Health Equity in New Mexico: A Report on Racial and Ethnic Health Disparities, 9th Edition

NEW MEXICO DEPARTMENT OF HEALTH

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To access this document electronically, visit our website at http://nmhealth.org/about/asd/opa. To obtain this document in an alternate format, contact our office at 827-1052.

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INTRODUCTION

The New Mexico Department of Health is pleased to present the ninth edition of *Health Equity in New Mexico: A Report on Racial and Ethnic Health Disparities.*

The mission of the Department of Health is to promote health and wellness, improve health outcomes, and assure safety net services for all people in New Mexico. As part of this mission, one of the goals of the department is to eliminate health disparities.

Health disparities refer to differences in health outcomes between groups of people based on their similar experiences within society. The sources of health disparities can be diverse and include such things as low socioeconomic status, racism, historical trauma, sexual orientation, gender identity, cultural and linguistic barriers, and inadequate access to health care. Achieving equity in health outcomes depends upon a shared understanding of health disparities among different racial and ethnic populations and the social determinants that precede them.

The purpose of this report is to identify important racial and ethnic health disparities in New Mexico so that state, community, and tribal partners can design and implement effective strategies to decrease them. Where available, the report includes national data so that comparisons can be made between New Mexico and the United States. Gender-specific data are also provided to allow comparisons between women and men in New Mexico.

We hope this report provides relevant and timely information regarding the health of racial and ethnic population groups in our state. As you review the information on health disparities presented in this report, we hope that you'll join us in asking "How did we get into to the situation that we find ourselves in?" and "What can we do to improve the health of our communities?"

Did You Know?

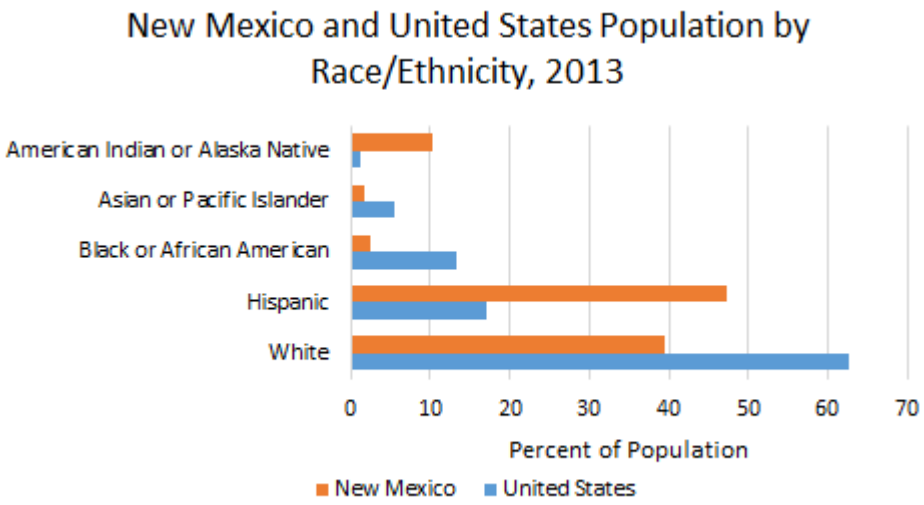
- 6 in 10 New Mexicans belong to racial/ethnic minorities
- 1 in 10 were born outside the United States
- 36 in 100 speak a language other than English at home
- 1 in 5 live below the federal poverty level
- 1 in 5 have no health insurance coverage

Source: http://factfinder2.census.gov, retrieved 11/25/2014

Data for this report were compiled by the New Mexico Department of Health's Office of Policy and Accountability with input from the Department's Offices of Health Equity and Tribal Liaison. The New Mexico Department of Health continues to work to improve the quality of this report and invites your input and suggestions.

WHO WE ARE

The concept of health disparities is especially relevant for New Mexico, where the state population is composed of less than 50% non-Hispanic whites (hereafter referred to as White). According to 2013 population estimates from the Geospatial and Population Studies Program at the University of New Mexico, 2,095,159 people live in New Mexico. Of these, 46.4% are Hispanic and 41.3% are White. Although the United States is increasingly diverse, Whites who are not Hispanic comprise over sixty percent of the national population compared to about forty percent of New Mexico's population.



Source: http://factfinder2.census.gov, retrieved 11/25/2014

Additionally, 8.7% of New Mexicans are American Indian. These residents represent 23 federally recognized tribes, pueblos, and nations as follows: 19 pueblos—Acoma, Cochiti, Isleta, Laguna, Nambe, Ohkay Owingeh, Picuris, Pojoaque, Sandia, San Felipe, San Ildefonso, Santa Ana, Santa Clara, Santo Domingo, Taos, Tesuque, Jemez, Zia, Zuni; Navajo Nation; Mescalero Apache Tribe; Jicarilla Apache Nation; Fort Sill Apache Tribe of Oklahoma, as well as urban off-reservation populations, within the state's geographic borders.

New Mexico is a vast state comprising 121,298 square miles. It is the fifth largest state by land mass, but with only four cities having populations of 50,000 or more, and only 17.2 persons per square mile, it is one of the most rural states. Due to its size and lack of population centers, many people residing in rural parts of the state find it difficult to access basic resources such as health centers, hospitals, food pantries, and grocery stores. Thirty-two of New Mexico's thirty-three counties contain U.S. Health and Human Services Health Resources and Services Administration designated Health Professional Shortage Areas, and over 40% of the state's population is estimated to live in a Primary Care Health Professional Shortage Area.

Mirroring national trends, New Mexico's older population is growing rapidly. The number of New Mexicans over the age of 65 increased 26 percent between 2000 and 2010. This number is expected to increase even more rapidly in the next decade with the aging of the "Baby Boomers."

Note: Population estimates from the Geospatial Population Studies Program slightly differ from U.S. Census estimates.

TOWARD HEALTH EQUITY

A Healthier New Mexico, the state's Health Improvement Plan, describes a comprehensive strategic approach for New Mexico to address health disparities and improve health equity. This approach requires a community-wide commitment that includes contributions from every partner in every sector. It includes a focus on the social determinants of health that perpetuate health disparities, including poverty, transportation systems, built environments, and access to health care and public health services among others. It also calls for increased cultural and linguistic effectiveness throughout the public health and health care workforce.

By developing a shared commitment to a common result, and leveraging the contributions of state, community, and tribal partners, New Mexico can move from talk to action and realize the goal of eliminating health disparities so that every person has the opportunity to attain their full health potential.

A Commitment to Action

Cultural and linguistic competency for New Mexico's public health and health care workforce is essential to achieving health equity. Competencies include knowledge and skills related to race, ethnicity, language, sexual orientation, and cultural expectations and understanding which contribute to the health status of population groups. To this end, the New Mexico Department of Health is dedicated to developing its capacity to communicate effectively and to convey information in a way that is easily understood by the state's diverse populations (e.g., persons of limited English proficiency, low literacy skills or who are not literate, and people with disabilities).

Further, the New Mexico Department of Health proposes to develop a cultural assessment tool by which health care and public health agencies may gauge their effectiveness to draw on community based values, traditions, customs, and languages to provide access to and deliver better health care. The assessment tool will help agencies develop operational and decisional processes to eliminate barriers to service provision, and inform policy development and resource management.

RECOGNIZING SOCIAL DETERMINANTS OF HEALTH

Where people live, learn, work, and play is an important factor that contributes to health. Similarly, factors such as economic opportunity, safe schools, walkable neighborhoods, housing, food security, transportation, geographic isolation, and many others, also contribute to health by providing opportunities to improve health or presenting barriers to obtaining and maintaining good health. At the population level, these underlying community, environmental, and social factors that contribute to health are termed *social determinants of health* (SDOH). For American Indians, the complex history of inter-governmental policies and relationships offers a particularly compelling example of how SDOH impact health equity.

SDOH include many "upstream" causes of the health disparities presented in this report. When we think of them in this way, SDOH can be recognized as early or primary influences on health. Improving health outcomes for entire population groups, without understanding how important upstream factors contribute to those outcomes, is an inefficient, costly, and ultimately ineffective approach. Rather, by viewing health disparities through a lens that incorporates the underlying upstream factors that contribute to health—the social determinants of health—strategies can be implemented that more effectively address the health outcomes downstream from those conditions.

As Dr. Howard Koh, the United States Assistant Secretary for Health, described in *Healthy People 2020—A 2020 Vision for the Social Determinants Approach*, health outcomes result from choices that people are able to make in response to the options they have. In other words, poor health outcomes disparately effect people who have fewer options from which to make choices for optimum health. By viewing health disparities through our SDOH lens, we can address the underlying factors and create better options that enable better choices for entire populations.

As we work together to reduce health disparities in our state, it is essential that state, community, and tribal partners be informed and involved. Further, it is important for everyone to be familiar with the social determinants of health and how they impact health. With this understanding we can utilize our limited resources effectively to reduce health disparities and move toward health equity.

Voice of the Community

New Mexico's teen birth rate has decreased by 48% from 2000-2013. While the rate has been declining, disparities among American Indian, Black or African American, Hispanic, and White youth still exist. Disproportionate rates of poverty, school dropout rates, the rural nature of communities, and lack of access to clinical services contribute to high teen birth rates, particularly among Hispanic and American Indian youth. To address these disparities, the New Mexico Department of Health Family Planning Program provides evidence-based, teen pregnancy prevention programing in communities with disproportionately high teen birth rates. These programs focus on positive youth development and community service learning, as well as sexual health education.

Andrea Sandoval, Teen Outreach Program® (TOP) Coordinator at Mesa Vista Middle School in Ojo Caliente, NM, works for Las Clinicas del Norte, which is the only health care provider in its service area. When asked about the need for teen pregnancy prevention programs in her community, Andrea said "The Teen Outreach Program® has helped provide students of the Mesa Vista School District with valuable information to help guide them to make the best choices when they encounter situations that may put them at risk. Through the Teen Outreach Program® the students are also able to connect with their communities and contribute to making their communities a better place to live."

UNDERSTANDING THE REPORT

Population Health Indicators and Data Sources

The indicators included in this report represent population health issues of importance in New Mexico. Indicators were selected for inclusion in the report based on several factors, including:

1. The health issue is included in *A Healthier New Mexico: New Mexico State Health Improvement Plan*. Published in May 2014, the New Mexico State Health Improvement Plan describes 10 health issues that have been prioritized for action in New Mexico. The report provides context to help develop an in-depth understanding of population health in New Mexico and includes recommended strategies to reduce the severity of each of the 10 priority health issues in the state.
2. The health issue is recognized nationally as an issue of concern for which effective strategies exist to improve population health relating to that issue.
3. Disparities in the health of certain racial/ethnic population groups are known to exist. In some cases racial/ethnic data may not be presented because there were too few events occurring for those populations in New Mexico. In these cases, further exploration of the population health disparities, including adoption of a data development agenda, is suggested.

For detailed information about each indicator in the report, including a description of its calculation and sources of data, please refer to the following section.

Maternal and Child Health

Prenatal Care—Late or No Care

Late or no prenatal care is the number of live births to women who did not receive prenatal care at all or who began prenatal care after the first trimester of pregnancy, divided by the number of live births, and multiplied by 100. Births to women with unknown prenatal care are excluded.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 birth files.

United States data—National Center for Health Statistics, as reported in national vital statistics reports for final birth data for calendar years 2003-2010. (http://www.cdc.gov/nchs.deaths.htm.)

Infant Mortality

Infant mortality is the number of deaths to infants before the first birth divided by the number of live births and multiplied by 100.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 birth and death files.

United States data—National Center for Health Statistics, as reported in national vital statistics reports for final death data for calendar years 2003-2011. (http://www.cdc.gov/nchs.deaths.htm.)

Teen Births Ages 15—17

Teen births is the number of births to females ages 15—17 years divided by the number of females ages 15—17 years and multiplied by 1,000.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 birth files. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—National Center for Health Statistics, as reported in national vital statistics reports for final birth data for calendar years 2003-2011.

Screening and Preventive Services

Adults with Diabetes Not Receiving All Recommended Diabetes Preventive Services

By controlling diabetes, disease progression and damage to the body can be delayed or prevented. Adults with diabetes are recommended to receive three health services annually in order to prevent disease progression: Hemoglobin A1C test, foot exam, and eye exam. Adults with diabetes not receiving all three of these services is the number of adult respondents to the survey questions who have doctor –diagnosed diabetes who did not receive all three of these services, divided by the number of adult respondents who have doctor-diagnosed diabetes and multiplied by 100. These data are weighted so that the estimates represent the entire population in New Mexico and not only those people who participated in the survey.

Source of data:

New Mexico data—New Mexico Behavioral Risk Factor Surveillance System (BRFSS), New Mexico Department of Health, Epidemiology and Response Division, Survey Unit. Users should note that the BRFSS data collection and weighting methods changed in 2011, including, of particular importance to this report, weighting adjustments by race and ethnicity. Comparisons between data collected from 2011 forward to data collected prior to 2011 should be done with caution.

United States data—National estimates are not available for this indicator.

Population Health Indicators and Data Sources

Not Had Pneumonia Vaccination (Adults 65 +)

Pneumococcal vaccination is recommended for adults age 65 and older once during their lifetime. The Not Had Pneumonia Vaccination indicator is the number of adults ages 65 years and older who report not having ever received pneumococcal vaccination divided by the number of adults ages 65 and older and multiplied by 100. These data are weighted so that the estimates represent the entire population of people ages 65 and older in New Mexico.

Source of data:

New Mexico data—New Mexico Behavioral Risk Factor Surveillance System (BRFSS), New Mexico Department of Health, Epidemiology and Response Division, Survey Unit. Users should note that the BRFSS data collection and weighting methods changed in 2011, including, of particular importance to this report, weighting adjustments by race and ethnicity. Comparisons between data collected from 2011 forward to data collected prior to 2011 should be done with caution.

United States data—Centers for Disease Control Behavioral Risk Factor Surveillance System online database (http://apps.nccd.cdc.gov/brfss/index.asp).

Adults Who Did Not Have a Dental Visit in the Past 12 Months

Access to oral health care is one of the nation's leading health indicators. Adults Who Did Not Have a Dental Visit in the Past 12 Months is the number of adult (ages 18 years and older) respondents to the survey who report not having visited a dentist in the past year, divided by the number of adult (ages 18 and older) survey respondents and multiplied by 100. These data are weighted so that the estimates represent the entire population of adults ages 18 and older in New Mexico.

Source of data:

New Mexico data—New Mexico Behavioral Risk Factor Surveillance System (BRFSS), New Mexico Department of Health, Epidemiology and Response Division, Survey Unit. Users should note that the BRFSS data collection and weighting methods changed in 2011, including, of particular importance to this report, weighting adjustments by race and ethnicity. Comparisons between data collected from 2011 forward to data collected prior to 2011 should be done with caution.

United States data—Centers for Disease Control Behavioral Risk Factor Surveillance System online database (http://apps.nccd.cdc.gov/brfss/index.asp).

Chronic Diseases

Diabetes Deaths

Diabetes deaths are deaths for which diabetes is identified as the underlying cause of death on the death certificate. To construct the indicator, the number of diabetes deaths is divided by the total population and multiplied by 100,000. This indicator is age-adjusted to the 2000 United States standard population. Diabetes deaths were identified by ICD-10 codes E10—E14.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 death files. Population data are provided by the University of New Mexi-co Geospatial and Population Studies Program, 2003 -2013.

