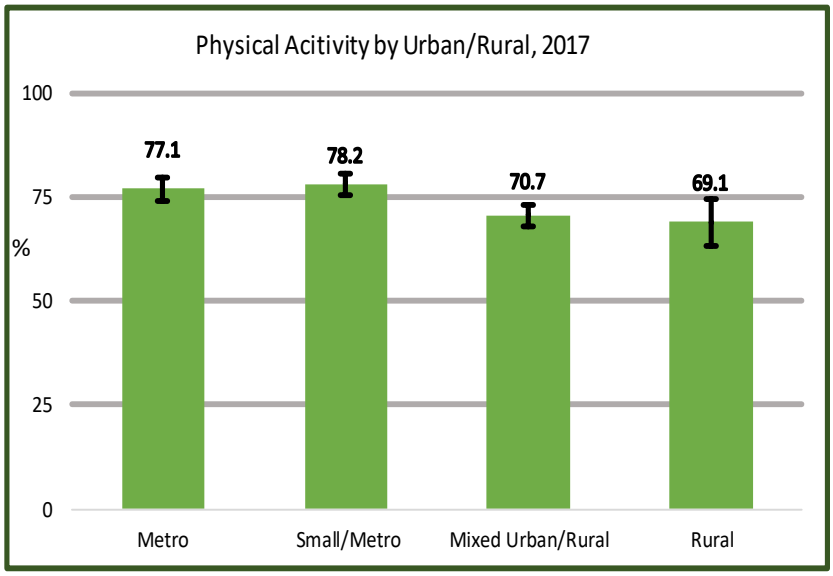


Leisure-Time Physical Activity

- There was not a statistically significant difference in leisure-time physical activity between LGB/Other adults (81.4%) and straight adults (74.9%).
- There was a gradient in leisure-time physical activity by level of education and by annual household income. 66.9% of adults with less than a high school education engaged in leisure-time physical activity, compared to 86.2% of those with a college education. Similarly, 66.9% of adults living in households with annual income of less than $15,000 engaged in leisure-time physical activity, compared to 83.5% of those living in households with annual income of $75,000 or more.
- By employment status, leisure-time physical activity was lowest among those unemployed/unable to work (68.0%). Employed adults had the highest rate of leisure-time physical activity at 78.2%.
- Adults residing in the Southeast region (66.4%) were less likely to have engaged in leisure-time physical activity than those residing in the Northeast or Metropolitan area at 78.8% and 77.6% respectively.
- Adults who engaged in leisure-time physical activity were less likely to have fair or poor general health status (16.8% vs. 34.7%), diabetes (8.8% vs. 16.3%), any cardiovascular disease (6.5% vs. 10.9%), or to be obese (25.7% vs. 36.9%).







Fruit and Vegetable Consumption

Question:

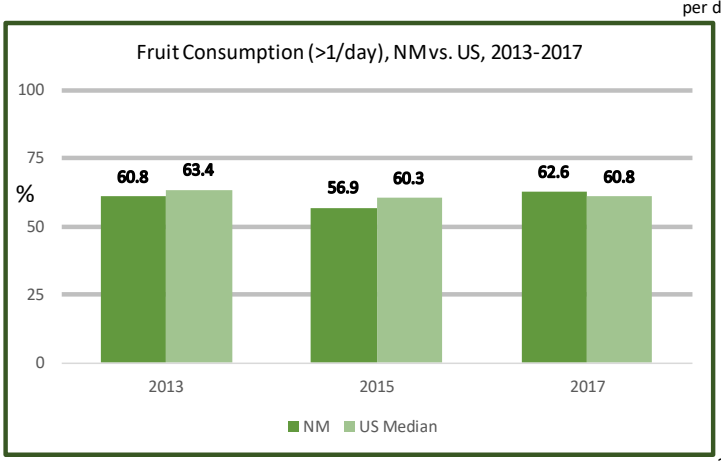
"How often do you eat vegetables?
How often do you eat fruit?"

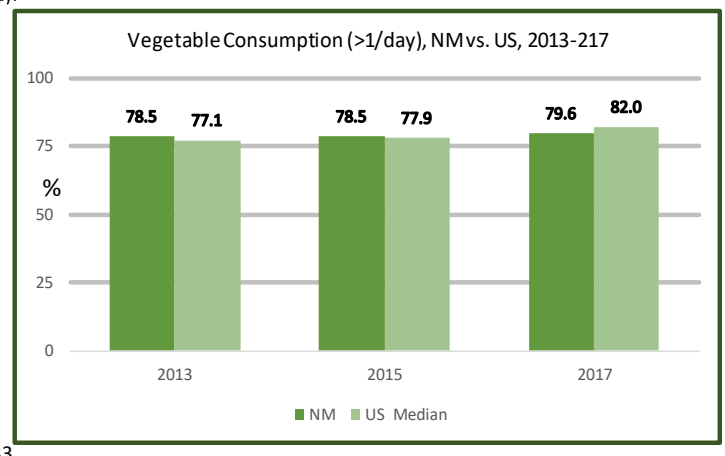
Seven of the top 10 leading causes of death in the United States are from chronic diseases. Eating a diet rich in fruits and vegetables daily can help reduce the risk of many leading causes of illness and death, including heart disease, type 2 diabetes, some cancers, and obesity.[21]

- In 2017, 16.8% of New Mexico Adults consumed 5 or more fruits and vegetables per day.
- There was no measurable difference in fruit and vegetable consumption by age.
- Females had a higher prevalence of consuming 5 or more fruits and vegetables per day (19.3%) than males (14.0%).
- AIAN adults had a significantly higher prevalence of consuming more than 5 fruits and vegetables per day compared to all other race/ethnicities.
- There was no measurable difference by household income.
- New Mexico and the US have similar rates of consuming at least one fruit and one vegetable per day.

	Fruits and Vegetables (>5/Day)[a]	
Demographic Characteristics	**%**	**(95% Confidence Interval)**
Total	**16.8**	**(15.4-18.3)**
Age		
18-44	17.5	(15.1-20.1)
45-64	16.8	(14.7-19.1)
65+	15.6	(13.5-17.8)
Gender		
Male	14.0	(12.3-16.0)
Female	19.3	(17.3-21.5)
Race/Ethnicity		
AIAN	27.8	(22.1-34.3)
Asian or NHOPI	7.4	(2.8-18.1)
Black/AA	17.1	(8.8-30.6)
Hispanic	15.5	(13.4-17.9)
White	16.6	(14.8-18.7)
Sexual Orientation		
Straight	16.0	(14.7-17.5)
LGB/Other	22.3	(13.9-33.8)
Household Income		
< $15,000	18.0	(14.3-22.4)
$15,000-$24,999	16.2	(13.2-19.8)
$25,000-$49,999	16.4	(13.6-19.5)
$50,000-$74,999	15.8	(12.4-19.9)
> $75,000	17.1	(14.5-20.1)
Geographic Region		
Northwest	21.8	(18.4-25.6)
Northeast	20.1	(16.8-23.7)
Metropolitan	16.3	(14.0-18.9)
Southeast	12.5	(10.0-15.7)
Southwest	15.8	(13.2-18.8)

[a]Among all adults, the proportion who reported consuming 5 or more fruits and vegetables per day.



