

The State of Health in New Mexico 2013

New Mexico Department of Health



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About this Report

Variety of Health Topics and Issues

The **State of Health in New Mexico 2013** report was designed to describe the health status of the New Mexico population on a variety of health measures. The *Table of Contents* lists the health issues and topics covered in this report. The report includes data from a variety of sources, including both primary data, collected by the New Mexico Department of Health, and secondary data from other sources, such as the U.S. Bureau of the Census. A *References* section includes a listing of data and information sources, chapter by chapter.

Social Determinants, State Demographics and Health Disparities

Three overarching chapters cover multiple topics. The, "*Preface: Health And Socioeconomic Status*," describes social determinants of health and the powerful linkage between socioeconomic status and health and wellbeing. "*Population Characteristics*," describes the demographic characteristics of the population. The "*Health Disparities*," chapter highlights disparities in health status and access to care particularly for New Mexico's minority and low-income populations.

Information in Each Chapter

Information on risk factors for illness and injury may be found within each chapter. Also found within each chapter, in the light-blue sidebar on the right side of each two-page spread, is a list of assets and evidence-based practices focused on health improvement with respect to the topic covered in the chapter.

A list of health status improvement resources and contact information has also been included in the "*Resources*" appendix. Additional data, including county rankings and data stratified by sex and race/ethnicity, may be found in the "*Indicator Maps and Tables*" appendix.

Resources in NM-IBIS

Extensive online data and information for community health assessment may be found on the New Mexico Indicator-based Information System for Public Health (NM-IBIS) website (<http://ibis.health.state.nm.us>). NM-IBIS provides data tables, graphs and maps for over 100 health

issues. Public health contextual information is also presented, including a description of why the issue is important and evidence-based practices for health improvement. One popular feature in NM-IBIS is presentation of 46 *Community Health Status Indicators* organized by county. This New Mexico report (akin to Wisconsin's County Health Rankings) may be found at <https://ibis.health.state.nm.us/community/highlight/Selection.html>. A companion report, the *Community Snapshot Report* (<https://ibis.health.state.nm.us/community/snapshot/Builder.html>), produces the same data in a one-page format, along with colorful icons indicating a county's performance relative to the state. One strength of these county reports is that they are dynamically produced, and automatically updated as soon as an NM-IBIS indicator report has been updated. For both county reports, the default set of indicators is the *Community Health Status Indicators*.

Community Health Status Indicators

The Community Health Status Indicators (CHSIs) were identified through a community process. A workgroup consisting of state and regional DOH staff and community members designed a survey that was emailed to 137 individuals in state government, University of New Mexico, tribal epidemiology centers, and community health councils. During 2014, nearly five years after the original survey, the DOH will carry out another community process to review and revise the list of CHSIs.

Links to Health Improvement Process

Two statewide and five regional *Turn the Curve on Health* events were conducted during the period 2011–2013. The input collected informs the content of our State of Health in New Mexico (state health assessment) and *A Healthier New Mexico*, the state's health improvement plan. An appendix to this report includes a list of state, community and local public health partners.

- Statewide **Turn the Curve on Health** meeting (December 2011)
- Regional **Turn the Curve on Health** listening and engagement events (Spring 2012)
- Statewide **Turn the Curve on Health** Albuquerque meeting (October 2013)

The Results-Based Accountability model integrates the concepts of assessment and health improvement planning and performance management. The process begins with the "end in mind" result, participants then engage in a discussion of the relevant data (e.g., state population and/or small area population data). Participants offer their knowledge and experience related to the story behind the data, which adds qualitative information for consideration as partners move toward an action plan. After identifying partners who have the ability to contribute resources, participants consider evidence-based and promising practice strategies toward improving health among the selected population. It is at this point that the group determines where they want to start taking action by selecting strategies to include in an action plan. The data selected to monitor performance toward the health improvement result is collected and added to the baseline. The intent is for the baseline to curve in the direction of improvement; therefore, the "Turn the Curve" terminology becomes meaningful. (For more information about RBA, go to: <http://www.raguide.org/index.shtml>)

State-Tribal Collaboration

Our work with tribal partners is facilitated by our DOH tribal liaison and tribal epidemiologist positions. In addition, New Mexico is the only state in the U.S. with a legislated State-Tribal Collaboration Act, which was designed to promote effective communication and collaboration, and positive government-to-government relations between state agencies and Indian nations, tribes and pueblos.

Looking Forward

Going forward, the New Mexico Department of Health will continue to rely on our web-based NM-IBIS system for dissemination of community assessment data in a meaningful context. NM-IBIS is continuously being upgraded through the work and contributions of DOH staff. A national IBIS-PH Community of Practice, consisting of 10 state and local health departments and two federal agencies, contributes to the maintenance and development of the IBIS-PH software. In the near future, the IBIS-PH software will allow New Mexico and other IBIS states to produce community reports that display dynamic, interactive maps, other dashboard-type data visualizations, and community trend data in addition to rankings.