United States data—National Center for Health Statistics compressed Mortality File for calendar years 2003-2011; Centers for Disease Control WONDER online database.

Obesity Among Adults

Obesity is defined as a Body Mass Index (BMI) of 30 or greater. BMI is a standard calculation based on a person's height and weight. The Obesity Among Adults indicator is the number of adult (ages 18 years and older) respondents to the survey who report height and weight measurements that result in a calculated BMI of 30 or more, divided by the number of adult (ages 18 and older) survey respondents and multiplied by 100. These data are weighted so that the estimates represent the entire population of adults ages 18 and older in New Mexico.

Source of data:

New Mexico data—New Mexico Behavioral Risk Factor Surveillance System (BRFSS), New Mexico Department of Health, Epidemiology and Response Division, Survey Unit. Users should note that the BRFSS data collection and weighting methods changed in 2011, including, of particular importance to this report, weighting adjustments by race and ethnicity. Comparisons between data collected from 2011 forward to data collected prior to 2011 should be done with caution.

United States data—Centers for Disease Control Behavioral Risk Factor Surveillance System online database (http://apps.nccd.cdc.gov/brfss/index.asp).

Obesity Among Youth

Obesity among youth is defined as a Body Mass Index (BMI) greater than the 95th percentile of a national multi-year reference database. BMI is a standard calculation based on a person's height and weight. For youth, this calculation is age and gender specific. The Obesity Among Youth indicator is the number of public high school student respondents to the survey who report height and weight measurements that result in a calculated BMI greater than the 95th percentile of reference youth, divided by the number of public high school student survey respondents and multiplied by 100. These data are weighted so that the estimates represent the entire population of public high school youth in New Mexico.

Source of data:

New Mexico data—New Mexico Youth Risk and Resiliency Survey, school-district level sample, New Mexico Department of Health, Epidemiology and Response Division and New Mexico Public Education Department. Users should note that these data include results from a multiple concurrent surveys and estimates presented in this report may differ from other reported statewide estimates.

Population Health Indicators and Data Sources

Infectious Diseases

Pneumonia and Influenza Deaths

Despite the availability of vaccines, pneumonia and influenza remain among the leading causes of death in the United States. Pneumonia and Influenza deaths are deaths for which pneumonia or influenza were identified as the underlying cause of death on the death certificate. The indicator is the number of pneumonia deaths plus the number of influenza deaths, divided by the total population, and divided by 100,000. This indicator is age-adjusted to the 2000 United States standard population. Pneumonia and influenza deaths were identified by ICD-10 codes J09—J18.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 death files. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—National Center for Health Statistics compressed Mortality File for calendar years 2003-2011; Centers for Disease Control online database. (http://www.wonder.cdc.gov)

Chlamydia

Chlamydia is the most commonly reported sexually transmitted infection in the United States. It is most frequently diagnosed among young women. The indicator is the number of women ages 15—24 years with diagnosed chlamydia infection divided by the number of women ages 15—24 in the population, multiplied by 100,000.

Source of data:

New Mexico data—New Mexico Department of Health, Public Health Division, Infectious Disease Bureau, Sexually Transmitted Diseases Program. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

Hepatitis B Infection (Acute and Chronic)

Hepatitis B is a viral infection of the liver. People with acute hepatitis B infection may recover on their own, or they may develop chronic infection. The indicator is the number of confirmed or probable cases reported to the New Mexico Department of Health divided by the population and multiplied by 100,000. Cases with unknown race/ethnicity were included in the calculation of the state's rate but were excluded in the calculation of race/ethnicity group rates.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Infectious Disease Epidemiology Bureau. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—National estimates are not available for this indicator.

Population Health Indicators and Data Sources

HIV Infection

Human Immunodeficiency Virus (HIV) infection is the number of adults and adolescents ages 13 years and older who are newly diagnosed with HIV infection, divided by the number of adults and adolescents ages 13 years and older, and divided by 100,000.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Infectious Disease Epidemiology Bureau, HIV Epidemiology Program. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Division of HIV/AIDS Prevention.

Pertussis (Whooping Cough)

Pertussis is a highly contagious respiratory disease; it is commonly known as Whooping Cough due to the "whooping" sound someone with pertussis often makes when trying to take a breath after a fit of coughing. The indicator is the number of confirmed or probable pertussis cases reported to the New Mexico Department of Health divided by the population and divided by 100,000.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Infectious Disease Epidemiology Bureau. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, Division of Bacterial Diseases.

Injury and Violence

Motor Vehicle Deaths

Motor vehicle deaths are deaths for which any type of motor vehicle accident was identified as the underlying cause of death on the death certificate. To construct the indicator, the number of motor deaths is divided by the total population and multiplied by 100,000. This indicator is age-adjusted to the 2000 United States standard population. Motor vehicle deaths were identified by ICD-10 codes V02—V04, V09.0, V09.2, V12—V14, V19.0—V19.2, V19.4—V19.6, V20—V79, V80.3—V80.5, V81.0—V81.1, V82.0—V82.1, V83—V86, V87.0—V87.8, V88.0—V88.8, V89.0, V89.2

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 death files. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—National Center for Health Statistics compressed Mortality File for calendar years 2003-2011; Centers for Disease Control WONDER online database. (http://www.wonder.cdc.gov)

Fall-Related Deaths (Adults 65 +)

Falls among older adults are common and often cause serious injuries that can lead to death. Fall-related deaths are deaths for which a fall was identified as the underlying cause of death on the death certificate. To construct the indicator, the number of fall-related deaths occurring among people ages 65 years and older is divided by the number of people ages 65 and older and multiplied by 100,000. Fall-related deaths were identified by ICD-10 codes W00—W19.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 death files. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—National Center for Health Statistics compressed Mortality File for calendar years 2003-2011; Centers for Disease Control WONDER online database. (http://www.wonder.cdc.gov)

Suicide

Suicides are deaths that occur to people when they direct violence at themselves with the intent to end their lives. Suicide deaths are those deaths for which suicide was identified as the underlying cause of death on the death certificate. The indicator is the number of suicide deaths divided by the total population and multiplied by 100,000. This indicator is age-adjusted to the 2000 United States standard population. Suicide deaths were identified by the ICD-10 codes *U03, X60—X84, Y87.0.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 death files. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—National Center for Health Statistics compressed Mortality File for calendar years 2003-2011; Centers for Disease Control WONDER online database.

Youth Suicide

Youth suicides are deaths that occur to young people ages 15-24 years when they direct violence at themselves with the intent to end their lives. Youth suicide deaths are those deaths occurring among people ages 15-24 years for which suicide was identified as the underlying cause of death on the death certificate. The indicator is the number of suicide deaths among people ages 15-24 years divided by the total number of people ages 15-24 years and multiplied by 100,000. Suicide deaths were identified by the ICD-10 codes *U03, X60—X84, Y87.0.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 death files. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—National Center for Health Statistics compressed Mortality File for calendar years 2003-2011; Centers for Disease Control WONDER online database.

Homicide

Homicides are deaths that occur when people direct violence toward another person with the intent to end their life. Homicide deaths are those deaths for which homicide was identified as the underlying cause of death on the death certificate. The indicator is the number of homicide deaths divided by the total population and multiplied by 100,000. This indicator is age-adjusted to the 2000 United States standard population. Homicide deaths were identified by the ICD-10 codes *U01—*U02, X85—Y09, Y87.1.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 death files. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—National Center for Health Statistics compressed Mortality File for calendar years 2003-2011; Centers for Disease Control WONDER online database.

Risk Behaviors

Smoking Among Adults

Smoking among adults is the number of adult (ages 18 years and older) respondents to the survey who report having ever smoked at least 100 cigarettes and who report cigarette smoking, divided by the number of adult (ages 18 and older) survey respondents and multiplied by 100. These data are weighted so that the estimates represent the entire population of adults ages 18 and older in New Mexico.

Source of data:

New Mexico data—New Mexico Behavioral Risk Factor Surveillance System (BRFSS), New Mexico Department of Health, Epidemiology and Response Division, Survey Unit. Users should note that the BRFSS data collection and weighting methods changed in 2011, including, of particular importance to this report, weighting adjustments by race and ethnicity. Comparisons between data collected from 2011 forward to data collected prior to 2011 should be done with caution.

United States data—Centers for Disease Control Behavioral Risk Factor Surveillance System online database (http://apps.nccd.cdc.gov/brfss/index.asp).

Population Health Indicators and Data Sources

Alcohol-Related Deaths

Alcohol-related deaths are identified based on Centers for Disease Control and Prevention Alcohol-Related Disease Impact (ARDI) software, version 2.0. Alcohol-related deaths are those deaths considered to be entirely attributable to alcohol (e.g., alcohol poisoning, alcoholic liver disease) as well as a portion of the deaths in which alcohol contributed to the death (e.g., motor-vehicle traffic crashes, liver cancer, hypothermia). A complete list of conditions included in the calculation and a description of ARDI methodology is available at the ARDI website: www.cdc.gov/alcohol/ardi.htm. The indicator is the number of alcohol-related deaths divided by the total mid-year population and multiplied by 100,000. This indicator is age-adjusted to the 2000 United States standard population.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 death files. Number of deaths was compiled by the Substance Abuse Epidemiology Unit. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—National Center for Health Statistics Multiple Cause of Death Files.

Drug Overdose Deaths

Drug overdose deaths are deaths caused by an overdose of illicit or prescription drugs. Drug overdose deaths are those deaths for which drug overdose is listed as the underlying cause of death on the death certificate. The indicator is the number of drug overdose deaths divided by the total population and multiplied by 100,000.

Source of data:

New Mexico data—New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics, 2003-2013 death files. Population data are provided by the University of New Mexico Geospatial and Population Studies Program, 2003-2013.

United States data—National Center for Health Statistics compressed Mortality File for calendar years 2003-2011; Centers for Disease Control WONDER online database. (http://www.wonder.cdc.gov)

Population Health Indicators and Data Sources

Voice of the Community

In response to chronic health disparities that persist in our communities and result in decreased life expectancy of African Americans, we strive to provide greater focus, resources and coordination for health initiatives. Because there has been an increase in the prevalence of cardiovascular disease, stroke, obesity, breast cancer, diabetes, smoking and infant mortality in ethnic communities around the United States, we must work to educate communities about healthy lifestyles and disease prevention. By staying connected in partnership with referral systems, that have a clear mission and proven outcomes, we will make strides to improve and address health disparities in the State of New Mexico.

~ New Mexico Office of African American Affairs

New Mexico Indicator Based Information System

Many of the estimates included in this report were derived using the New Mexico Department of Health's Indicator Based Information System (IBIS). This is an internet based public access system of data files relating to the health of New Mexico. IBIS can be accessed at https://ibis.health.state.nm.us/.
(http://www.wonder.cdc.gov)

International Classification of Diseases

ICD stands for International Classification of Diseases. It is a coding system maintained by the World Health Organization and the U.S. National Center for Health Statistics used to classify causes of death on death certificates and diagnoses, injury causes, and medical procedures for hospital and emergency department visits. These codes are updated periodically to account for advances in medical technology. The U.S. is currently using the 10th revision (ICD-10) to code causes of death. The 9th revision (ICD-9) is still used for hospital and emergency department visits.

UNDERSTANDING THE REPORT

REPORT LEGEND

Disparity Ratio	Disparity Level	Meaning/Interpretation
1.0 - 1.4	Low/No	Little or no disparity exists although continued monitoring is advisable.
1.5 - 2.4	Moderate	A moderate disparity exists which requires intervention.
≥ 2.5	Major	A major disparity exists which requires urgent intervention.
	Reference Group	The group with the best rate (and 20 or more cases). It is the group to which all other groups are compared.
	Not Enough Data	Groups with less than 20 events during time period or fewer than 50 survey respondents. Disparity ratios and levels are not calculated for these populations because the data are considered unstable.

RATES AND THE DISPARITY RATIO

Rates are used to allow direct comparisons between populations of different size. Rates are derived by taking the number of events occurring during a given time period, dividing by the population at risk, and multiplying by a constant. The constant used is generally chosen so that the rate is expressed as a whole number. Constants used in this report include 100, 1,000, and 100,000.

Some rates are adjusted to allow direct comparison between populations that are made up of people of different age distributions. When the indicator of interest varies in relation to age (as is the case for many mortality indicators), adjusting for differences in the age distribution of populations is important before making comparisons between those populations. Age adjustment is useful to reduce or remove the effect differences in the age of populations may have on the indicator.

The disparity ratio is a way to look at the severity of a health problem within a population group by comparing the rate for that group to the rate of the group having the best rate (the reference group). It is calculated by dividing the rate for the population group of interest by the reference group rate. In this report, disparity ratios were not calculated for populations with less than 20 cases during the time period, or, when the data were collected by a survey, when fewer than 50 people responded to the survey question.

DISPARITY LEVEL

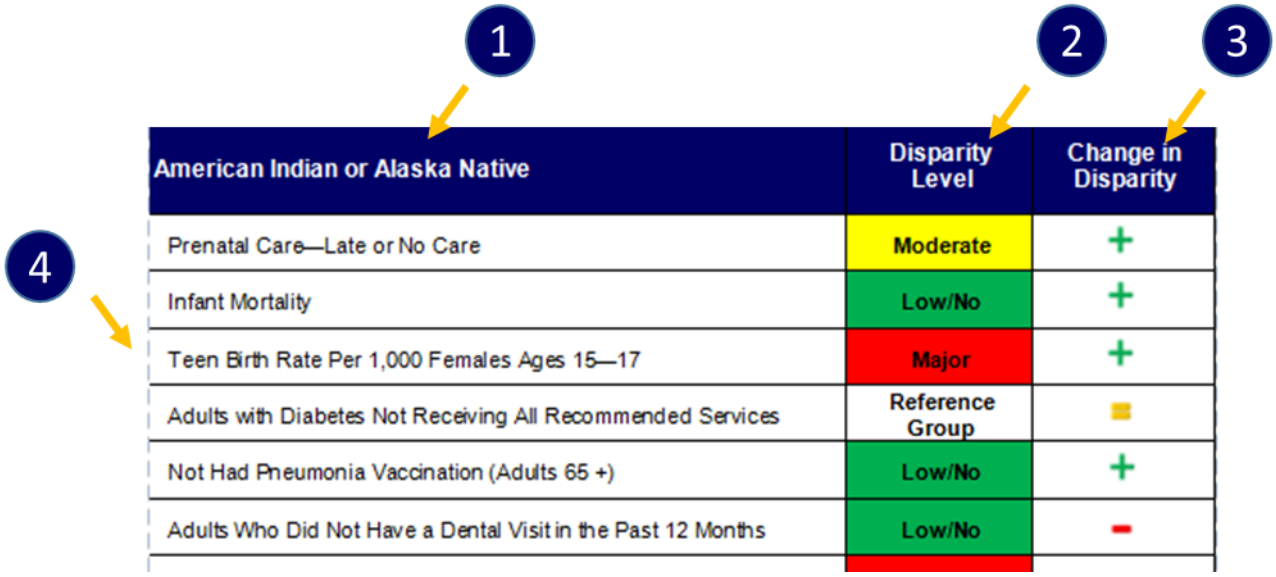
The disparity level indicates how many times higher or lower a particular group's rate is from the reference group's rate. For example, a disparity level of 3.0 indicates that the health problem is three times as severe for that group as compared to the reference group. The disparity level is one way of thinking about the significance of the disparity for a group.