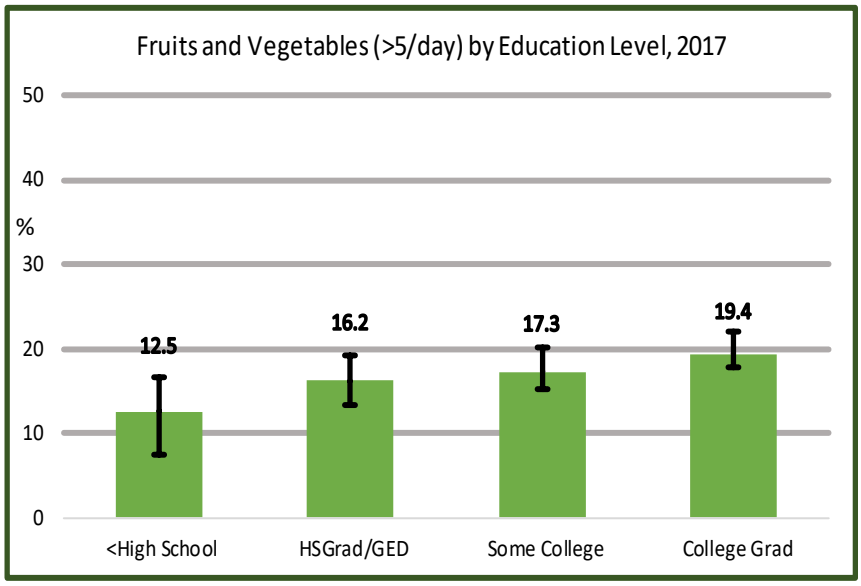


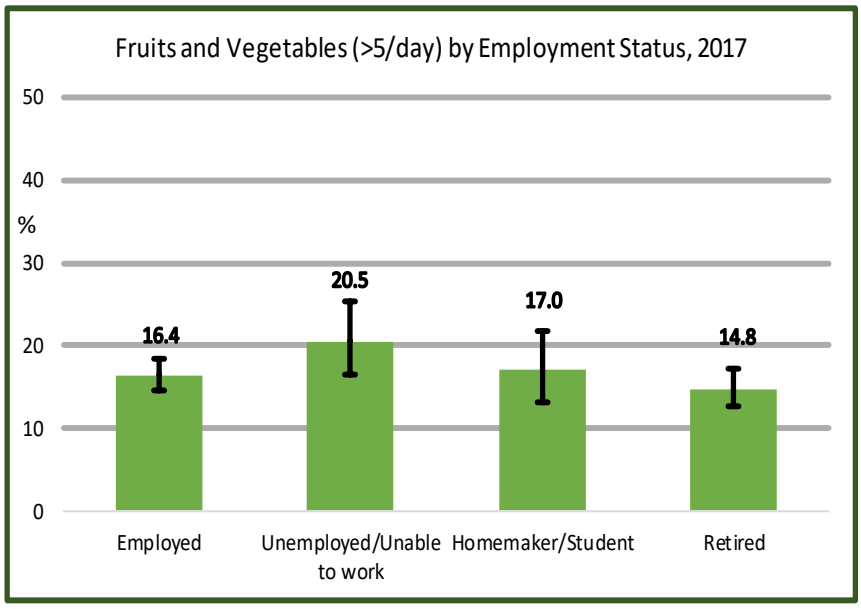
Fruit and Vegetable Consumption

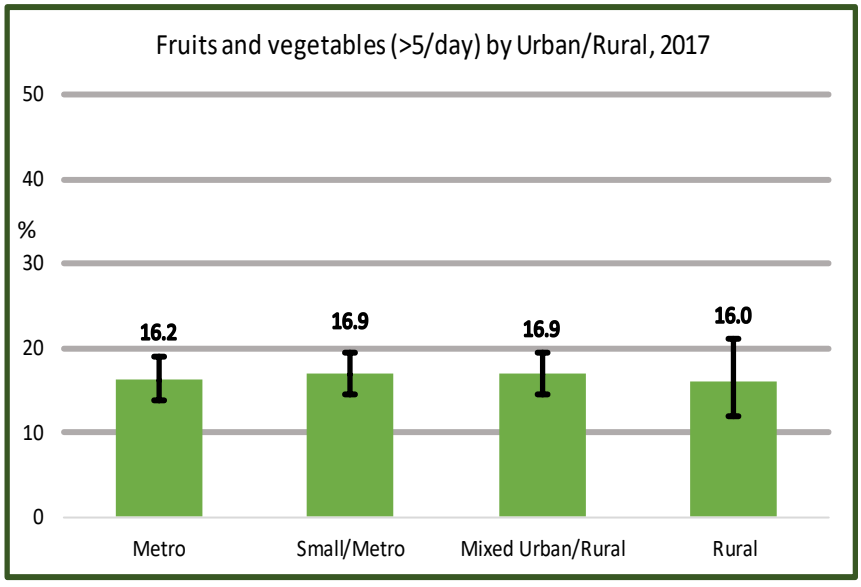
- Adults in the highest education level category with a college degree or greater had a significantly higher prevalence of consuming more than 5 servings of fruits and vegetables (19.4%) compared to adults with less than high school education (12.5%).

- There was no measurable difference by employment status or urban/rural county designation in adults consuming more than 5 fruits and vegetables per day.

- There was no measurable difference in the prevalence of obesity, any cardiovascular disease, or diabetes by New Mexico adults fruits and vegetables consumption.







Seatbelt Use

Question:

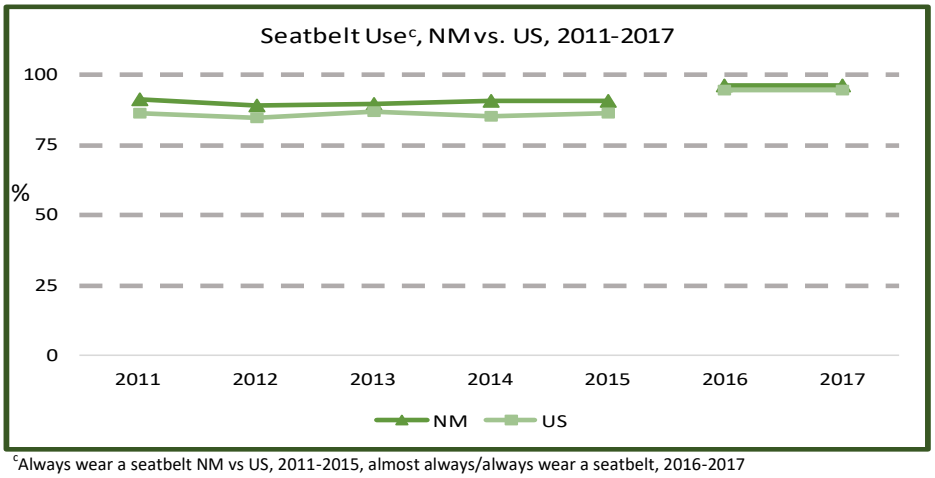
"How often do you use seat belts when you drive or ride in a car? Would you say— Always, Nearly Always, Sometimes, Seldom, Never?"

The consistent use of seat belts greatly reduces the risk of injury and increases the probability of survival. The National Highway Traffic Safety Administration (NHTSA) estimated that nearly 15,000 lives were saved by seat belts during 2016.[22] The Healthy People 2020 Objective IVP-15 is that 92% of adults are using a seat belt every time when driving or riding in a car.[23]

- In New Mexico in 2017, 96.3% of adults reported always or almost always use a seatbelt when driving or riding in a car, higher than the median percentage of adults across the U.S. (94.3%).
- The percentage of adults who always or almost always wore a seatbelt when driving or riding in a car was lowest among adults less than 45 years of age (94.6%).
- 95.0% of males always or almost always use a seatbelt when driving or riding in a car, significantly lower than the percentage of females (97.6%).
- There was no statistically significant difference in the prevalence of consistent seatbelt use by race/ethnicity, household income, sexual orientation, or geographic region.

Demographic Characteristics	Seatbelt Use[a] %	Seatbelt Use[a] (95% Confidence Interval)
Total	**96.3**	**(95.5-96.9)**
Age		
18-44	94.6	(92.9-95.8)
45-64	97.3	(96.1-98.1)
65+	98.2	(97.3-98.7)
Gender		
Male	95.0	(93.7-96.0)
Female	97.6	(96.5-98.3)
Race/Ethnicity		
AIAN	96.3	(94.3-97.6)
Asian or NHOPI	**	**
Black/AA	97.6	(85.0-99.7)
Hispanic	95.9	(94.5-97.0)
White	96.9	(95.9-97.6)
Sexual Orientation		
Straight	96.0	(95.2-96.8)
LGB/Other	98.5	(94.8-99.6)
Household Income		
< $15,000	95.8	(93.3-97.4)
$15,000-$24,999	95.1	(92.9-96.6)
$25,000-$49,999	96.8	(95.1-97.9)
$50,000-$74,999	96.5	(93.5-98.1)
> $75,000	96.8	(95.0-97.9)
Geographic Region		
Northwest	96.6	(95.0-97.7)
Northeast	97.3	(95.6-98.3)
Metropolitan	96.5	(95.0-97.6)
Southeast	95.5	(93.5-97.0)
Southwest	95.2	(93.0-96.7)

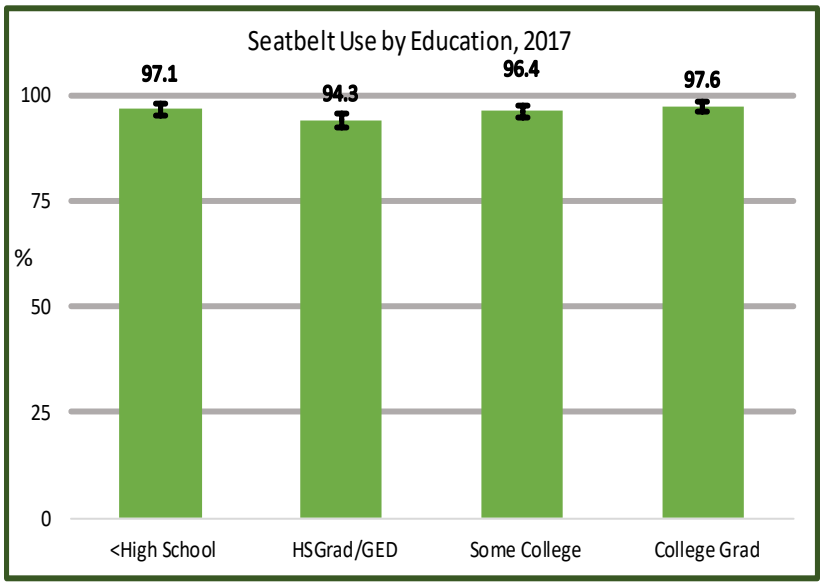
[a]Among adults, the proportion reporting that they always used a seatbelt when driving or riding in a car. ** Suppressed due to a denominator <50.