Health and Socioeconomic Status in

Wealthy New Mexicans are more likely to report that they experience “Good” or “Better” health than those who are poor (Figure 1). This year’s New Mexico State of Health Report presents health status for New Mexicans within the context of the many influences on health, with a special focus on socioeconomic status (SES) and health. Issues of low SES and poverty affect individuals and families of all racial, ethnic and religious backgrounds in New Mexico.¹ Some of the many and complex factors that influence health include genetics, individual choices, as well as neighborhood, environmental and institutional factors. This report brings together information on health outcomes for New Mexicans, of all ages and backgrounds, with a broad view of the social and economic determinants of health that can influence wellbeing in our state.

More than half a million New Mexicans—over one-quarter of the state’s population—live in poverty, with Hispanics and American Indians more likely to suffer from the problems of low-income than non-Hispanic Whites. Over one-third of the state’s children live in low-income families that struggle to meet their most basic needs for food, shelter, transportation, healthcare, and other necessities.¹ Another way of measuring the burden of poverty is the Asset Poverty Rate. This measure

expands the notion of poverty to include how much of a financial cushion a household has to weather financial crises, including job loss, medical emergency, or the need to fix a car or to live for three months without expected income. By this measure, in 2011, 29% of New Mexicans were considered poor.²

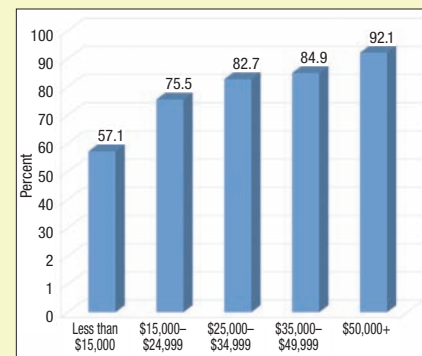
People’s health is significantly influenced by their homes, jobs and schools. Food security, education and employment are also ways to document SES differences. Participation in SNAP, the food stamp program, increased by 20,000 during fiscal year 2012 and 17% of New Mexicans reduced or disrupted their eating patterns because the household lacked money and other resources for food.³ Fifty-four percent of high-school seniors do not graduate from high-school and low-wage jobs comprise 33% of positions in the state, ranking New Mexico 48th for earning potential among other states.³ Almost half of all New Mexico residents (47%, 914,000 people) are eligible for state assistance with health insurance premiums (Medicaid, State Coverage Insurance) due to low incomes and lack of employer-based health plans, and 21% of the population does not have health insurance¹ (Figure 3).

The impact of low SES on health in New Mexico can be seen at many levels. At the individual level this can appear as variable access to care due to health insurance coverage and ability to pay, or by differing opportunity to engage in healthy behavior given economic, family and/or employment demands. At the neighborhood or community level, differential exposure to environmental public health concerns by geography or the built environment, including quality housing, parks and public transport, should be considered. And at the institutional level, the influence of health policy, including the Affordable Care Act, and it’s effect on health and healthcare accessibility, according to SES and poverty level, can be significant.

Health Disparities, SES and Health Information

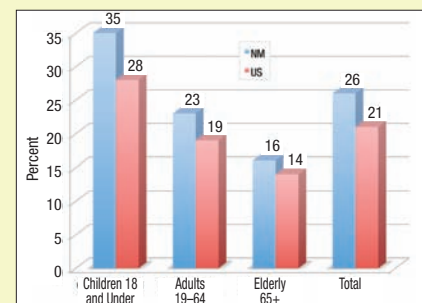
Poor health affects people of all racial and ethnic groups although there are some significant differences in disease or risk factor rates among groups, which can be described as health disparities. Health disparities can be defined as differences in the incidence, prevalence,

FIGURE 1. Respondents Who Reported “Good or Better Health” by Income, NM, 2011



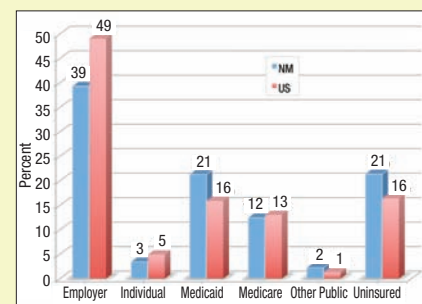
Source: Behavioral Risk Factor Surveillance System (BRFSS), NMDOH

FIGURE 2. Poverty by Age, NM and US, 2009–2010



Source: Kaiser Family Foundation

FIGURE 3. Distribution of Insurance Coverage by Provider, NM and US, 2011



Source: Current Population Survey, StateHealthFacts.org

Note: The grouping used for analysis is the health insurance unit (HIU), which groups individuals according to their insurance eligibility, rather than by relatedness or household



New Mexico

mortality, survival and burden of health conditions that exist between specific population groups. These population groups may be characterized by gender, age, ethnicity, education, income, social class, disability, geographic location, and sexual orientation.