The disparity level can also be thought of as a measure of how well society is doing in addressing the particular health needs of the racial/ethnic group. Please note that the disparity level is only related to the differences among racial/ethnic populations within the state (disparity ratio) and is not an indication of how well or poorly New Mexico is doing in relation to the nation.

Disparities by Population

This report includes a single-page summary of the disparities experienced by each racial/ethnic population in New Mexico. For each health indicator included in the report, the summary includes the group's disparity level and an indication whether the difference in rate for this population group has gotten better, gotten worse, or stayed the same. The change in disparity is another way we can think about population health differences. Large disparities that are getting worse may represent key opportunities for improving the health of whole populations.

Reading the Disparities by Population Tables



1. Name of population group
2. Disparity Level: Difference between the rate for this population group and the reference group.
3. Change in Disparity: Indicates whether the disparity experienced by this population group has gotten better +, gotten worse -, or stayed the same = since the earliest measurement period included in this report.
4. Health Indicator

Disparities by Population

American Indian or Alaska Native	Disparity Level	Change in Disparity
Prenatal Care—Late or No Care	Moderate	+
Infant Mortality	Low/No	+
Teen Birth Rate Per 1,000 Females Ages 15—17	Major	+
Adults with Diabetes Not Receiving All Recommended Services	Reference Group	=
Not Had Pneumonia Vaccination (Adults 65 +)	Low/No	+
Adults Who Did Not Have a Dental Visit in the Past 12 Months	Low/No	-
Diabetes Deaths	Major	-
Obesity Among Adults	Major	-
Obesity Among Youth	Major	-
Pneumonia and Influenza Deaths	Major	-
Chlamydia	Major	-
Hepatitis B Acute and Chronic	Not Enough Data	Not Enough Data
HIV Infections	Major	-
Pertussis (Whooping Cough)	Low/No	-
Motor Vehicle Deaths	Major	-
Fall-Related Deaths (Adults 65 +)	Reference Group	+
Suicide	Moderate	-
Youth Suicide	Moderate	+
Homicide	Major	+
Smoking Among Adults	Low/No	+
Alcohol-Related Deaths	Major	+
Drug Overdose Deaths	Reference Group	=

Disparities by Population

Asian or Pacific Islander	Disparity Level	Change in Disparity
Prenatal Care—Late or No Care	Low/No	–
Infant Mortality	Not Enough Data	Not Enough Data
Teen Birth Rate Per 1,000 Females Ages 15—17	Not Enough Data	Not Enough Data
Adults with Diabetes Not Receiving All Recommended Services	Not Enough Data	Not Enough Data
Not Had Pneumonia Vaccination (Adults 65 +)	Not Enough Data	Not Enough Data
Adults Who Did Not Have a Dental Visit in the Past 12 Months	Low/No	Not Enough Data
Diabetes Deaths	Not Enough Data	Not Enough Data
Obesity Among Adults	Reference Group	=
Obesity Among Youth	Reference Group	=
Pneumonia and Influenza Deaths	Not Enough Data	Not Enough Data
Chlamydia	Reference Group	=
Hepatitis B Acute and Chronic	Major	–
HIV Infections	Not Enough Data	Not Enough Data
Pertussis (Whooping Cough)	Not Enough Data	Not Enough Data
Motor Vehicle Deaths	Not Enough Data	Not Enough Data
Fall-Related Deaths (Adults 65 +)	Not Enough Data	Not Enough Data
Suicide	Not Enough Data	Not Enough Data
Youth Suicide	Not Enough Data	Not Enough Data
Homicide	Not Enough Data	Not Enough Data
Smoking Among Adults	Reference Group	=
Alcohol-Related Deaths	Not Enough Data	Not Enough Data
Drug Overdose Deaths	Not Enough Data	Not Enough Data

Disparities by Population

Black or African American	Disparity Level	Change in Disparity
Prenatal Care—Late or No Care	Low/No	+
Infant Mortality	Not Enough Data	Not Enough Data
Teen Birth Rate Per 1,000 Females Ages 15—17	Moderate	+
Adults with Diabetes Not Receiving All Recommended Services	Not Enough Data	Not Enough Data
Not Had Pneumonia Vaccination (Adults 65 +)	Low/No	+
Adults Who Did Not Have a Dental Visit in the Past 12 Months	Low/No	Not Enough Data
Diabetes Deaths	Major	-
Obesity Among Adults	Major	+
Obesity Among Youth	Major	-
Pneumonia and Influenza Deaths	Not Enough Data	Not Enough Data
Chlamydia	Major	+
Hepatitis B Acute and Chronic	Major	-
HIV Infections	Not Enough Data	Not Enough Data
Pertussis (Whooping Cough)	Low/No	Not Enough Data
Motor Vehicle Deaths	Not Enough Data	Not Enough Data
Fall-Related Deaths (Adults 65 +)	Not Enough Data	Not Enough Data
Suicide	Not Enough Data	Not Enough Data
Youth Suicide	Not Enough Data	Not Enough Data
Homicide	Major	-
Smoking Among Adults	Moderate	+
Alcohol-Related Deaths	Low/No	-
Drug Overdose Deaths	Low/No	+

Disparities by Population

Hispanic	Disparity Level	Change in Disparity
Prenatal Care—Late or No Care	Low/No	+
Infant Mortality	Low/No	−
Teen Birth Rate Per 1,000 Females Ages 15—17	Major	+
Adults with Diabetes Not Receiving All Recommended Services	Moderate	=
Not Had Pneumonia Vaccination (Adults 65 +)	Low/No	+
Adults Who Did Not Have a Dental Visit in the Past 12 Months	Low/No	+
Diabetes Deaths	Moderate	=
Obesity Among Adults	Major	−
Obesity Among Youth	Major	−
Pneumonia and Influenza Deaths	Low/No	+
Chlamydia	Major	+
Hepatitis B Acute and Chronic	Reference Group	=
HIV Infections	Moderate	−
Pertussis (Whooping Cough)	Moderate	−
Motor Vehicle Deaths	Low/No	+
Fall-Related Deaths (Adults 65 +)	Low/No	−
Suicide	Reference Group	=
Youth Suicide	Reference Group	+
Homicide	Moderate	+
Smoking Among Adults	Moderate	+
Alcohol-Related Deaths	Low/No	+
Drug Overdose Deaths	Moderate	+

Disparities by Population

White	Disparity Level	Change in Disparity
Prenatal Care—Late or No Care	Reference Group	=
Infant Mortality	Reference Group	=
Teen Birth Rate Per 1,000 Females Ages 15—17	Reference Group	=
Adults with Diabetes Not Receiving All Recommended Services	Low/No	+
Not Had Pneumonia Vaccination (Adults 65 +)	Reference Group	=
Adults Who Did Not Have a Dental Visit in the Past 12 Months	Reference Group	=
Diabetes Deaths	Reference Group	=
Obesity Among Adults	Moderate	-
Obesity Among Youth	Major	-
Pneumonia and Influenza Deaths	Reference Group	=
Chlamydia	Moderate	+
Hepatitis B Acute and Chronic	Moderate	-
HIV Infections	Reference Group	=
Pertussis (Whooping Cough)	Reference Group	=
Motor Vehicle Deaths	Reference Group	=
Fall-Related Deaths (Adults 65 +)	Low/No	-
Suicide	Moderate	-
Youth Suicide	Reference Group	=
Homicide	Reference Group	=
Smoking Among Adults	Low/No	+
Alcohol-Related Deaths	Reference Group	+
Drug Overdose Deaths	Moderate	+

Chart Book

Voice of the Community

"It is impossible to achieve health equity without first understanding the disparities that are occurring within a community, and that cannot be done without data that can accurately portray what is currently happening. For local Asian communities, there is often no current data; if there is data, it is often out of date and aggregated. Disaggregating data would reveal disparities in health status among diverse Asian subgroups, unmasking real problems that are occurring so that resources can be more appropriately allocated to support these populations."

Kay Bounkeua, M.P.H.
Interim Director
New Mexico Asian Family Center

MOTHER AND CHILD HEALTH

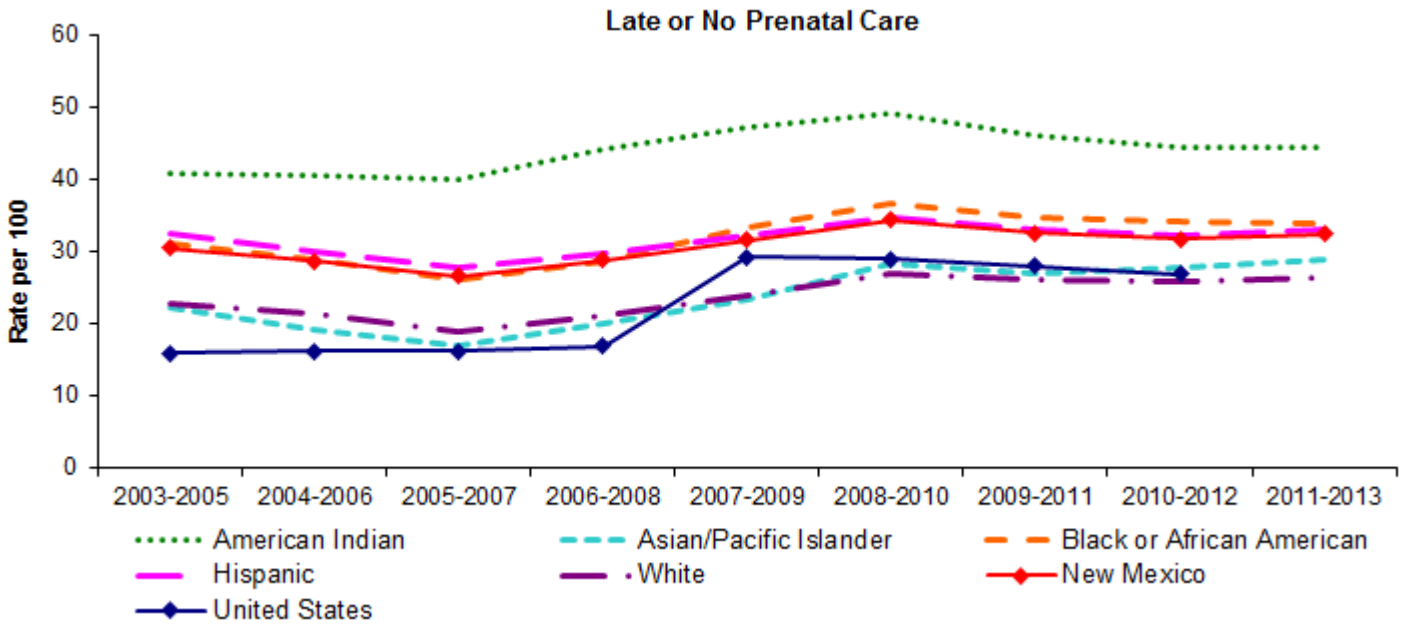
Prenatal Care - Late or No Care
(Care beginning after the 3rd month of pregnancy or no care during pregnancy)

Race/ Ethnicity	2011-2013 Rate (per 100)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	44.3	1.7	**Moderate**
Asian or Pacific Islander	28.8	1.1	**Low/No**
Black or African American	33.9	1.3	**Low/No**
Hispanic	32.9	1.2	**Low/No**
White	26.4	1.0	Reference Group

Notes:

- American Indian women have the highest rate of late prenatal care or no prenatal care.
- Asian or Pacific Islander women, Black or African American women, Hispanic women, and White women have similar rates of late prenatal care or no prenatal care.
- A higher percentage of women in New Mexico entered late into prenatal care or did not receive prenatal care as compared to women in the United States.

Trend in Late or No Prenatal Care by Race/Ethnicity



	New Mexico (2011 - 2013)	United States (2010)
Births with Late or No Prenatal Care Rate per 100	32.4	26.9

MOTHER AND CHILD HEALTH

Infant Mortality

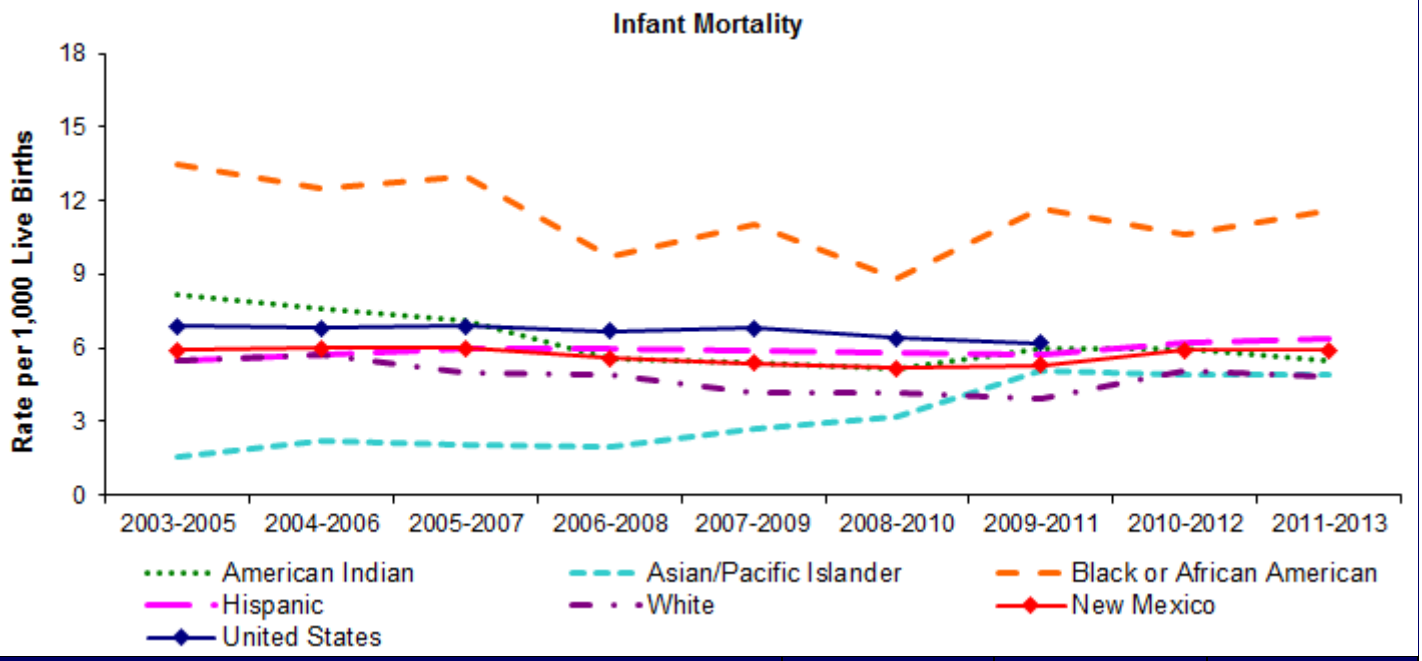
Race/ Ethnicity	2011-2013 Rate (per 100)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	5.5	1.1	**Low/No**
Asian or Pacific Islander	4.9*	Not Enough Data	Not Enough Data
Black or African American	11.6*	Not Enough Data	Not Enough Data
Hispanic	6.4	1.3	**Low/No**
White	4.8	1.0	Reference Group

Notes:

- Black or African Americans have the highest infant mortality rate.
- American Indians, Asian or Pacific Islanders, Hispanics, and Whites have similar rates of infant mortality.
- New Mexico has a lower infant mortality rate than the United States.