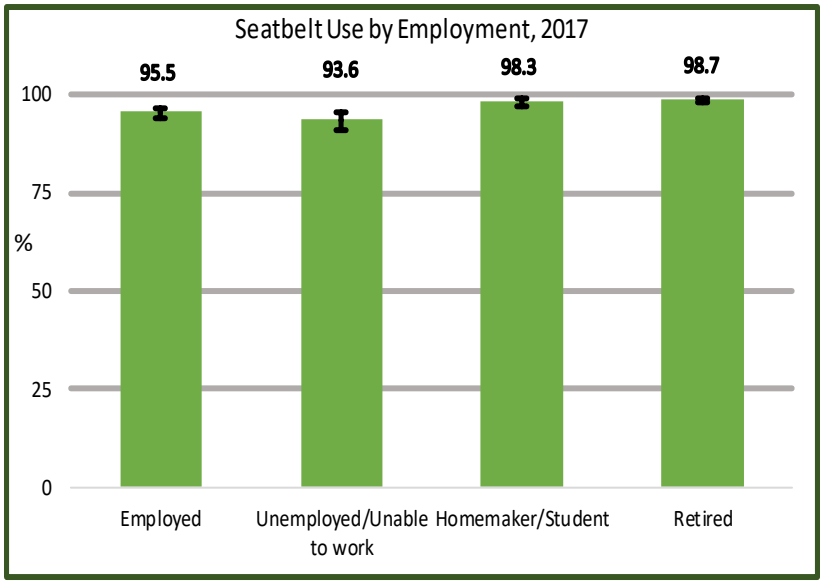


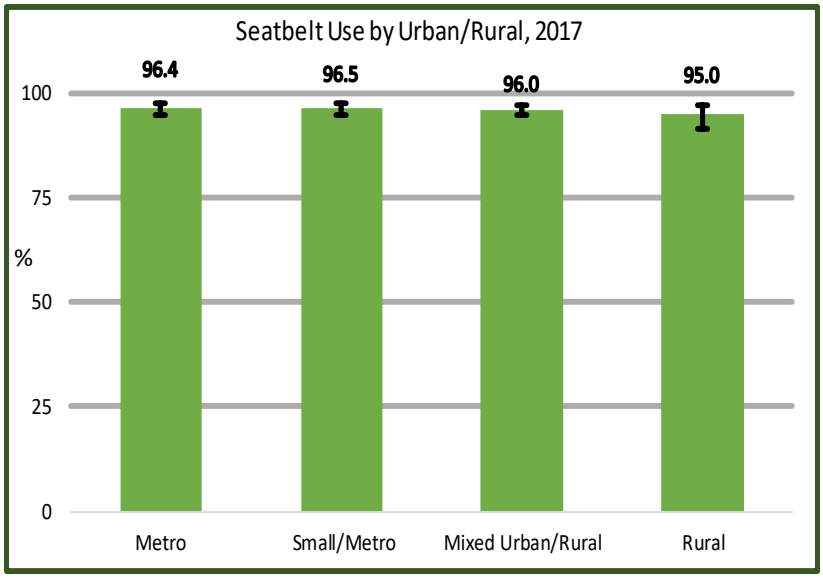
[c]Always wear a seatbelt NM vs US, 2011-2015, almost always/always wear a seatbelt, 2016-2017

Seatbelt Use

- Adults with a High School Diploma/GED had a significantly lower percentage of always or almost always using a seatbelt (94.3%) compared to college graduates (97.6%).
- Adults who were unemployed/unable to work had a lower percentage of always or almost always using a seatbelt (93.6%) compared to homemaker/student adults (98.3%) or retired adults (98.7%).
- The was no measurable difference in the percentage of seatbelt use by urban/rural county designation.
- Adults who had thoughts about committing suicide in the past year (89.1%) were less likely than adults who did not have thoughts about committing suicide (96.7%) to always or almost always wear their seat-belt.







Current Cigarette Smoking

Question:

"Have you smoked at least 100 cigarettes in your entire life?"

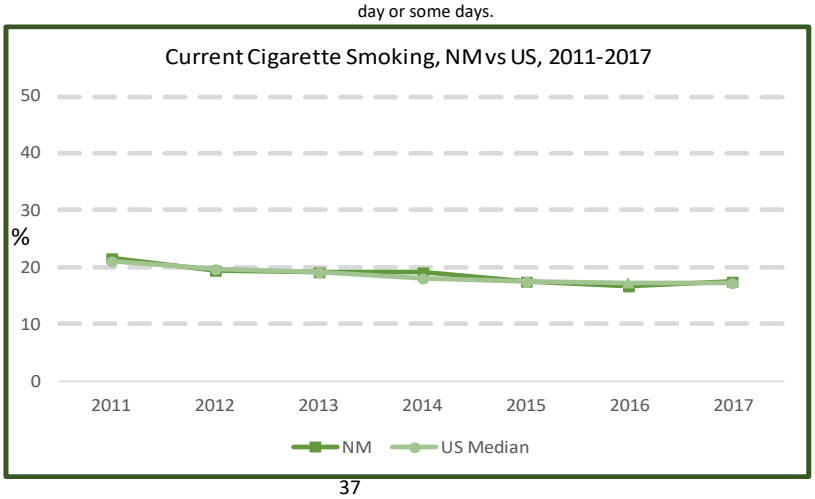
"Do you now smoke cigarettes every day, some days, or not at all?"

Smoking cigarettes harms nearly every organ of the body. It causes about 85% of deaths from lung cancer and chronic obstructive pulmonary disease. Smokers are 2 to 4 times more likely to have coronary heart disease and stroke.[24] An estimated 42,000 New Mexicans suffer from chronic smoking-related illnesses and about 2,100 die every year.[25] Exposure to second-hand smoke can cause serious health effects, including sudden infant death syndrome, asthma in children, heart attacks, and lung cancer.[26]

- In 2017, 17.5% of New Mexico adults were current smokers. This was similar to the U.S. median prevalence (17.1%).
- The prevalence of current smoking decreases significantly with age. Adults 18-44 were the most likely to be current smokers (19.5%) and adults 65+ were least likely (11.2%).
- Males (20.6%) reported a significantly higher prevalence of current smoking than females (14.5%).
- AIAN adults were less likely to be current cigarette smokers (14.8%) than Hispanic adults (18.2%).
- LGB/Other adults had significantly higher prevalence of current smoking (27.2%) than Straight adults (17.1%).
- The prevalence of tobacco use was highest among New Mexico adults with the lowest level of household income (30.4%) and lowest among adults with the highest level of household income (8.6%).

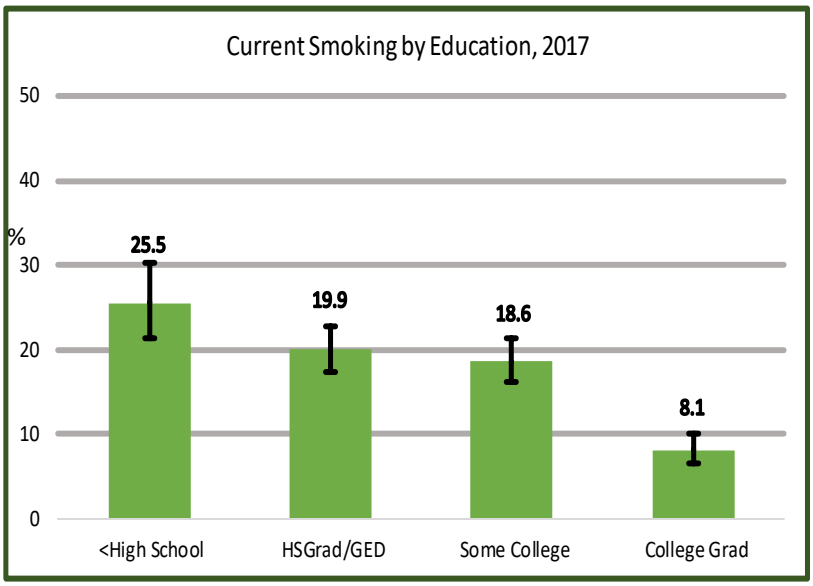
Demographic Characteristics	Current Smoking[a] %	Current Smoking[a] (95% Confidence Interval)
Total	**17.5**	**(16.1-18.9)**
Age		
18-44	19.5	(17.1-22.1)
45-64	19.2	(17.1-21.6)
65+	11.2	(9.5-13.2)
Gender		
Male	20.6	(18.5-22.9)
Female	14.5	(12.8-16.3)
Race/Ethnicity		
AIAN	14.8	(10.8-19.9)
Asian or NHOPI	10.7	(4.1-25.4)
Black/AA	20.1	(10.4-35.5)
Hispanic	18.2	(15.9-20.7)
White	17.3	(15.5-19.2)
Sexual Orientation		
Straight	17.1	(15.7-18.7)
LGB/Other	27.2	(19.7-36.3)
Household Income		
< $15,000	30.4	(25.8-35.5)
$15,000-$24,999	23.1	(19.8-26.8)
$25,000-$49,999	16.8	(14.0-19.9)
$50,000-$74,999	13.1	(10.1-16.8)
> $75,000	8.6	(6.7-11.0)
Geographic Region		
Northwest	16.3	(13.7-19.2)
Northeast	16.1	(13.4-19.4)
Metropolitan	16.8	(14.5-19.4)
Southeast	21.0	(17.8-24.6)
Southwest	18.3	(15.4-21.6)