* These rates are based on fewer than 20 events and may change greatly from one year to the next.

Trend in Infant Mortality by Race/Ethnicity



Infant Mortality Rate per 1,000	Total	Female	Male
New Mexico (2011—2013)	5.9	5.1	6.6
United States (2011)	6.1	5.5	6.6

MOTHER AND CHILD HEALTH

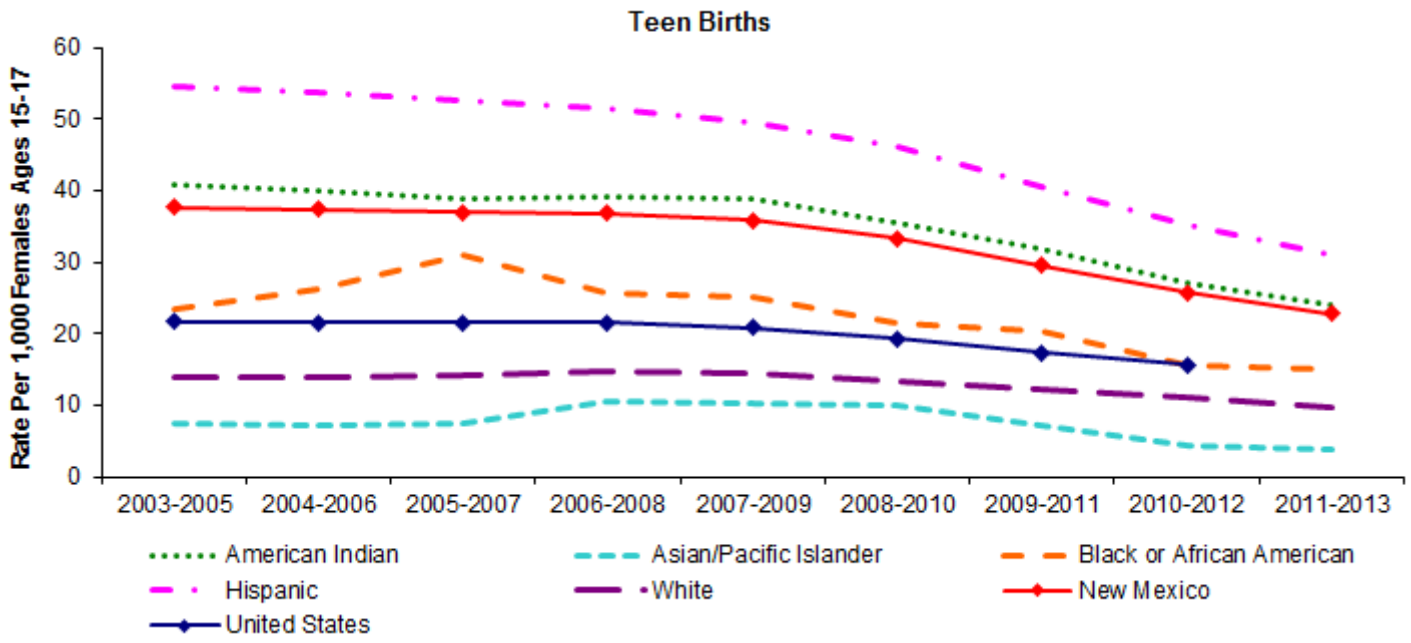
Teen Births (Ages 15—17)

Race/ Ethnicity	2011-2013 Rate (per1,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	24.1	2.5	**Major**
Asian or Pacific Islander	3.9	Not Enough Data	Not Enough Data
Black or African American	14.9	1.5	**Moderate**
Hispanic	31.1	3.2	**Major**
White	9.7	1.0	Reference Group

Notes:

- Hispanics, followed by American Indians, have the highest birth rate among females ages 15-17. Black or African Americans have the third highest birth rate among females ages 15-17.
- Asian or Pacific Islanders and Whites have similar birth rates among females ages 15-17.
- New Mexico has a higher birth rate among females ages 15-17 as compared to females in the United States.

Trend in Teen Birth Rates Ages 15 –17 by Mother's Race/Ethnicity



	New Mexico (2011 - 2013)	United States (2012)
Teen Birth Rate Per 1,000 Females Ages 15—17	22.8	14.1

SCREENING AND PREVENTIVE SERVICES

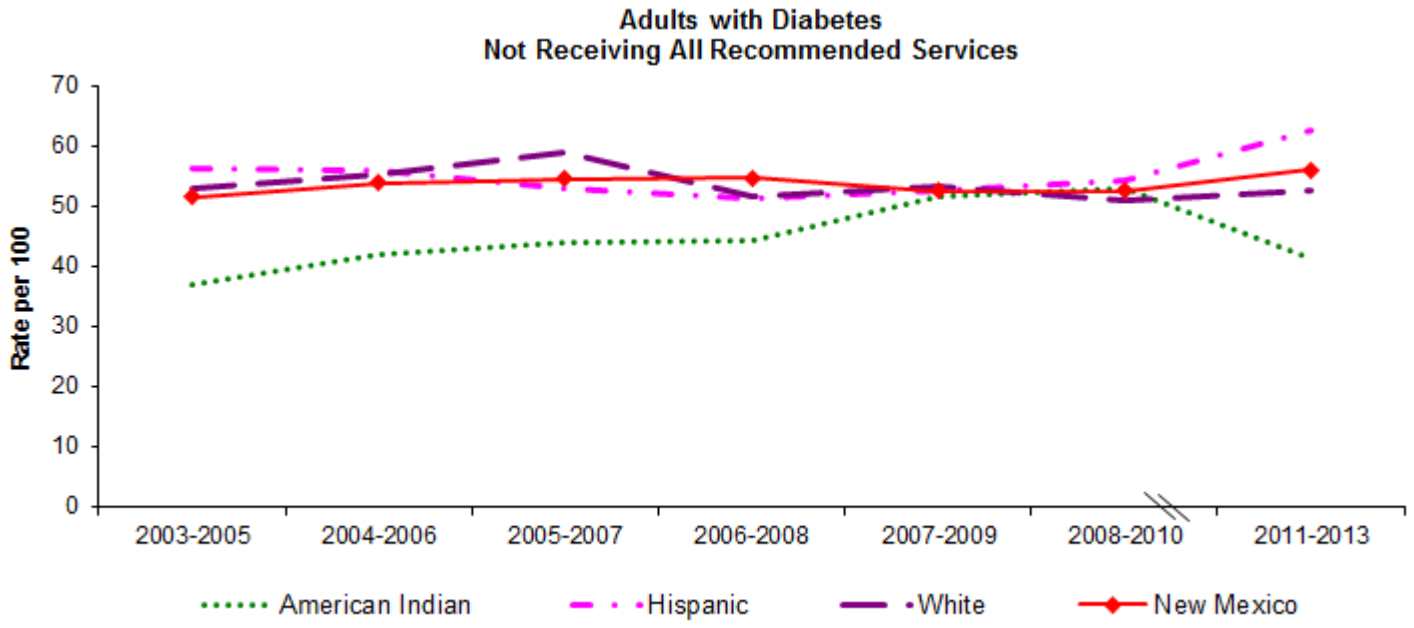
Adults with Diabetes Not Receiving All Recommended Diabetes Preventive Services

Race/ Ethnicity	2011-2013 Rate (per 100)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	41.3	1.0	Reference Group
Asian or Pacific Islander	Not Enough Data	Not Enough Data	Not Enough Data
Black or African American	Not Enough Data	Not Enough Data	Not Enough Data
Hispanic	62.6	1.5	**Moderate**
White	52.5	1.3	**Low/No**

Notes:

- Hispanics have the highest percentage of adults who are not receiving all recommended diabetes prevention services.
- American Indians and Whites have similar percentages of adults who are not receiving all recommended diabetes prevention services.
- A higher percentage of men with diabetes in New Mexico did not receive all recommended services as compared to women.

Trend in Adults with Diabetes Not Receiving All Recommended Services by Race/Ethnicity



Adults with Diabetes Not Receiving All Recommended Diabetes Preventive Services Rate per 100	Total	Female	Male
New Mexico (2011—2013)	56.1	53.8	58.5

SCREENING AND PREVENTIVE SERVICES

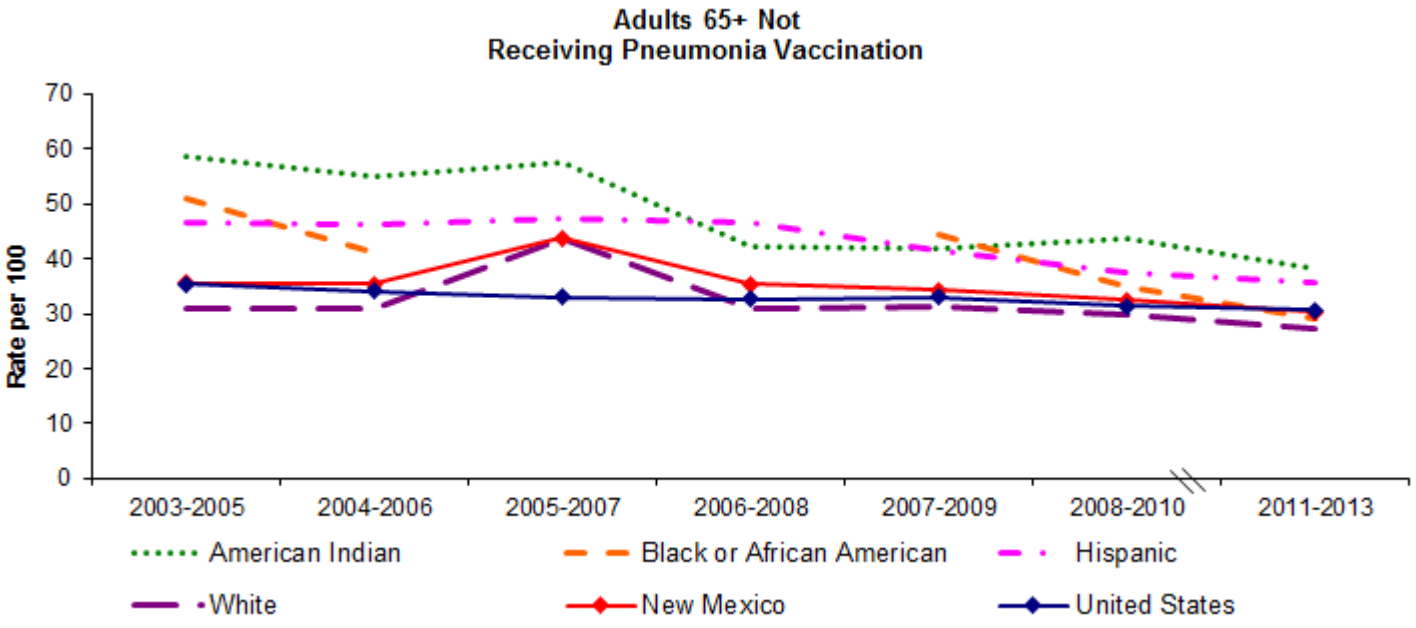
Not Had Pneumonia Vaccination (Adults 65 +)

Race/ Ethnicity	2011-2013 Rate (per 100)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	38.4	1.4	**Low/No**
Asian or Pacific Islander	Not Enough Data	Not Enough Data	Not Enough Data
Black or African American	29.2	1.1	**Low/No**
Hispanic	35.8	1.3	**Low/No**
White	27.4	1.0	Reference Group

Notes:

- Though disparities are modest, American Indians have the highest rate of not receiving pneumonia vaccination.
- A higher percentage of men do not receive pneumonia vaccination as compared to women.
- Similar rates of not receiving pneumonia vaccination are found in New Mexico as compared to the United States.

Trend in Adults 65+ Not Receiving Pneumonia Vaccination by Race/Ethnicity



Adults 65+ Not Receiving Pneumonia Vaccination Rate per 100	Total	Female	Male
New Mexico (2011—2013)	30.4	26.9	34.9
United States (2011—2013)	30.6	28.2	33.4

SCREENING AND PREVENTIVE SERVICES

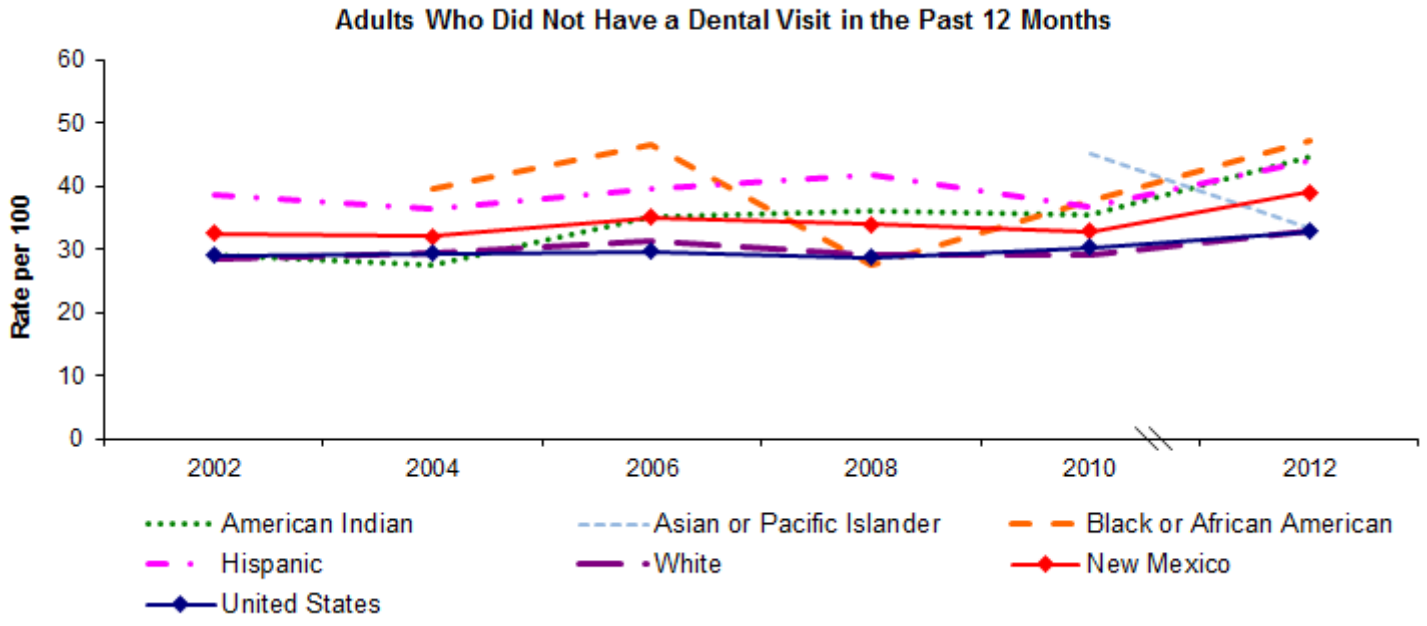
Adults Who Did Not Have a Dental Visit in the Past 12 Months

Race/ Ethnicity	2012 Rate (per 100)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	44.8	1.4	**Low/No**
Asian or Pacific Islander	33.4	1.0	**Low/No**
Black or African American	47.1	1.4	**Low/No**
Hispanic	44.1	1.3	**Low/No**
White	33.0	1.0	Reference Group

Notes:

- American Indians, Blacks or African Americans, and Hispanics have the highest percentages of adults who did not have a dental visit in the past 12 months.
- Asians or Pacific Islanders and Whites have similar percentages of adults who did not have a dental visit in the past 12 months.
- A higher percentage of adults in New Mexico did not have a dental visit in the past 12 months as compared to adults in the United States. Men are more likely to have not had a dental visit as compare to women.

Trend in Adults Who Did Not Have a Dental Visit in the Past 12 Months by Race/Ethnicity



Adults Who Did Not Have a Dental Visit in the Past 12 Months Rate per 100	Total	Female	Male
New Mexico (2012)	39.1	34.6	43.8
United States (2012)	32.8	29.6	36.4

CHRONIC DISEASES

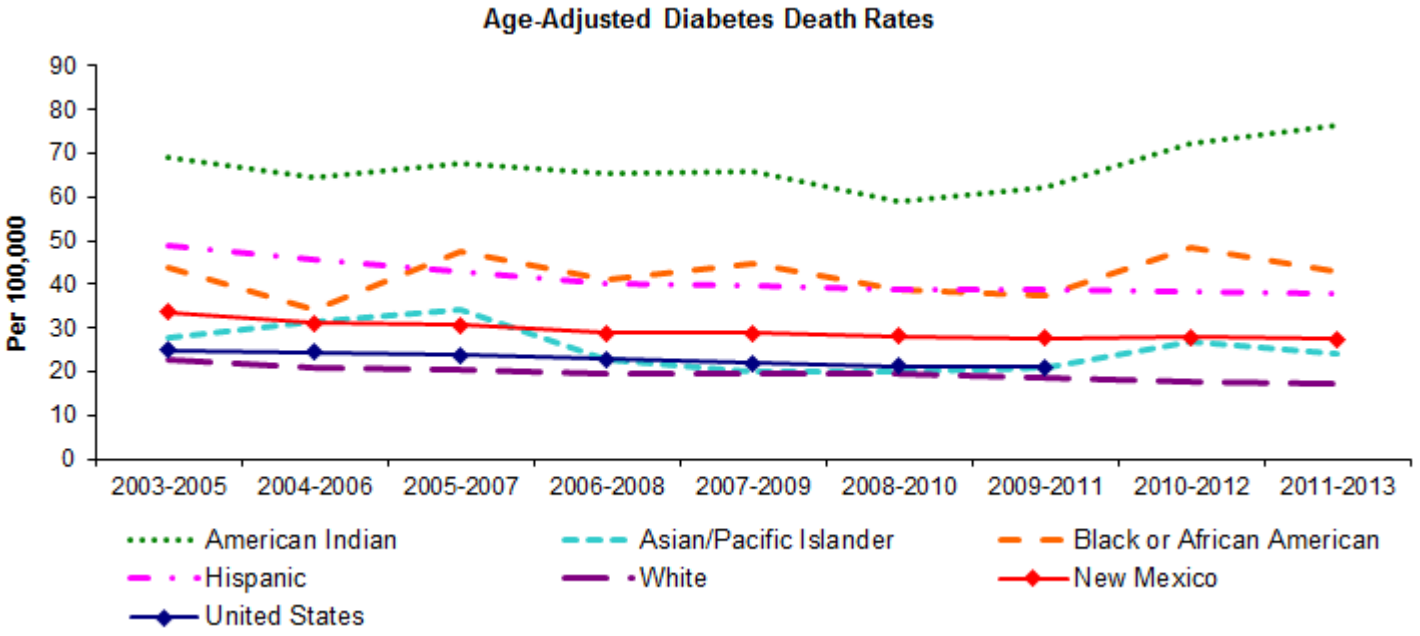
Diabetes Deaths (Age-Adjusted)

Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	76.5	4.4	**Major**
Asian or Pacific Islander	24.2	Not Enough Data	Not Enough Data
Black or African American	43.1	2.5	**Major**
Hispanic	37.9	2.2	**Moderate**
White	17.2	1.0	Reference Group

Notes:

- American Indians have the highest diabetes mortality rate.
- Black or African Americans have much higher rates of diabetes mortality than do Whites.
- Both women and men in New Mexico have higher rates of diabetes mortality as compared to women and men in the United States.

Trend in Diabetes Deaths by Race/Ethnicity



Diabetes Death Rate per 100,000 (Age-Adjusted)	Total	Female	Male
New Mexico (2011—2013)	27.5	23.5	32.1
United States (2011)	21.6	18.2	26.0

CHRONIC DISEASES

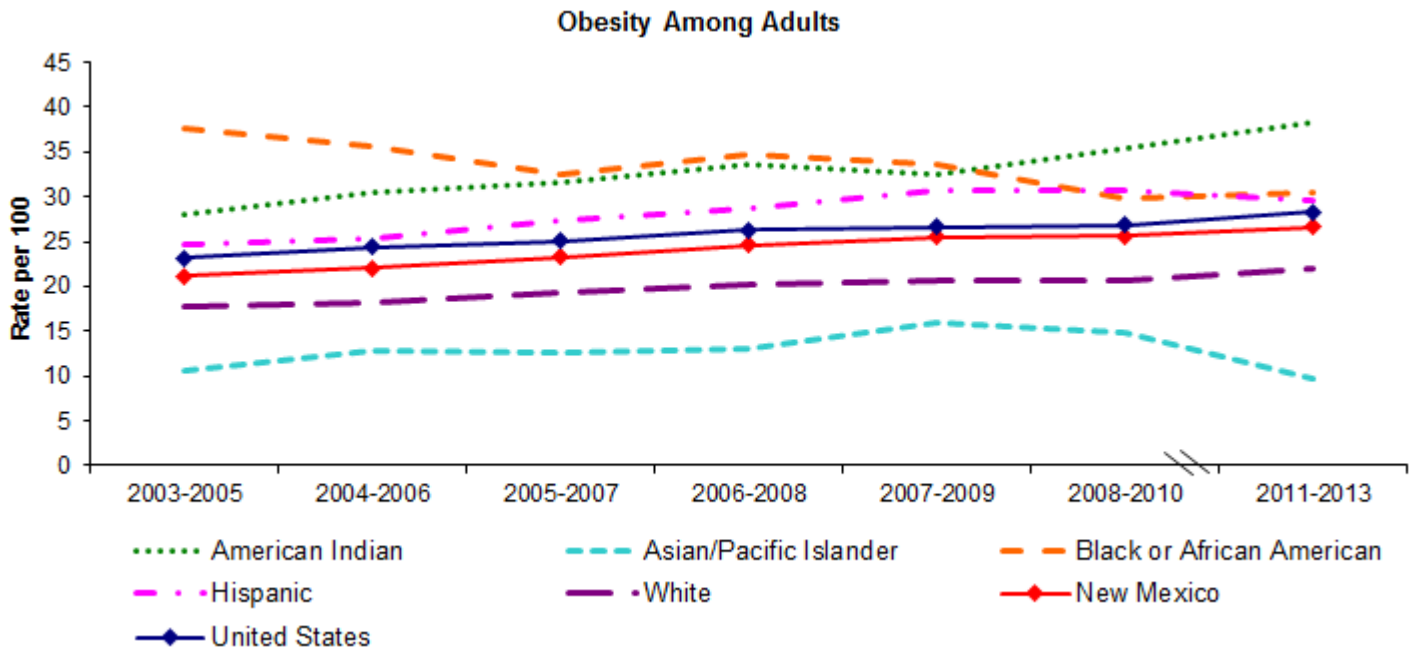
Obesity Among Adults

Race/ Ethnicity	2011-2013 Rate (per 100)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	38.2	4.0	**Major**
Asian or Pacific Islander	9.6	1.0	Reference Group
Black or African American	30.5	3.2	**Major**
Hispanic	29.7	3.1	**Major**
White	22.0	2.3	**Moderate**

Notes:

- American Indians, Black or African Americans, and Hispanics have much higher rates of obesity among adults as compared to Asian or Pacific Islanders.
- Whites have a moderately high rate of obesity among adults as compared to Asian or Pacific Islanders.
- New Mexico has a lower rate of obesity among adults as compared to the United States.

Trend in Obesity Among Adults by Race/Ethnicity



Adult Obesity Rate per 100	Total	Female	Male
New Mexico (2011—2013)	26.6	27.0	26.2
United States (2011—2013)	28.3	27.6	28.4

CHRONIC DISEASES

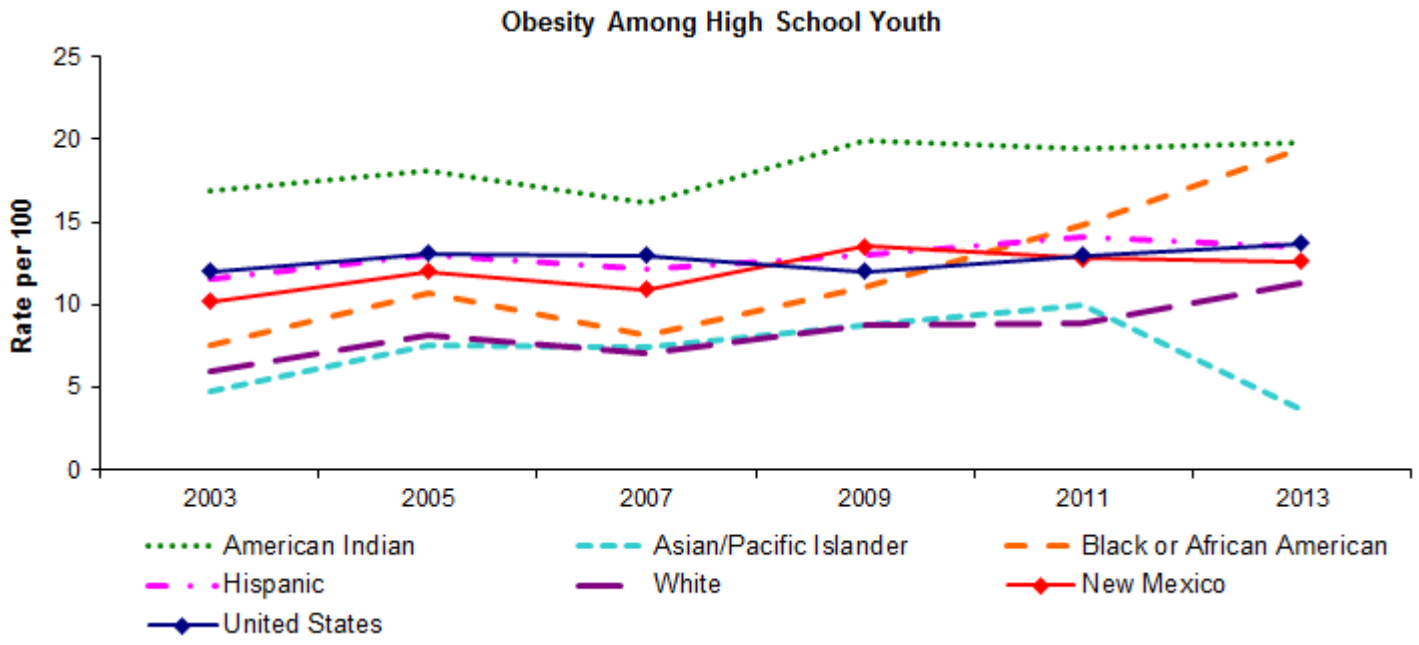
Obesity Among High School Youth

Race/ Ethnicity	2013 Rate (Per 100)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	19.8	5.5	**Major**
Asian or Pacific Islander	3.6	1.0	Reference Group
Black or African American	19.4	5.4	**Major**
Hispanic	13.5	3.8	**Major**
White	11.3	3.1	**Major**

Notes:

- American Indian and Black or African American youth have the highest rates of obesity.
- Asian or Pacific Islanders have the lowest rate of obesity among high school youth.
- The obesity rate among male youth in New Mexico is nearly double the obesity rate among female youth.

Trend in Obesity Among High School Youth by Race/Ethnicity



High School Youth Obesity Rate per 100	Total	Female	Male
New Mexico (2013)	12.6	8.5	16.6
United States (2013)	13.7	10.9	16.6

INFECTIOUS DISEASES

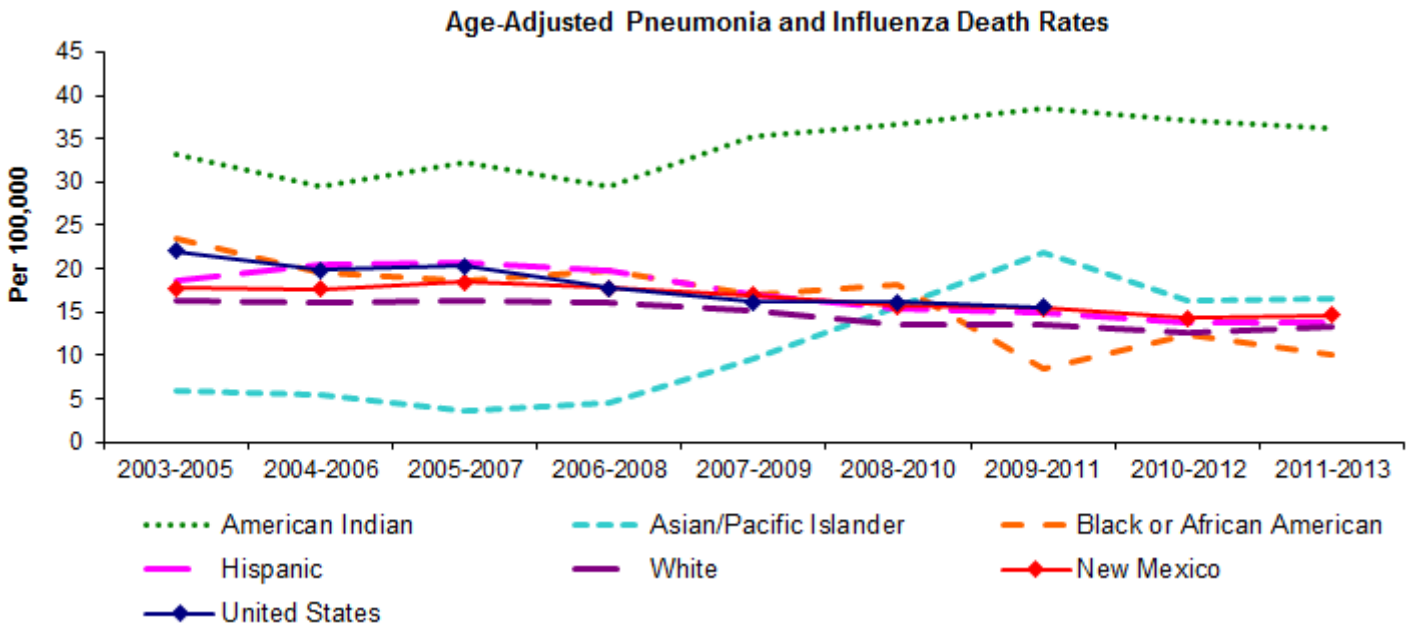
Pneumonia and Influenza Deaths (Age-Adjusted)

Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	36.3	2.7	**Major**
Asian or Pacific Islander	16.5	Not Enough Data	Not Enough Data
Black or African American	10.1	Not Enough Data	Not Enough Data
Hispanic	13.9	1.0	**Low/No**
White	13.3	1.0	Reference Group

Notes:

- American Indians have nearly 3-times the rate of death due to pneumonia and influenza as compared to Whites.
- Asian or Pacific Islanders, Black or African Americans, Hispanics, and Whites have similar pneumonia and influenza death rates.
- A higher percentage of men die from pneumonia and influenza as compared to women.