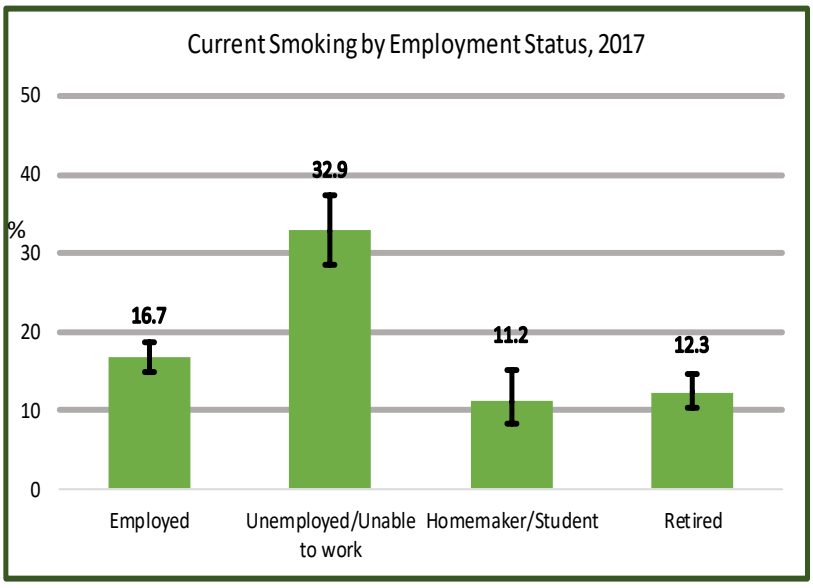
[a]Among all adults , the proportion who reported that they had ever smoked at least 100 cigarettes (5 packs) in their life and that they smoke cigarettes now, either every day or some days.

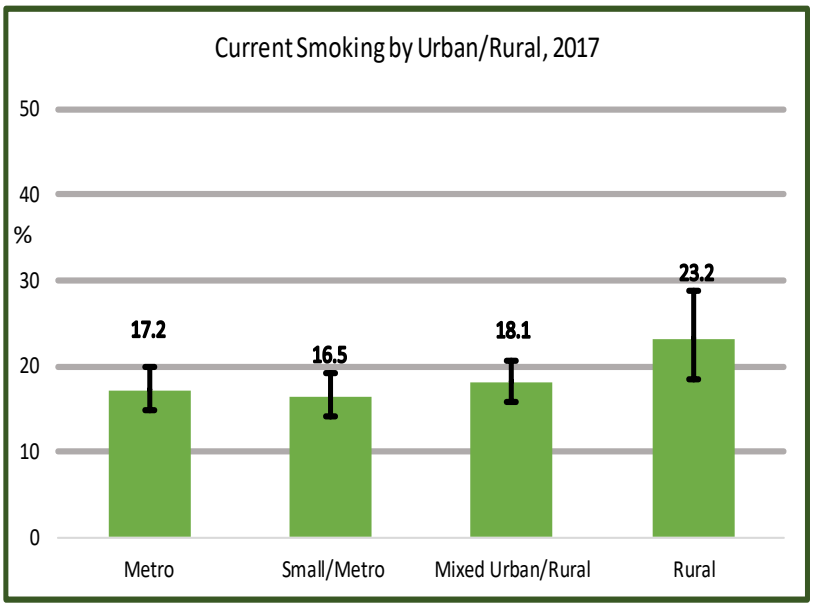


Current Cigarette Smoking

- The HP 2020 target for current smoking among adults is 12.0%. In order to meet this target the current smoking prevalence among New Mexico adults will need to decrease by 5.5 percentage points during the next three years.[5]
- The Southeast region had the highest prevalence of current smoking (21.0%) while the Northeast region had the lowest (16.1%).
- The prevalence of current cigarette smoking was highest among adults with less than a high school education (25.5%) and lowest among college graduates (8.1%).
- The prevalence of current smoking was higher among unemployed/unable to work adults (32.9%) than all other categories of employment status, most notably retired adults (12.3%).
- Current smoking was highest among Rural designated counties (23.2%) compared to Small/Metro designated counties (16.5%).
- 58.6% of adult current smokers tried to quit at least once in the past year.
- 23.9% of adults are former smokers, and 58.6% of adults have never smoked cigarettes.
- Current smokers (13.8%) were more likely than non-smokers to be without some form of health care coverage than non-smokers (11.0%); to have a disability (42.0% vs 27.1%); to describe their general health as Fair or Poor (29.0% vs 19.7%); to have been diagnosed with COPD, emphysema, or chronic bronchitis (13.2% vs 4.6%), or to be unable to work (16.9% vs 7.3%).







Sexual Violence

Question:

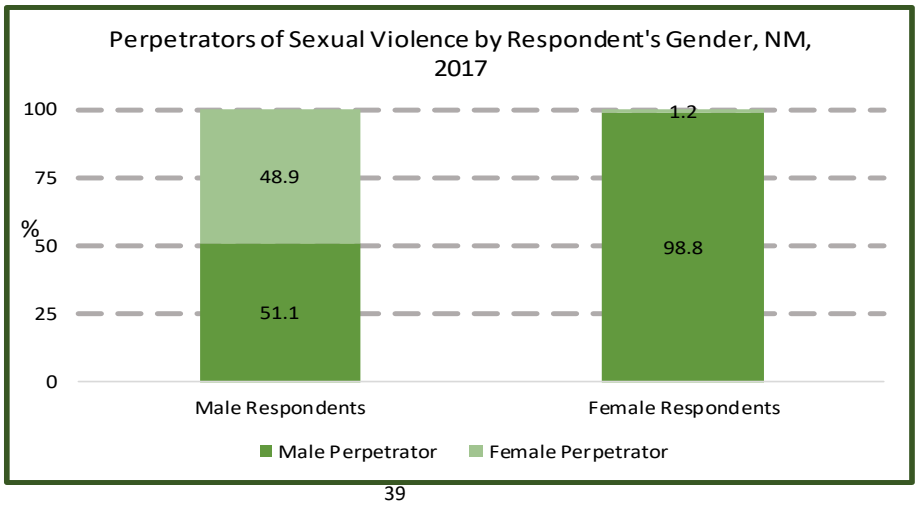
"In the past 12 months, has anyone ATTEMPTED to or HAD SEX with you after you said or showed that you didn't want to or without your consent ?"

Sexual violence and intimate partner violence are major public health problems. Survivors of these forms of violence can experience physical injury, mental health consequences such as depression, anxiety, low self-esteem, and suicide attempts, other health consequences such as gastrointestinal disorders, substance abuse, sexually transmitted diseases, and gynecological or pregnancy complications. These consequences can lead to hospitalization, disability, or death. [27]

- In 2017, 1.9% of New Mexico adults were victims of sexual violence.
- New Mexico adults 18-44 had the highest prevalence of sexual violence victimization (3.6%).
- Females (2.7%) reported a higher prevalence of being victims of sexual violence than males (1.0%) although the difference was not statistically significant.
- Perpetrators of sexual violence were overwhelmingly male. 98.8% of female victims said the person who committed the assault was male and 51.1% of male victims say the perpetrator was male.