Trend in Pneumonia and Influenza Deaths by Race/Ethnicity



Pneumonia and Influenza Death Rate per 100,000 (Age-Adjusted)	Total	Female	Male
New Mexico (2011—2013)	14.7	12.6	17.6
United States (2011)	15.7	13.6	18.7

INFECTIOUS DISEASES

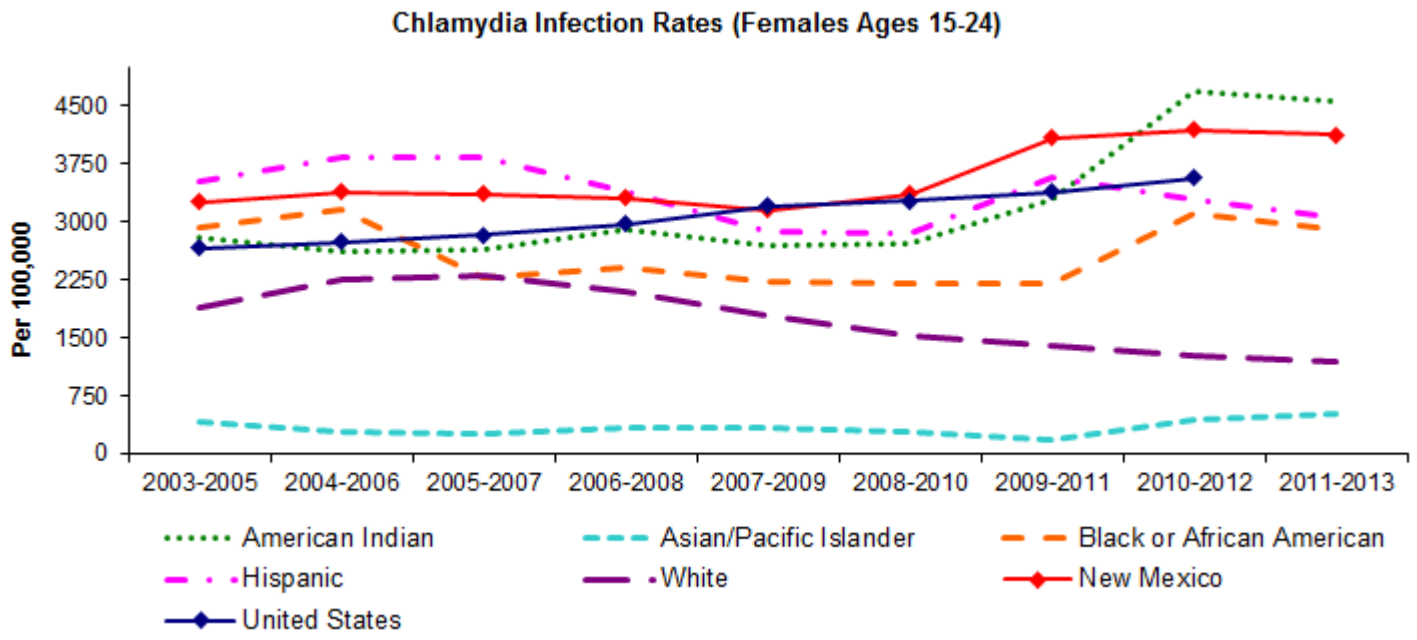
Chlamydia Infections (Females Ages 15-24)

Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	4,553.6	8.6	**Major**
Asian or Pacific Islander	530.6	1.0	Reference Group
Black or African American	2,897.1	5.5	**Major**
Hispanic	3,056.6	5.8	**Major**
White	1,186.6	2.2	**Moderate**

Notes:

- Among women ages 15-24, American Indian women have the highest rate of chlamydia infection.
- Black or African American women and Hispanic women have much higher rates of chlamydia infection than do Asian or Pacific Islander women.
- White women have twice the rate of chlamydia as compared to Asian or Pacific Islander women.
- Women age 15-24 have a higher rate of chlamydia infection than do women of the same age in the United States.

Trend in Chlamydia Infections by Race/Ethnicity



	New Mexico (2011—2013)	United States (2012)
Chlamydia Infection Rate Among Females Ages 15-24 per 100,000	4,127.4	3,485.8

INFECTIOUS DISEASES

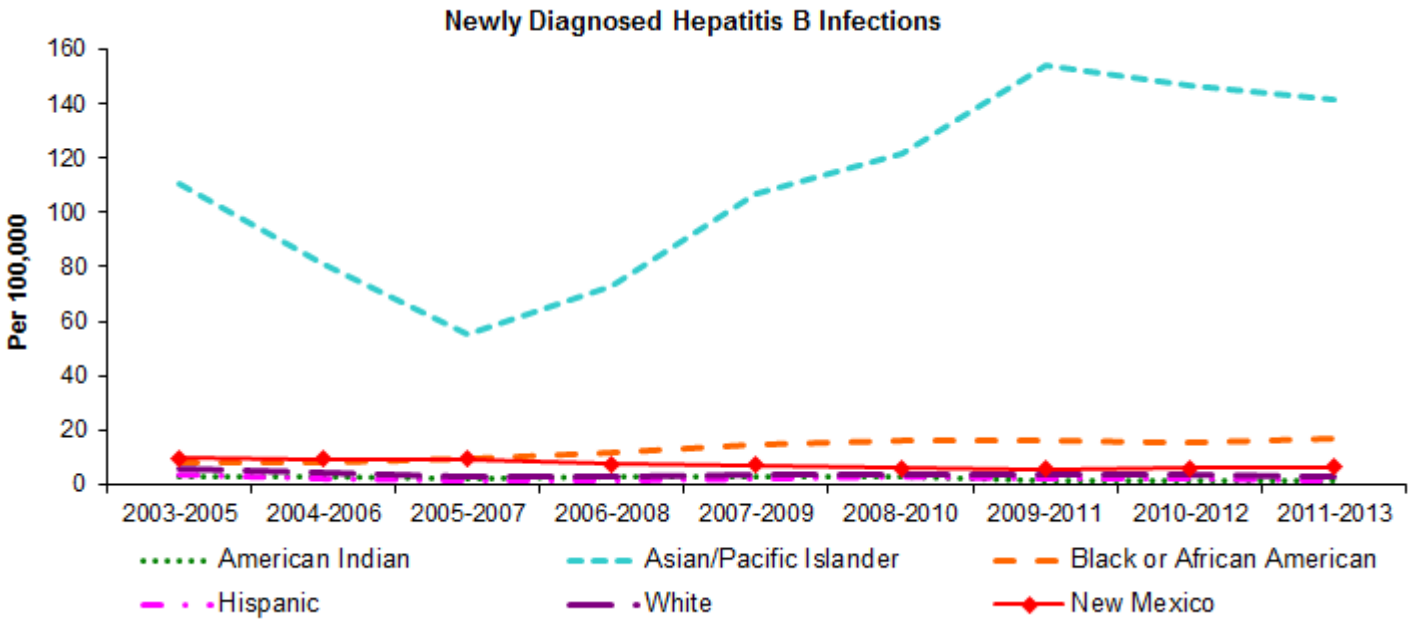
Hepatitis B Infections (Acute and Chronic)

Race/ Ethnicity	2011-2013 Rates (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	*1.1	Not Enough Data	Not Enough Data
Asian or Pacific Islander	141.8	88.6	**Major**
Black or African American	17.1	10.7	**Major**
Hispanic	1.6	1.0	Reference Group
White	3.2	2.0	**Moderate**

Notes:

- Asian or Pacific Islanders have the highest rate of newly diagnosed hepatitis B infection. Many of these infections are not new infections rather they are being diagnosed in New Mexico for the first time.
- Black or African Americans have the second highest rate of newly diagnosed hepatitis B in New Mexico; Whites have the third highest rate.

Trend in Hepatitis B Infections by Race/Ethnicity



Acute and Chronic Hepatitis B Infection Rate per 100,000	Total	Female	Male
New Mexico (2011—2013)	6.4	5.1	7.6

INFECTIOUS DISEASES

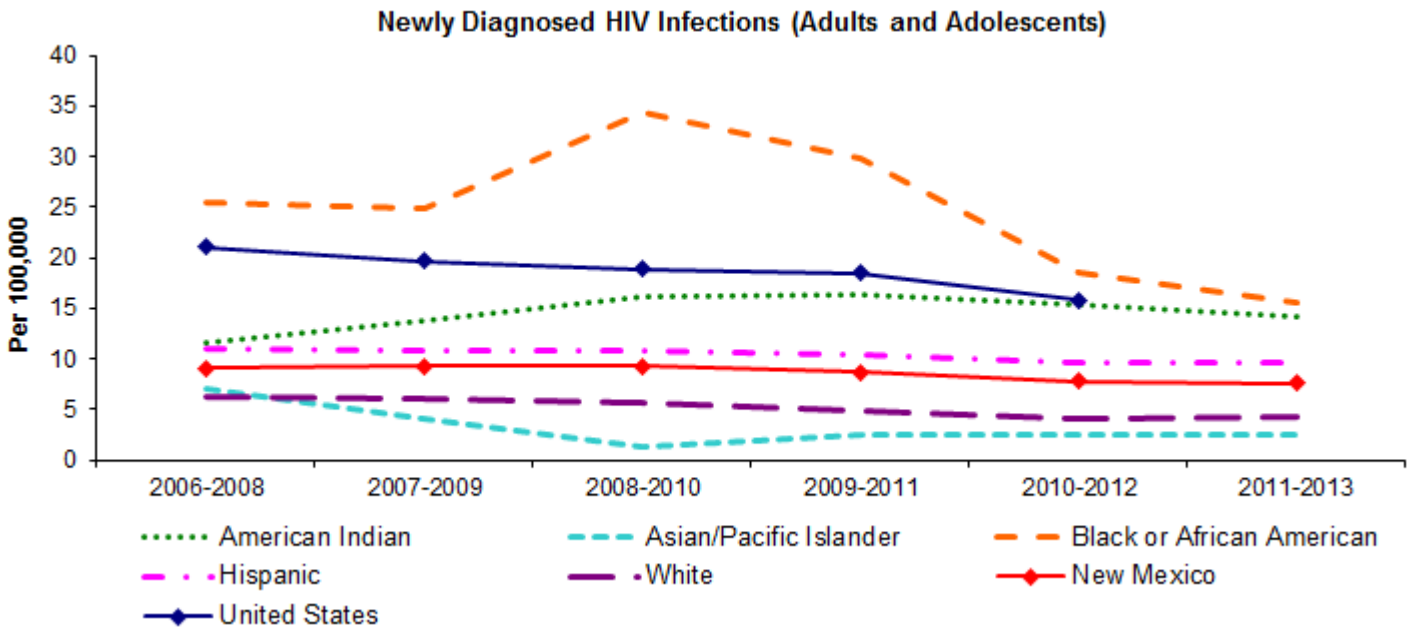
HIV Infections (Ages 13 and Older)

Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	14.3	3.4	**Major**
Asian or Pacific Islander	2.5	Not Enough Data	Not Enough Data
Black or African American	15.5	Not Enough Data	Not Enough Data
Hispanic	9.7	2.3	**Moderate**
White	4.2	1.0	Reference Group

Notes:

- American Indians and Black or African Americans have the highest rate of HIV infection in New Mexico.
- Though their rate is lower as compared to American Indians and Black or African Americans, Hispanics have twice the rate of HIV infection as do Whites.
- Men have much higher rates of HIV infection than do women.

Trend in HIV Infections by Race/Ethnicity



HIV Infection Rate per 100,000 (Ages 13 and Older)	Total	Female	Male
New Mexico (2011—2013)	7.8	1.9	14.0
United States (2011)	15.8	7.7	30.8

INFECTIOUS DISEASES

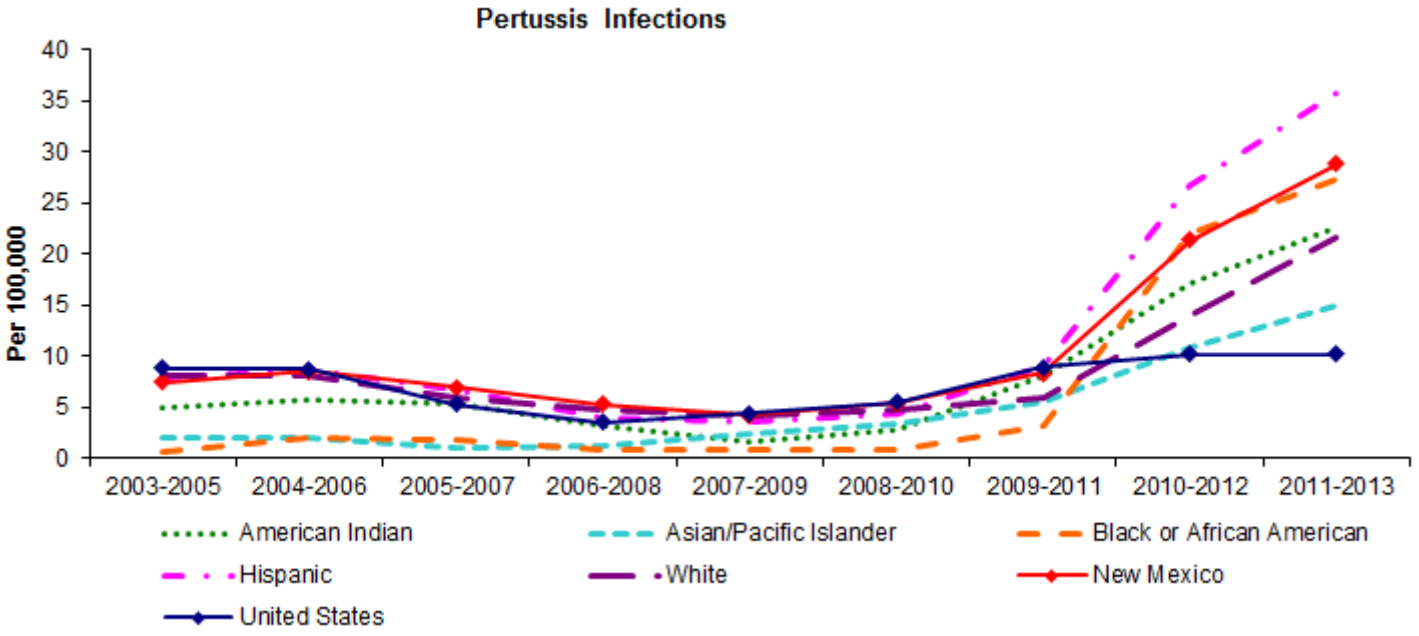
Pertussis (Whooping Cough) Infections

Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	22.6	1.1	**Low/No**
Asian or Pacific Islander	14.9	Not Enough Data	Not Enough Data
Black or African American	27.2	1.3	**Low/No**
Hispanic	35.7	1.7	**Moderate**
White	21.5	1.0	Reference Group

Notes:

- Since 2009-2011 New Mexico has had much higher rates of pertussis infection as compared to the United States.
- Hispanics have the highest rate of pertussis infection in New Mexico.
- American Indians, Black or African Americans, and Whites have similar rates of pertussis infection.