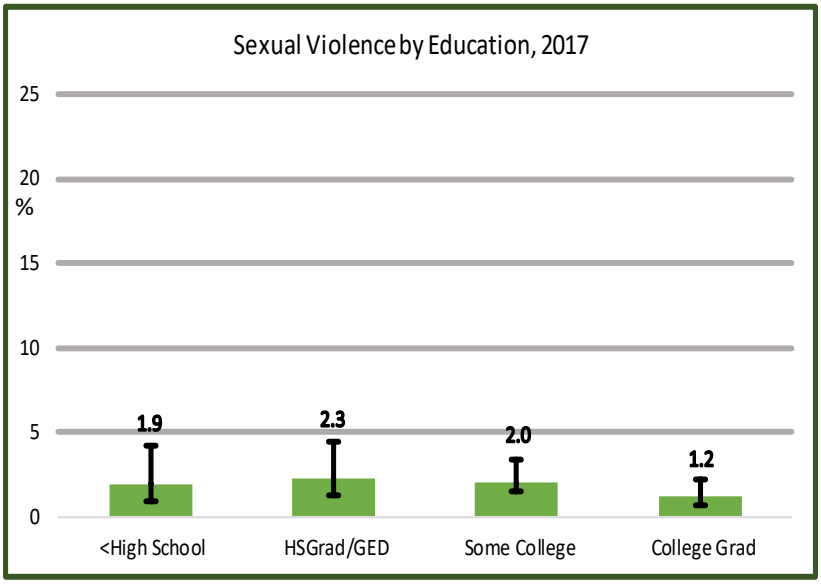
Demographic Characteristics	Sexual Violence[a] %	Sexual Violence[a] (95% Confidence Interval)
Total	**1.9**	**(1.4-2.6)**
Age		
18-44	3.6	(2.4-5.2)
45-64	0.9	(0.5-1.6)
65+	0.2	(0.1-0.6)
Gender		
Male	1.0	(0.5-2.0)
Female	2.7	(1.9-3.9)
Race/Ethnicity		
AIAN	1.4	(0.6-3.2)
Asian or NHOPI	**	**
Black/AA	5.0	(1.2-18.3)
Hispanic	2.2	(1.3-3.7)
White	1.6	(1.0-2.5)
Sexual Orientation		
Straight	1.8	(1.3-2.6)
LGB/Other	4.1	(1.9-8.5)
Household Income		
< $15,000	4.5	(2.6-7.4)
$15,000-$24,999	3.1	(1.7-5.4)
$25,000-$49,999	0.5	(0.2-1.8)
$50,000-$74,999	0.5	(0.1-1.7)
> $75,000	1.2	(0.5-2.8)
Geographic Region		
Northwest	1.6	(0.8-3.2)
Northeast	1.0	(0.4-2.4)
Metropolitan	2.2	(1.3-3.7)
Southeast	1.7	(0.9-3.2)
Southwest	2.1	(1.1-4.1)

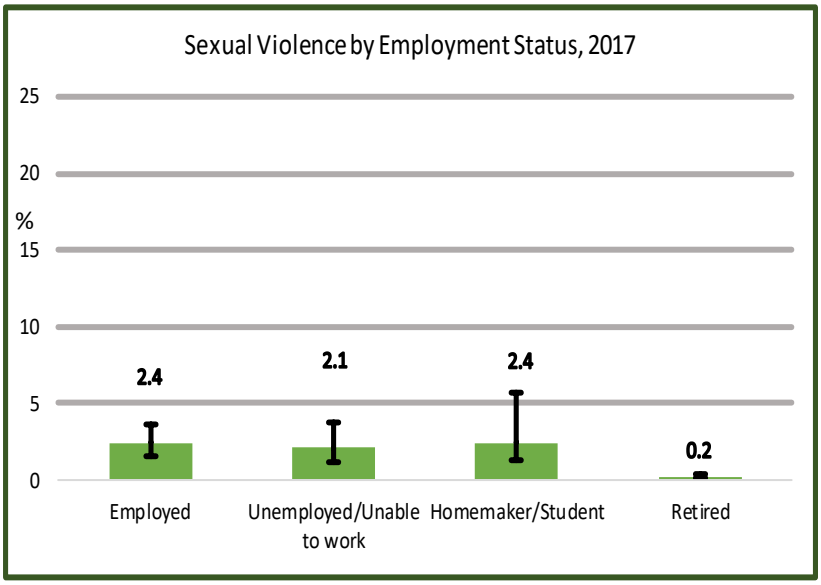
[a]Among adults, the proportion who reported that anyone attempted to or had sex with them after they said or showed that they didn't want to or without their consent.
** Suppressed due to a denominator <50.

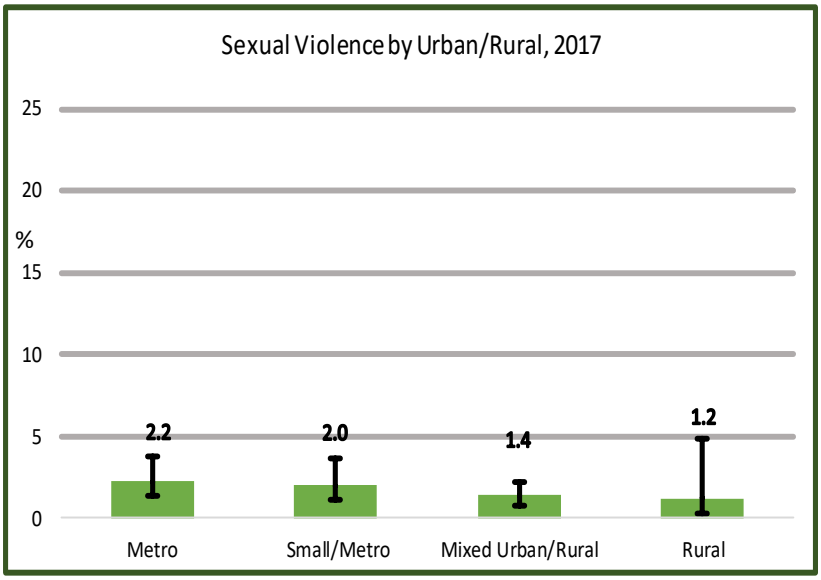


Sexual Violence

- In New Mexico, adults who were lesbian, gay, or bisexual (LGB/Other), were more than twice as likely to have been the victim of sexual assault/attempt than Straight adults at 4.1% and 1.8%, respectively.
- There was not a statistically significant difference in the reported sexual assault/attempt by race/ethnicity.
- Among adults living in households with an annual income of less than $15,000, the likelihood of sexual assault/attempt (4.5%) was higher than adults with an annual income of more than $75,000 (1.2%).
- There was not a statistically significant difference in the reported sexual assault/attempt by geographic region or urban/rural county designation.
- There was not a statistically significant difference in sexual assault/attempt by education level, or employment status.







Suicidal Behaviors

Question:

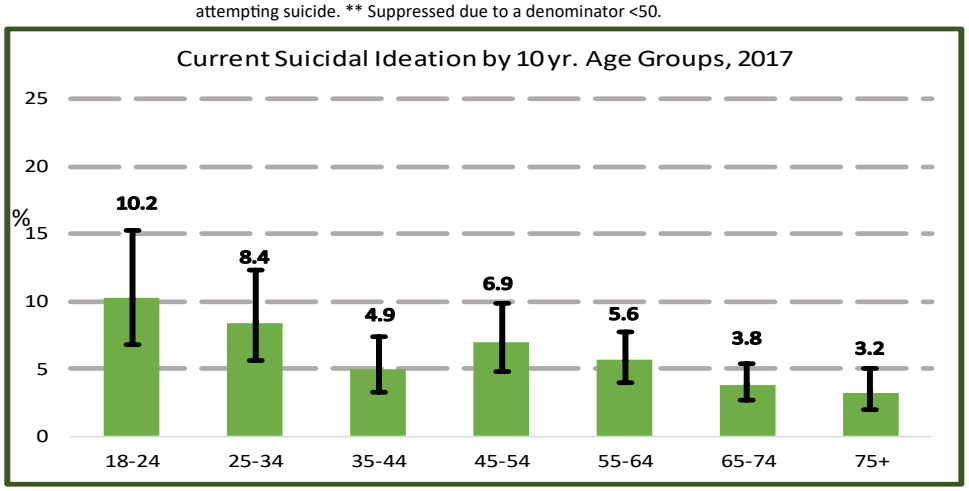
"In the past year, have you felt so low at times that you thought about committing suicide? Have you ever attempted suicide?"

Suicidal behaviors are a serious public health problem and a major cause of morbidity and mortality in New Mexico. Suicide deaths have been increasing in both New Mexico and the United States, with suicide death rates in NM at least 50% higher than U.S. rates over the past 20 years. Mental disorders, particularly clinical depression, increase the risk for both attempted suicide and suicide.[28]

- In 2017, an estimated 6.2% of New Mexico adults thought about committing suicide in the past year and 6.3% have ever attempted suicide.
- For adults 18-44, the prevalence of suicidal ideation in the past year and having ever attempted suicide are 7.7% and 7.0% respectively, and 3.6% and 2.9% among adults aged 65+.
- There was no measurable difference by gender for suicidal ideation or ever attempted suicide.