Trend in Pertussis Infections by Race/Ethnicity



Pertussis Infection Rate per 100,000	Total	Female	Male
New Mexico (2011—2013)	28.8	32.4	25.0
United States (2013)	9.1	9.6	8.2

INJURY AND VIOLENCE

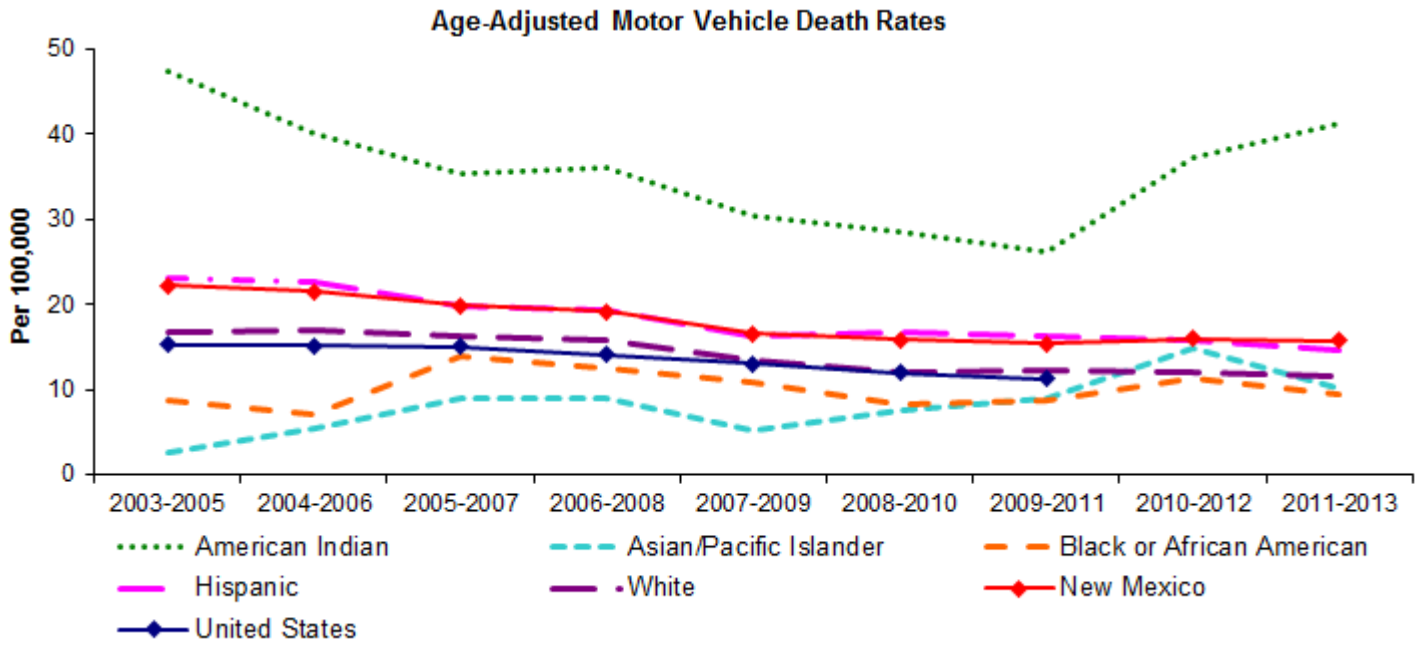
Motor Vehicle Deaths (Age-Adjusted)

Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	41.2	3.6	**Major**
Asian or Pacific Islander	10.2	Not Enough Data	Not Enough Data
Black or African American	9.4	Not Enough Data	Not Enough Data
Hispanic	14.7	1.3	**Low/No**
White	11.5	1.0	Reference Group

Notes:

- American Indians have the highest motor vehicle death rate.
- Asian or Pacific Islanders, Black or African Americans, Hispanics, and Whites have similar motor vehicle death rates.
- Men have a higher rate of motor vehicle deaths as compared to women.

Trend in Motor Vehicle Deaths by Race/Ethnicity



Motor Vehicle Death Rate per 100,000 (Age-Adjusted)	Total	Female	Male
New Mexico (2011—2013)	15.7	9.2	22.6
United States (2011)	11.1	6.3	16.1

INJURY AND VIOLENCE

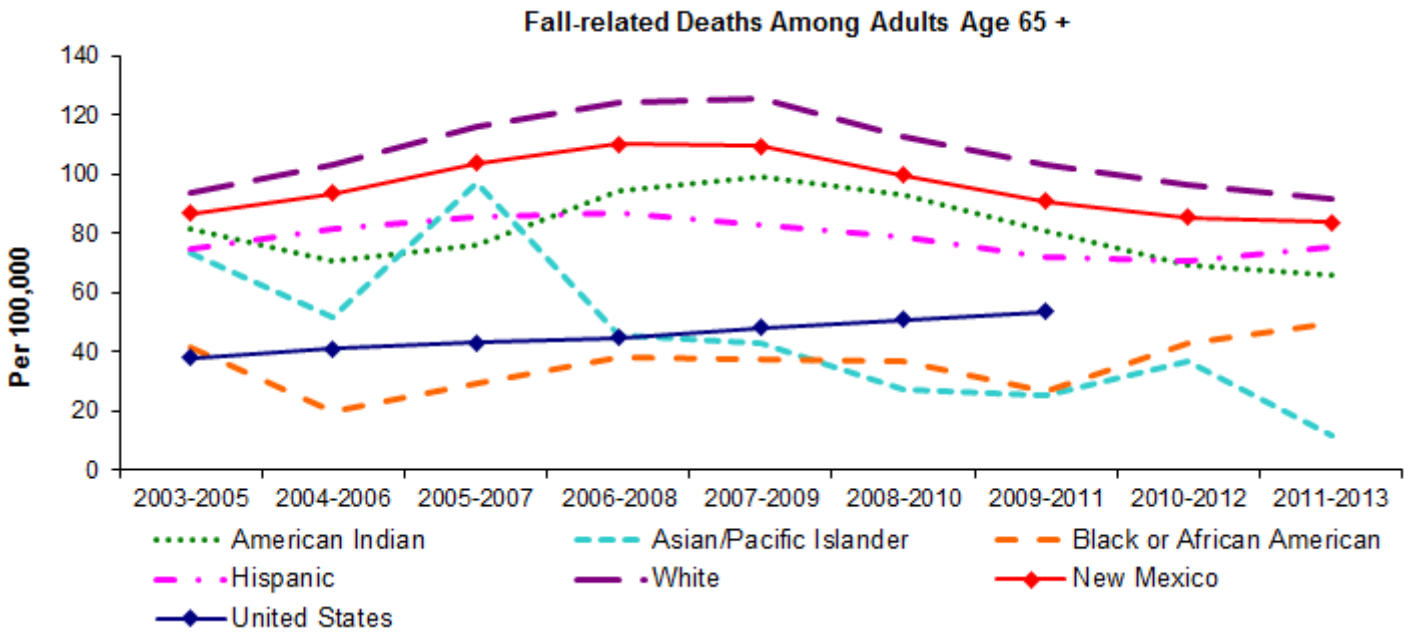
Fall-related Deaths (Ages 65 +)

Race/ Ethnicity	2011-2013 Rates (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	65.8	1.0	Reference Group
Asian or Pacific Islander	11.9	Not Enough Data	Not Enough Data
Black or African American	49.6	Not Enough Data	Not Enough Data
Hispanic	75.2	1.1	**Low/No**
White	91.6	1.4	**Low/No**

Notes:

- American Indians have the lowest rate of fall-related deaths among adults ages 65 and older.
- A higher percentage of women age 65+ in New Mexico died related to a fall as compared to men.
- Adults ages 65+ in New Mexico had a higher rate of fall-related deaths as compared to adults ages 65+ in the United States.

Trend in Fall-related Deaths by Race/Ethnicity



Fall-related Death Rate per 100,000 (Ages 65 +)	Total	Female	Male
New Mexico (2011—2013)	83.8	87.1	79.6
United States (2011)	55.3	53.0	58.4

INJURY AND VIOLENCE

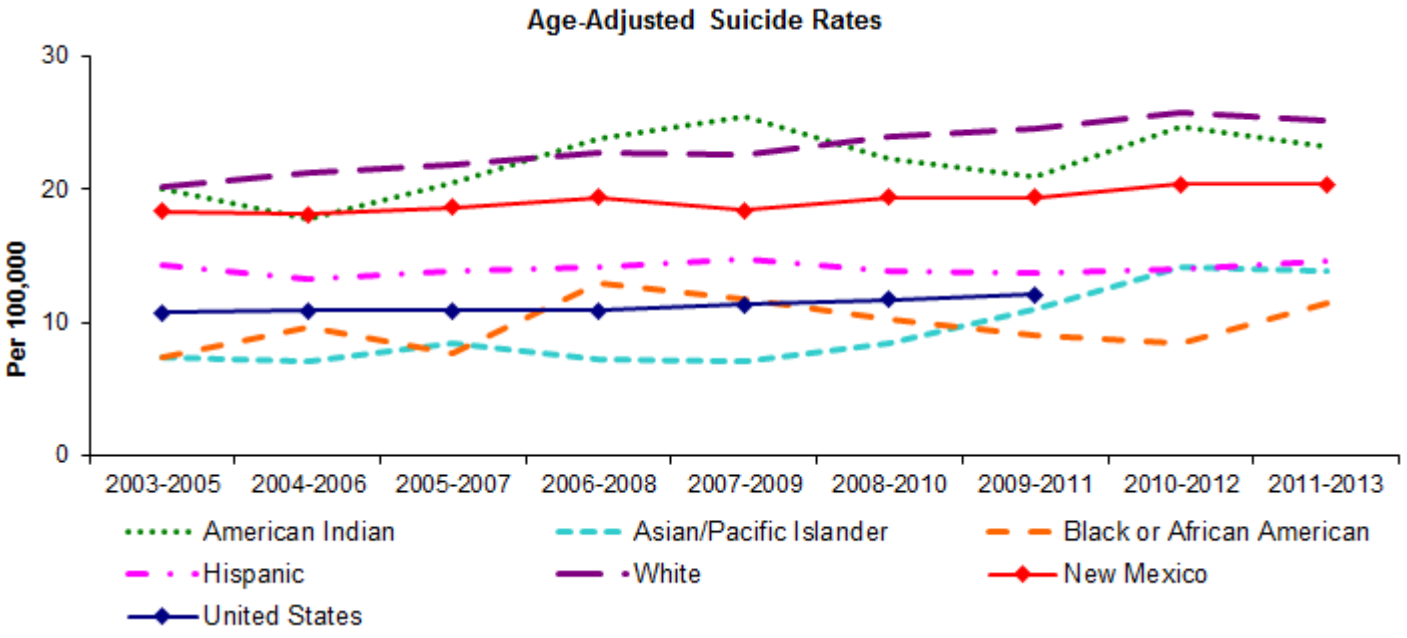
Suicide Deaths (Age-Adjusted)

Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	23.2	1.6	**Moderate**
Asian or Pacific Islander	13.9	Not Enough Data	Not Enough Data
Black or African American	11.5	Not Enough Data	Not Enough Data
Hispanic	14.6	1.0	Reference Group
White	25.2	1.7	**Moderate**

Notes:

- American Indians and Whites have the highest rates of suicide deaths.
- Men have a higher rate of suicide deaths as compared to women.
- New Mexico has a higher rate of suicide deaths as compared to the United States.

Trend in Suicide Deaths by Race/Ethnicity



Suicide Death Rate per 100,000 (Age-Adjusted)	Total	Female	Male
New Mexico (2011—2013)	20.4	9.7	31.6
United States (2011)	12.3	5.2	20.0

INJURY AND VIOLENCE

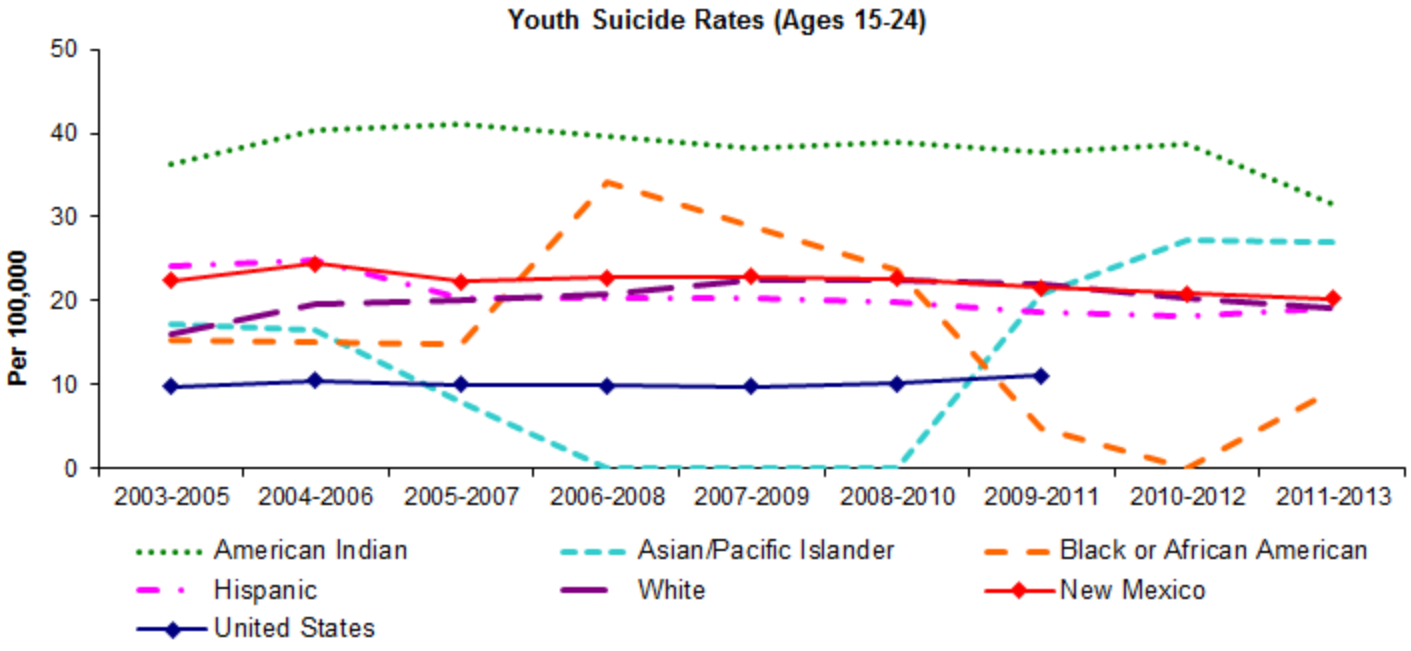
Youth (Ages 15-24) Suicide Deaths

Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	31.6	1.7	**Moderate**
Asian or Pacific Islander	27.1	Not Enough Data	Not Enough Data
Black or African American	9.3	Not Enough Data	Not Enough Data
Hispanic	19.0	1.0	Reference Group
White	19.0	1.0	Reference Group

Notes:

- American Indian youth have the highest rate of suicide deaths.
- Young men have a higher rate of suicide deaths as compared to young women.
- New Mexico has a higher rate of youth suicide deaths as compared to the United States.