Demographic Characteristics	Current Suicidal Ideation[a] %	Current Suicidal Ideation[a] (95% Confidence Interval)	Ever Attempted Suicide[b] %	Ever Attempted Suicide[b] (95% Confidence Interval)
Total	**6.2**	**(5.3-7.2)**	**6.3**	**(5.4-7.4)**
Age				
18-44	7.7	(6.0-9.7)	7.0	(5.4-8.9)
45-64	6.2	(4.9-7.9)	7.8	(6.1-9.7)
65+	3.6	(2.7-4.7)	2.9	(2.0-4.2)
Gender				
Male	7.0	(5.7-8.7)	5.7	(4.4-7.3)
Female	5.4	(4.3-6.7)	6.9	(5.6-8.4)
Race/Ethnicity				
AIAN	5.7	(3.2-9.8)	6.4	(4.0-9.9)
Asian or NHOPI	**	**	**	**
Black/AA	9.4	(3.1-25.0)	7.2	(1.9-23.2)
Hispanic	5.8	(4.5-7.6)	6.6	(5.1-8.5)
White	6.7	(5.5-8.2)	5.5	(4.4-6.9)
Sexual Orientation				
Straight	5.5	(4.6-6.5)	5.7	(4.8-6.7)
LGB/Other	18.6	(12.1-27.4)	17.6	(11.5-25.9)
Household Income				
< $15,000	10.2	(7.6-13.6)	15.1	(11.5-19.5)
$15,000-$24,999	7.6	(5.6-10.3)	5.7	(4.0-8.0)
$25,000-$49,999	6.2	(4.3-8.7)	6.7	(4.8-9.4)
$50,000-$74,999	3.1	(1.7-5.7)	4.8	(2.8-8.0)
> $75,000	3.8	(2.6-5.7)	2.4	(1.5-4.0)
Geographic Region				
Northwest	6.7	(4.7-9.4)	6.4	(4.6-8.8)
Northeast	4.9	(3.4-7.0)	4.1	(2.8-6.0)
Metropolitan	6.4	(4.9-8.4)	7.0	(5.4-9.1)
Southeast	6.2	(4.4-8.6)	6.9	(5.0-9.5)
Southwest	6.5	(4.6-9.0)	5.8	(4.0-8.4)

[a]Among all adults , the proportion who reported having thoughts about suicide in the past year, [b]and reported ever attempting suicide. ** Suppressed due to a denominator <50.



Suicidal Behaviors

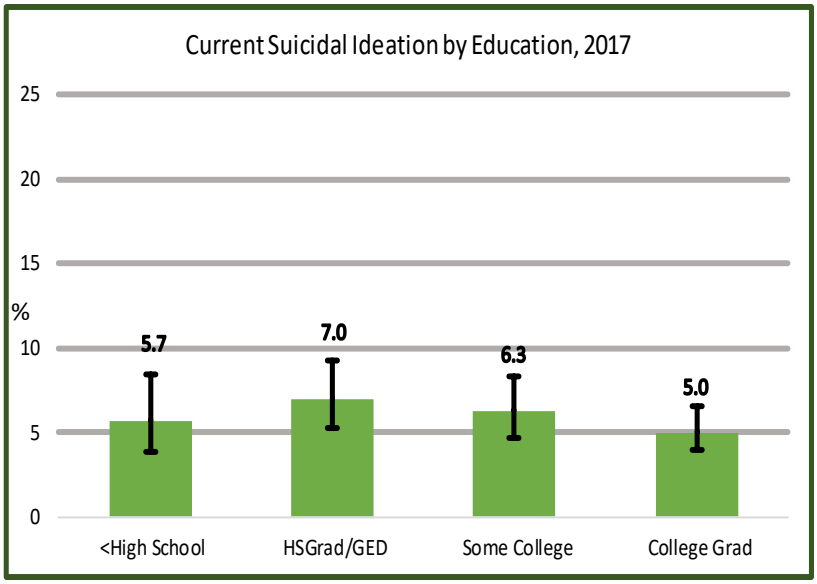
- There was no statistically significant difference among racial categories with current suicidal ideation or attempted suicide.

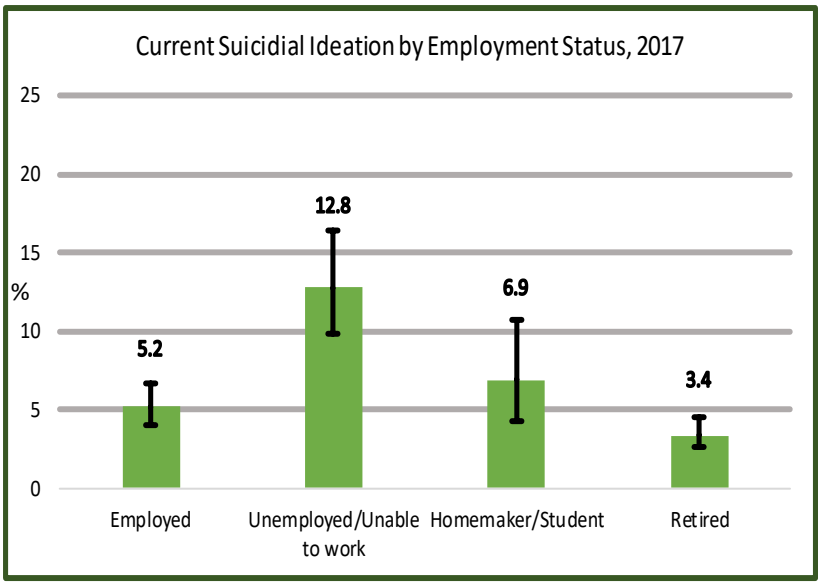
- Nearly one in five (18.6%) of LGB/other adults said they thought about committing suicide in the past year compared to 5.5% of Straight adults. Also 17.6% of LGB/Other adults had ever attempted suicide compared to 5.7% of Straight adults.

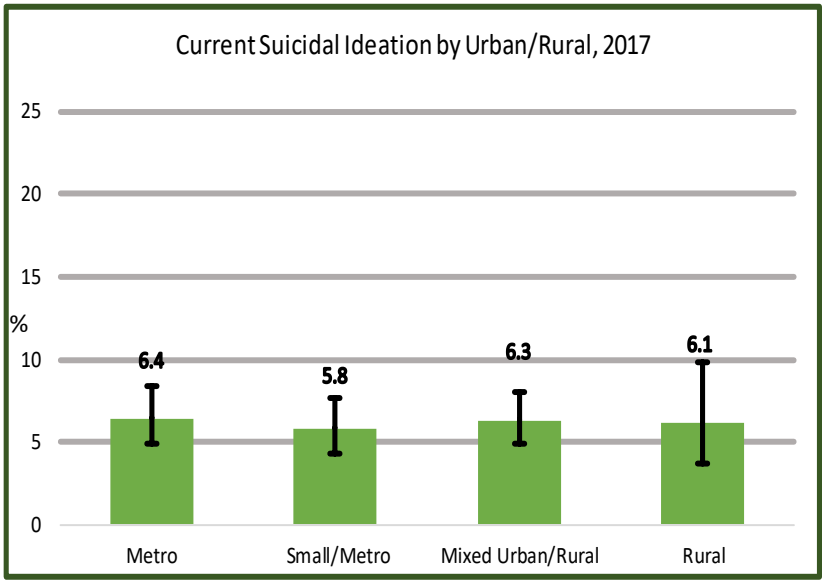
- There was a gradient in the prevalence of suicidal ideation by income with adults in the lowest household income category, (less than $15,000 per year) reporting a prevalence of 10.2% compare to adults in the highest income category (3.8%).

- New Mexico adults who were Unemployed/ Unable to work were more likely to have thought about suicide in the past year (12.8%) compared to employed adults (5.2%).

- Adults with at least one disability and adults with fair or poor health were more likely to have thought about suicide in the past year (12.6% and 11.5% respectively) compared to adults with no disabilities and adults with excellent, very good, or good health (3.3% and 4.7%, respectively).

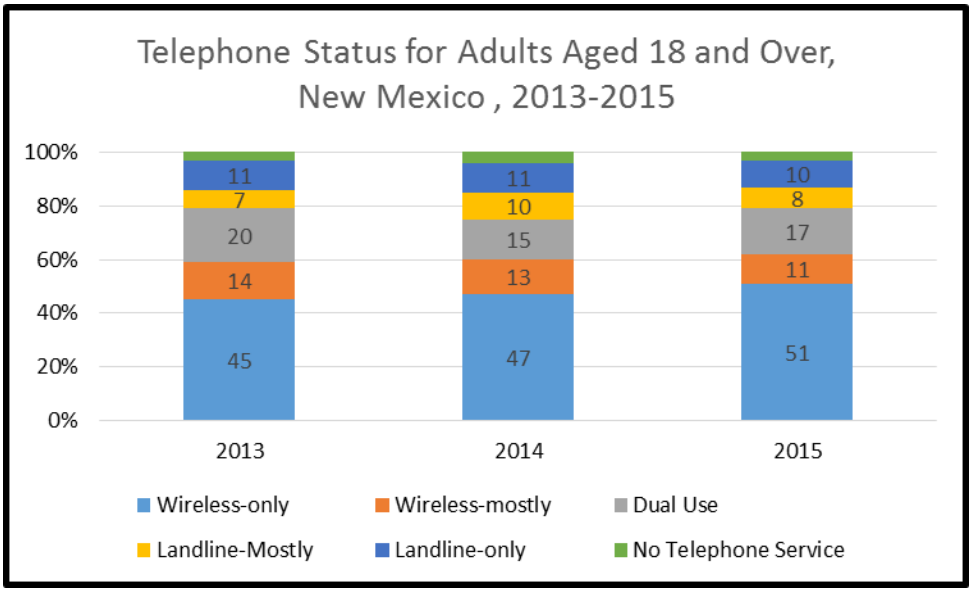






Appendix I-Methods

The New Mexico Behavioral Risk Factor Survey (BRFSS) is an annual, statewide telephone survey of New Mexico adults aged 18 years and older that is conducted through a collaborative effort between the Population Health Surveillance Branch (PHSB) of the Centers for Disease Control and Prevention (CDC) and the New Mexico Department of Health (NMDOH). New Mexico's Behavioral Risk Factor Surveillance System (BRFSS) data contribute to the CDC Behavioral Risk Factor Surveillance System (BRFSS) that is conducted within every state, the District of Columbia, and several U.S. territories. In 2017, the New Mexico BRFSS collected data from both landline and cell phone respondents. The sample of landline telephone numbers was selected using a list-assisted, random-digit-dialed methodology with a disproportionate stratification based on phone bank density, and whether or not the phone numbers were directory listed. The sample of cell phone numbers was randomly selected from dedicated cellular telephone banks sorted on the basis of area code and exchange**.**



Quality assurance

While error in survey estimates cannot be avoided entirely, the Survey Section goes to great lengths to reduce non-sampling error. Some examples of measures taken to reduce error include:

- Training the interviewers at hire, at the beginning of each new survey year, and at the beginning of each new month of the survey.
- Prompt and frequent feedback to interviewers
- Review of keyed data for extreme or invalid values by a software program at the end of the each month, prior to submission of the data to the CDC.
- Monitoring interviewers at least once a month, new interviewers are monitored closely until the CDC BRFSS protocol is followed consistently.

Appendix I-Methods

Implications of Sampling Design for Estimates Presented in this Report

The estimates presented in this report are weighted percentages. Records of the sample were adjusted by a weighting factor to produce the prevalence estimates representative of the adult population as a whole. There are several components to the weight used to adjust the sample percentage.

- The Sampling Weight adjusts for the fact that adults within the population had different probabilities of being included in the sample, because:

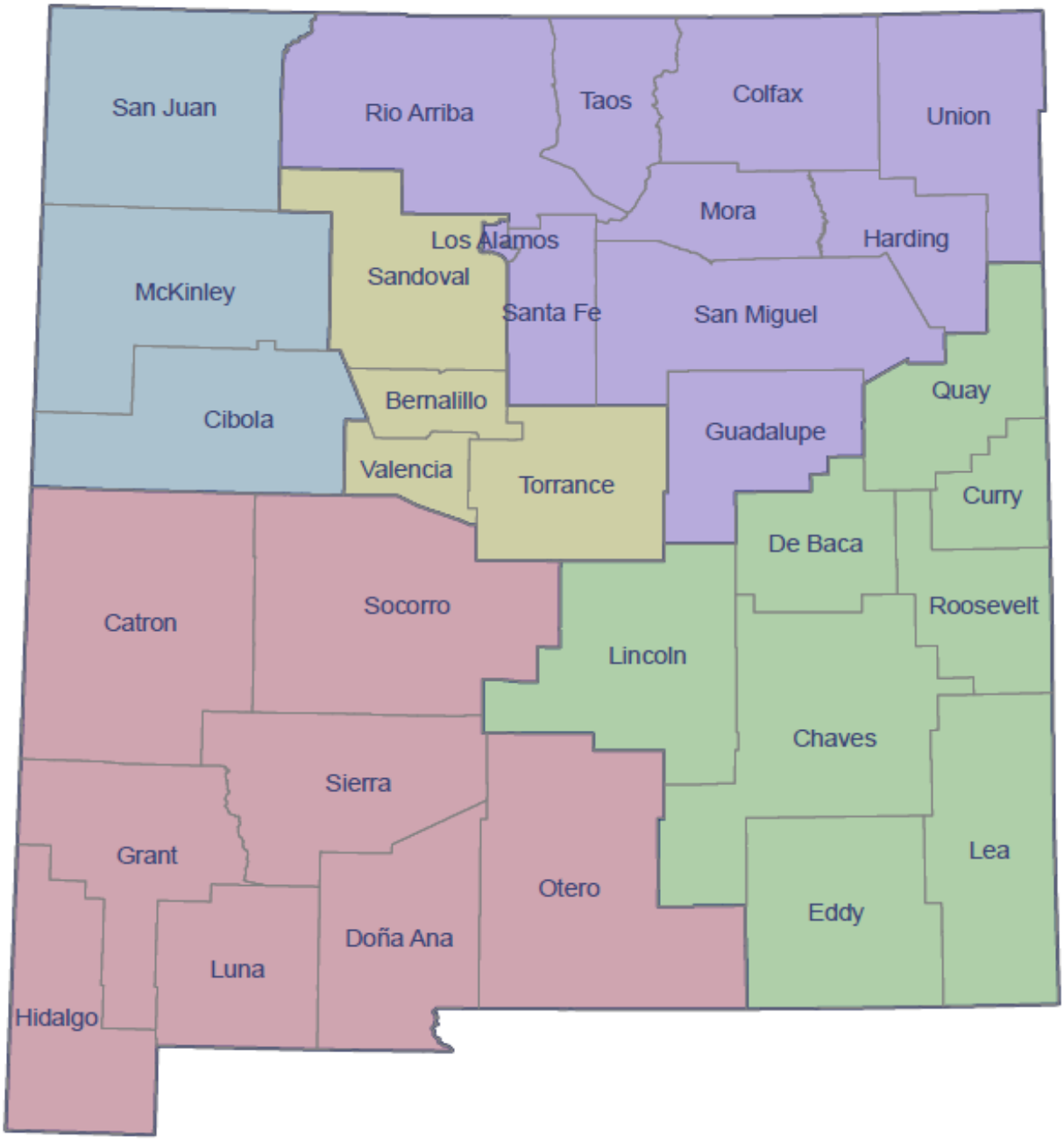
  - Households with landline telephone numbers in the low-density stratum had a lower probability of being selected than households with phone numbers in the high-density stratum.
  - Households with more than one landline telephone line had a greater chance of being selected.
  - In landline households housing many adults, each adult had a proportionally smaller chance of being randomly selected than an adult who was the sole adult of the selected household.
  - Each cellular telephone number had a probability of selection based on the total number of cell phone numbers in the cell phone sample.

- A weighting procedure known as iterative proportional fitting (known commonly as "raking") was used to adjust for differences between the distribution of the sample and that of the adult population, by gender, age, Region of residence, Race/Ethnicity, Phone Type (Cell or Landline), Home Ownership (Rent or Own), Education, Marital Status, Gender by Race/Ethnicity, Age by Gender, and Age by Race/Ethnicity, as determined by the Bureau of the Census. This component of the weighting process attempts to adjust the estimates so that they better reflect the adult population of the state. This weighting system, new in 2011, along with inclusion of cell phone interviews, results in some important changes in estimates over those of previous years. Studies have demonstrated that there is every reason to believe these improvements to the BRFSS, inclusion of cellular telephones and weighting by iterative proportional fitting result in improved, more representative, estimates over those of previous years.

Stata 14.2 MP software was used for all analyses in this report. Stata 14.2 MP includes a suite of data analysis commands which are specifically designed for the analysis of complex sample survey data, such as that of the BRFSS.