Trend in Youth Suicide Deaths by Race/Ethnicity



Youth Suicide Death Rate per 100,000 (Ages 15-24)	Total	Female	Male
New Mexico (2011—2013)	20.9	8.6	31.4
United States (2011)	11.0	4.0	17.6

INJURY AND VIOLENCE

Homicide Deaths (Age-Adjusted)

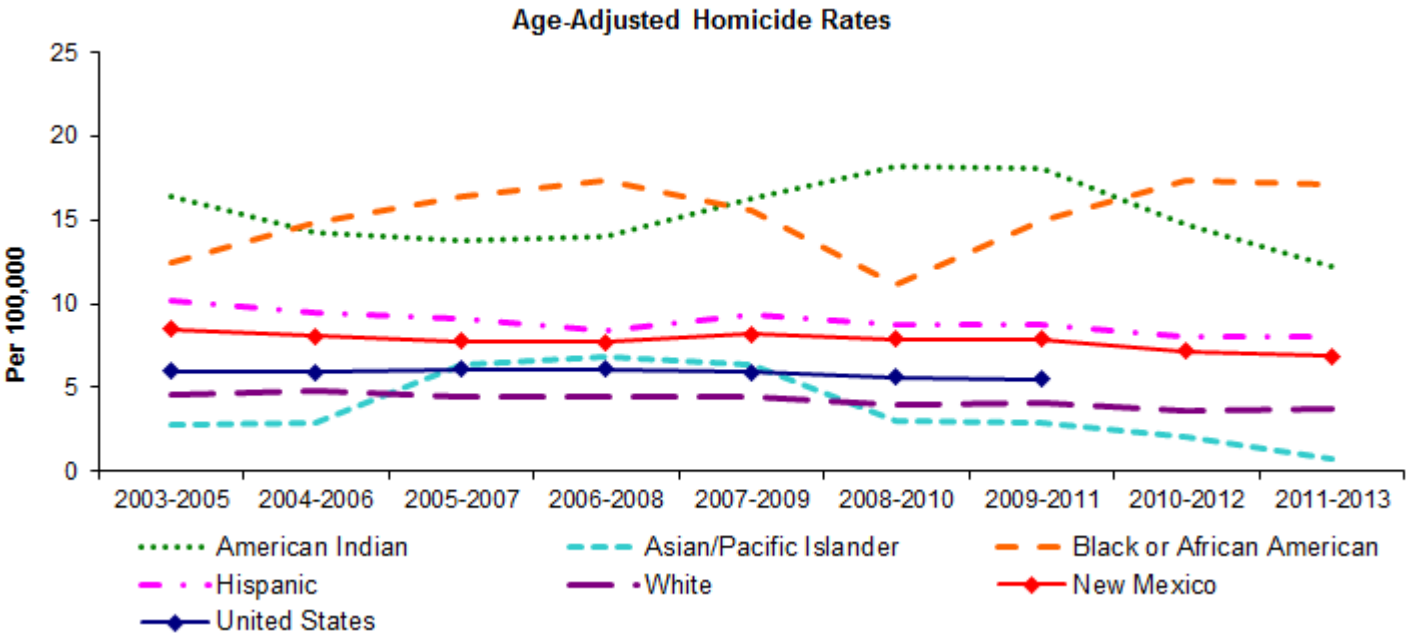
Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	12.2	3.2	**Major**
Asian or Pacific Islander	*0.8	Not Enough Data	Not Enough Data
Black or African American	17.1	4.5	**Major**
Hispanic	8.0	2.1	**Moderate**
White	3.8	1.0	Reference Group

Notes:

- American Indians and Black or African Americans have the highest rates of homicide deaths.
- Men have a higher rate of homicide deaths as compared to women.
- New Mexico has a higher rate of homicide deaths as compared to the United States.

* These rates are based on fewer than 20 events and may change greatly from one year to the next.

Trend in Homicide Deaths by Race/Ethnicity



Homicide Death Rate per 100,000 (Age-Adjusted)	Total	Female	Male
New Mexico (2011—2013)	6.9	2.6	11.2
United States (2011)	5.3	2.2	8.3

RISK BEHAVIORS

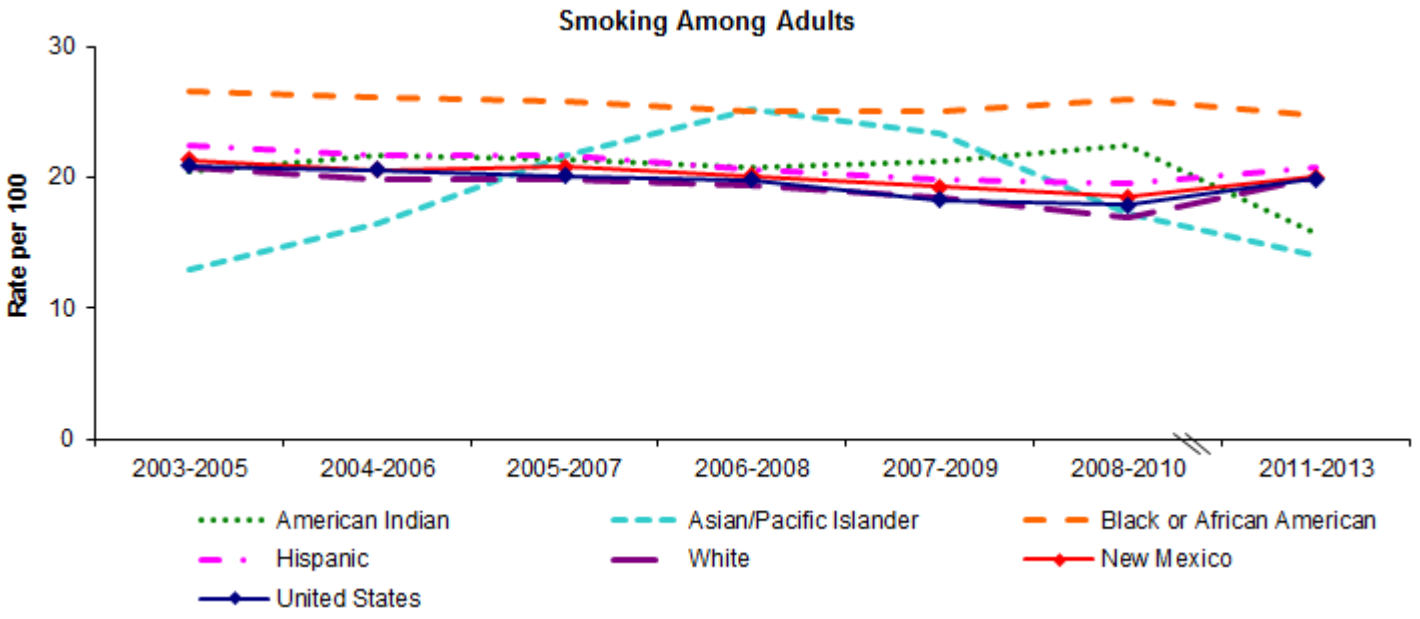
Smoking Among Adults

Race/ Ethnicity	2011-2013 Rate (per 100)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	15.7	1.1	**Low/No**
Asian or Pacific Islander	14.0	1.0	Reference Group
Black or African American	24.8	1.8	**Moderate**
Hispanic	20.7	1.5	**Moderate**
White	20.0	1.4	**Low/No**

Notes:

- Black or African Americans have the highest percentage of adults who smoke.
- Hispanics and Whites have similar percentages of adults who smoke.
- A higher percentage of men in New Mexico smoke as compared to women.

Trend in Smoking Among Adults by Race/Ethnicity



Adult Smoking Rate per 100	Total	Female	Male
New Mexico (2011—2013)	20.0	17.0	23.1
United States (2011—2013)	19.9	18.7	22.3

RISK BEHAVIORS

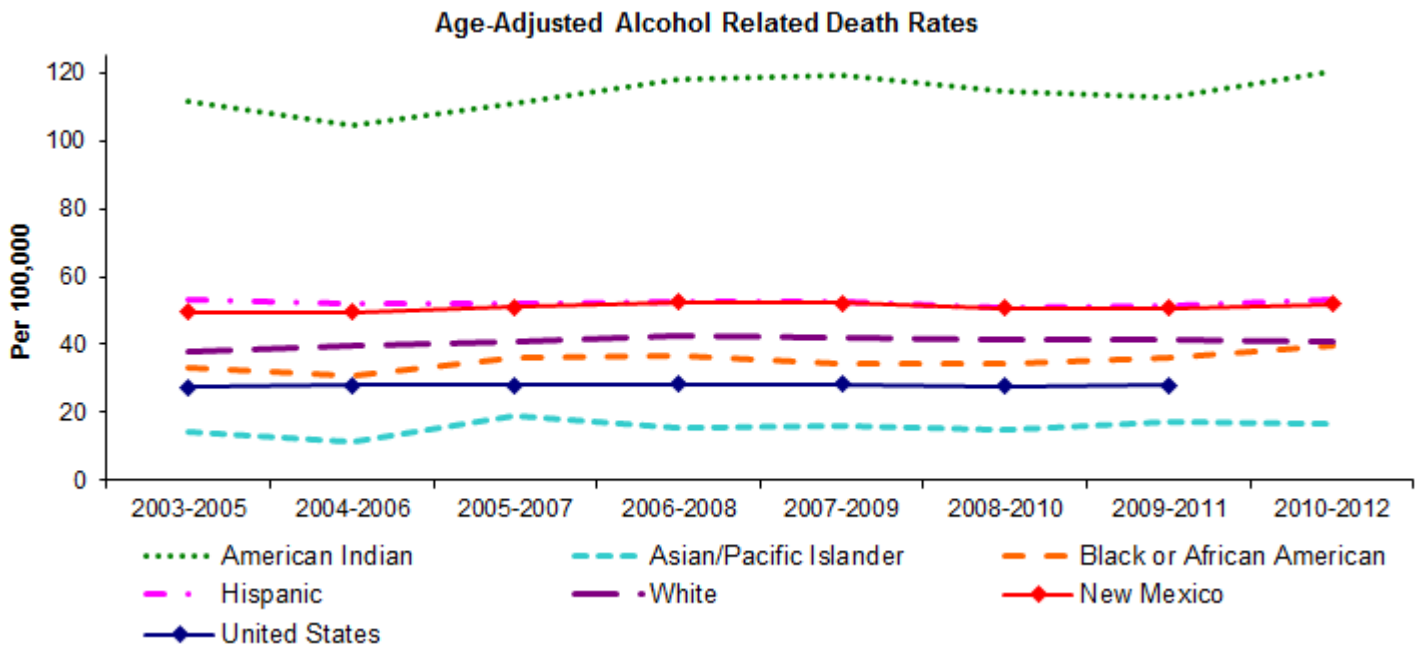
Alcohol-Related Deaths (Age-Adjusted)

Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	144.3	3.3	**Major**
Asian or Pacific Islander	16.3	Not Enough Data	Not Enough Data
Black or African American	47.1	1.1	**Low/No**
Hispanic	56.3	1.3	**Low/No**
White	43.8	1.0	Reference Group

Notes:

- American Indians have the highest alcohol-related death rate.
- Black or African Americans, Hispanics, and Whites have similar rates of alcohol-related deaths.
- Men have a higher rate of alcohol-related deaths as compared to women.
- New Mexico has a higher alcohol-related death rate as compared to the United States.

Trend in Alcohol-related Deaths by Race/Ethnicity



Alcohol-Related Death Rate per 100,000 (Age-Adjusted)	Total	Female	Male
New Mexico (2011—2013)	56.6	32.8	81.7
United States (2009—2011)	28.0	15.5	41.7

RISK BEHAVIORS

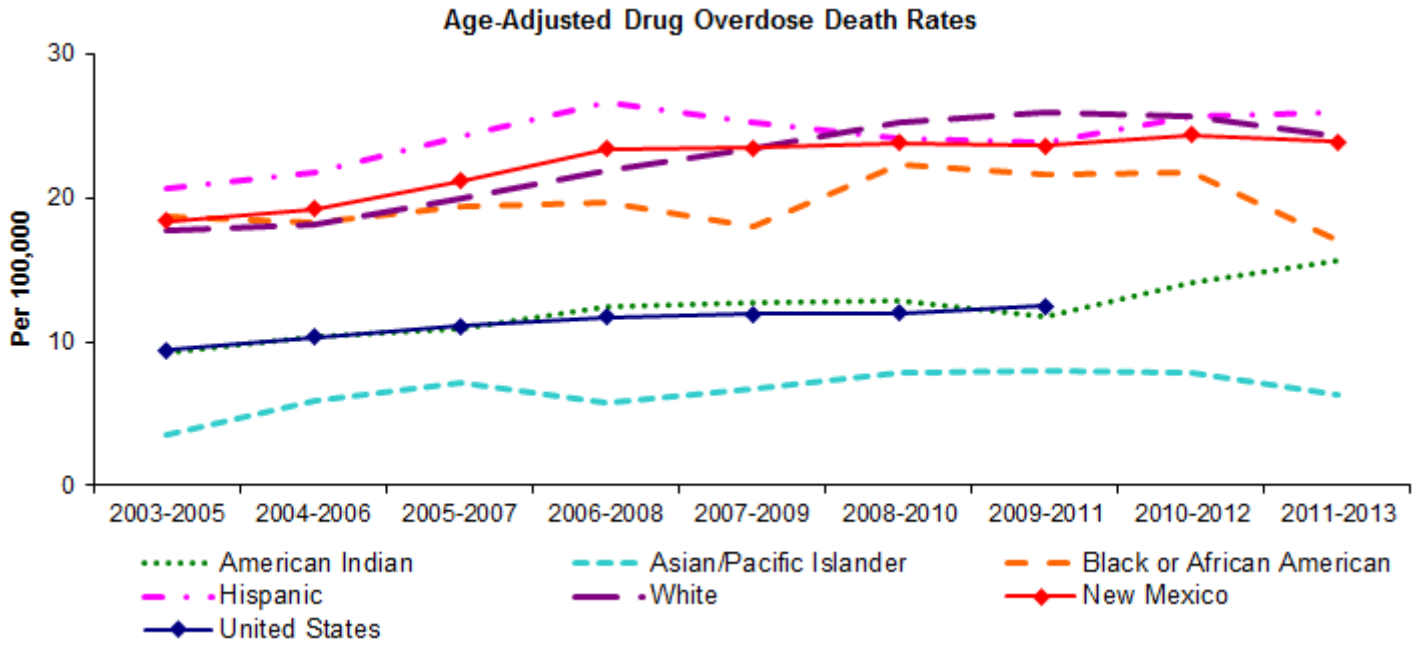
Drug Overdose Deaths (Age-Adjusted)

Race/ Ethnicity	2011-2013 Rate (per 100,000)	Disparity Ratio	Disparity Level
American Indian or Alaska Native	15.7	1.0	Reference Group
Asian or Pacific Islander	6.3	Not Enough Data	Not Enough Data
Black or African American	17.1	1.1	**Low/No**
Hispanic	26.0	1.7	**Moderate**
White	24.2	1.5	**Moderate**

Notes:

- Hispanics and Whites have the highest drug overdose death rates.
- American Indians and Black or African Americans have similar rates of drug overdose deaths.
- Men have a higher rate of drug overdose deaths as compared to women.
- New Mexico has a higher drug overdose death rate as compared to the United States.

Trend in Drug Overdose Deaths by Race/Ethnicity



Drug Overdose Death Rate per 100,000	Total	Female	Male
New Mexico (2011—2013)	23.9	19.1	28.7
United States (2011)	13.2	10.2	16.1

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