Appendix II-Maps

New Mexico Health Regions

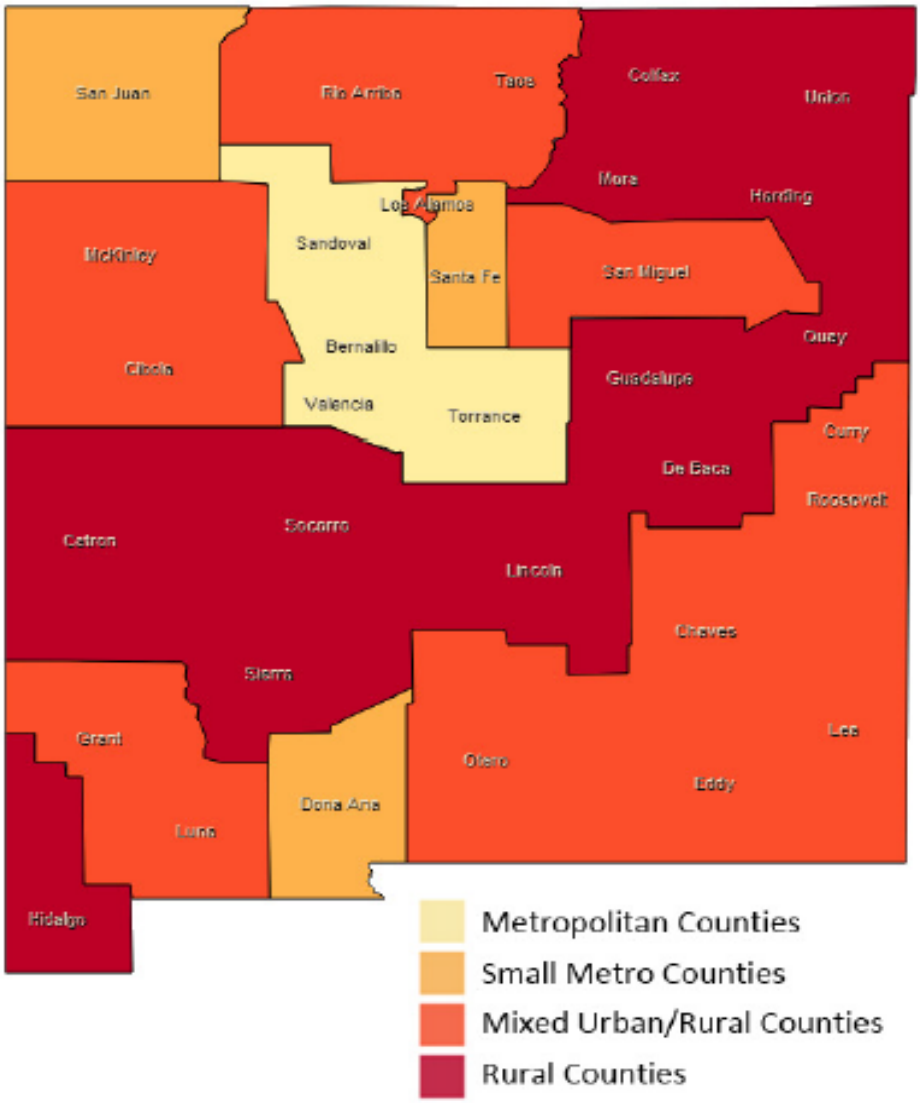


Northwest Region: San Juan, McKinley, and Cibola Counties
Northeast Region: Rio Arriba, Taos, Colfax, Union, Los Alamos, Santa Fe, Mora, San Miguel, Guadalupe, and Harding Counties
Metro Region: Bernalillo, Sandoval, Torrance, and Valencia Counties
Southeast Region: Quay, DeBaca, Curry, Lincoln, Roosevelt, Chaves, Eddy, and Lea Counties
Southwest Region: Catron, Socorro, Grant, Sierra, Hidalgo, Luna, Doña Ana, Otero

Effective September 4, 2012

Appendix II-Maps

Metropolitan, Small Metro, Mixed Urban/Rural and Rural New Mexico Counties



Metopolitan Counties: Bernalillo, Sandoval, Torrance, Valencia

Small Metro Counties: Doña Ana, San Juan, Santa Fe

Mixed Urban/Rural Counties: Cibola, Chaves, Curry, Eddy, Grant, Lea, Los Alamos, Luna, McKinley, Otero, Rio Arriba, Roosevelt, San Miguel, Taos

Rural Counties: Catron, Colfax, De Baca, Guadalupe, Harding, Hidalgo, Lincoln, Mora, Quay, Sierra, Socorro, Union

November 2014

Source: https://ibis.health.state.nm.us/view/docs/CHA/UrbanRuralCounties.pdf

References

1. Centers for Disease Control and Prevention. 2015. 2015 Summary Data Quality Report. https://www.cdc.gov/brfss/annual_data/2015/pdf/2015-sdqr.pdf.
2. CDC. Measuring Healthy Days. Atlanta, Georgia: CDC, November 2000.
3. U.S. Department of Justice, Civil Rights Division. 2009. A Guide to Disability Rights Laws. https://www.ada.gov/cguide.htm.
4. National Institutes of Health, NHLBI Obesity Education Initiative. 1998. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. https://www.nhlbi.nih.gov/files/docs/guidelines/ob_gdlns.pdf.
5. U.S. Department of Health and Human Services. 2015. Healthy People 2020 Topics and Objectives. https://www.healthypeople.gov/2020/topics-objectives.
6. Ayanian JZ, Weissman JS, Schneider EC, Ginsburg JA, Zaslavsky AM. Unmet health needs of uninsured adults in the Unit-ed States. JAMA. 2000;284:2061-9. [PMID: 11042754
7. McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Use of health services by previously uninsured Medicare beneficiaries. N Engl J Med. 2007;357:143-53.
8. Centers for Disease Control & Prevention, Arthritis Program (http://www.cdc.gov/arthritis/#spotlight).
9. CDC National Asthma Control Program, http://www.cdc.gov/asthma/impacts_nation/AsthmaFactSheet.pdf.
10. National Institutes of Health, National Cancer Institute, http://www.cancer.gov/cancertopics/cancerlibrary/what-is-cancer.
11. CDC. Heart Disease Risk Factors (http://www.cdc.gov/heartdisease/risk_factors.htm).
12. Centers for Disease Control and Prevention, NCCDPHP, http://www.cdc.gov/copd/index.htm.
13. Boschetto P, Quintavalle S, Miotto D, Lo Cascio N, Zeni E, Mapp C. COPD and occupational exposures. JOMT, 2006, 1:11. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1513231/pdf/1745-6673-1-11.pdf.
14. Department of Health & Human Services, Centers for Disease Control & Prevention, Stroke, June 21, 2007, http://www.cdc.gov/stroke/.
15. Depression, Centers for Disease Control and Prevention, http://www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm
16. CDC/NCCDPHP. National Diabetes Fact Sheet (www.cdc.gov/diabetes/pubs/general.htm)
17. Dahlhamer J, Lucas J, Zelaya, C, et al. Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults — United States, 2016. MMWR Morb Mortal Wkly Rep 2018;67:1001–1006. DOI: http://dx.doi.org/10.15585/mmwr.mm6736a2
18. Leading Causes of Non-fatal Injury Reports, 2001-2014. CDC WISQARS, National Center for Injury Prevention and Con-trol, 2014, http://www.cdc.gov/injury/wisqars/index.html.
19. Centers for Disease Control and Prevention. 2017. Recommended Adult Immunization Schedule, by Vaccine and Age Group - United States, 2017. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html. (May 2017).
20. Francis K. The burden of physical inactivity & cardiovascular heart disease. Comprehensive Therapy 24:87-92 (1998).
21. Centers for Disease Control and Prevention. 2013. State Indicator Report on Fruits and Vegetables. https://www.cdc.gov/nutrition/downloads/state-indicator-report-fruits-vegetables-2013.pdf. (May 2017).
22. Dept of Transportation (U.S.), National Highway Traffic Safety Administration (NHTSA). Lives Saved in 2016 by Re-straint Use and Minimum-Drinking-Age Laws. Washington (DC): NHTSA; 2017. Available at URL: https://cdan.nhtsa.gov/tsftables/tsfar.htm
23. Healthy People 2020, HealthyPeople.gov, Injury and Violence Prevention: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=24.
24. The Health Consequences of Smoking: A Report of the Surgeon General. Atlanta: U.S. DHHS/CDC/NCCDPHP/Office of Smoking and Health, 2004.
25. State-Specific Smoking-Attributable Mortality and Years of Potential Life Lost—U.S., 2000-2004. MMWR, Vol. 58/No2.
26. Cigarette Smoking-Attributable Morbidity. United State, 2000, MMWR, 2003/52(35); 842-844.
27. National Intimate Partner and Sexual Violence, Survey 2010 Summary Report. National Criminal Justice Reference https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=259047., 2011: Service
28. Suicide Deaths, 2016 New Mexico Department of Health, Indicator-Based Information System for Public Health website: https://ibis.health.state.nm.us/indicator/view/SuicDeath.Year.NM_US.html

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