One of the most important influences on health status and risk is socioeconomic status (SES). Socioeconomic status is the social standing of an individual or group in terms of their income, education and occupation. An individual's income, education and occupational status are often closely interrelated. Health status, access and outcome differences between groups of different means, and the resulting inequities, are complicated concepts which are infrequently captured within our regular public health data reporting systems.

Using SES measures is a way to identify groups with need of health care and social services. In New Mexico we have several data sources that can be used to identify health differences by SES including the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Resiliency Survey (YRRS), the New Mexico Hospital Discharge Dataset (NMHIDD), death certificate data and the US Census.

These data sources include information that can be used to characterize populations, risk factors and health outcomes by various SES measures, although the need for more consistent collection of health data in conjunction with SES measures is a continued challenge that the New Mexico Department of Health has taken on.

Why Consider SES and Health?

Both physical and mental health are associated with SES. In particular, studies suggest that lower SES is linked to poorer health outcomes overall. Poor health may in turn decrease an individual's capacity to work, thus reducing their ability to improve their SES. Other health issues related to SES include:

- Low SES is associated with increased morbidity and mortality.
- Within families, economic hardship can lead to familial distress and disrupted parenting that in turn may increase mental health problems among children, such as depression, substance abuse and behavior problems.

- Educational and employment opportunities may be hindered by health problems.
- Access to health insurance and preventive services are part of the reason for health disparities.
- Those with low SES often experience barriers in obtaining health services, including lack of or limited access to preventive health care, child care and transportation.

Examples of SES related health issues that affect New Mexicans shown in this report include:

- Twenty-five percent of mothers living below the federal poverty level did not receive prenatal care, despite the availability of Medicaid.
- Children with special healthcare needs that live in poor families are least likely to have a source of regular medical care.
- Prevalence rates of smoking, physical activity, chronic disease and access to medical care vary by income and education.
- Risk of death from an unintentional injury varies by average county income.
- Risk of some infectious diseases, including pertussis (whooping cough), has been associated with household and dwelling size.
- Poor counties experience increased hospitalization rates due to asthma.
- Depression is more likely in the unemployed and those with multiple chronic diseases.

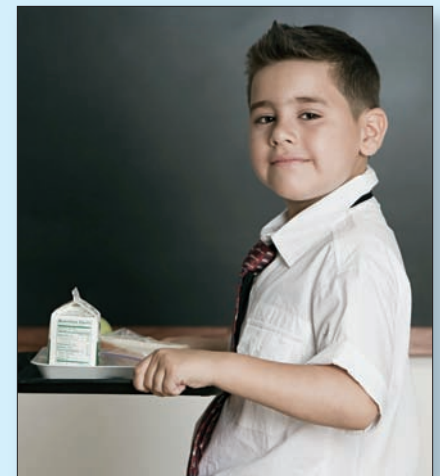
Throughout this report you will see the powerful linkage between socioeconomic status and health and wellbeing. For example, healthy activity varies by income in New Mexico and neighboring states. In our region, and in our state, poor people are less likely to engage in physical activity than those who have high incomes, and are more likely to subsequently suffer the effects of not exercising, including stress, weight gain and depression. Acknowledging the relationship between poverty, SES and health is important, and implementing policy strategies that address environmental, institutional and personal influences on SES and health are key to improving the health of New Mexicans.

What's Being Done

- ✓ New Mexico does not tax groceries.
- ✓ New Mexico has the Earned Income Tax Credit.
- ✓ Lottery scholarship for college attendees.
- ✓ New Mexico Workforce Solutions counseling, referral and job listings.
- ✓ Increased collection of socioeconomic status-related information in health surveys and datasets.

What Needs to be Done:

- Intervene in early childhood to support the health and educational development of low SES children.
- Increase resources for public education and access to higher education.
- Target interventions toward populations with the fewest resources.



New Mexico's People by the Numbers

Population Size

New Mexico is the fifth largest U.S. state in terms of land area, but in 2012, was only the 36th most populous state. New Mexico's population is not evenly distributed across the state geographically. In 2012, two-thirds of New Mexico's estimated 2,091,432 residents lived in the six most populous counties. Those six counties have an average population density of 80.3 persons per square mile, compared with 6.8 persons per square mile in the remaining 27 counties.

County	2012 Population
Bernalillo County	675,550
Dona Ana County	214,878
Santa Fe County	146,559
Sandoval County	135,950
San Juan County	128,805
Valencia County	77,361

For the five-year period from 2008–2012, New Mexico gained almost 80,000 residents (3.9% growth rate), with the highest rate of growth seen in the Metro Health Region (Bernalillo, Sandoval, Valencia and Torrance counties) (Figures 1 and 2).

Population by Age and Sex

In 2012, females outnumbered males by about 26,000 persons. Examination of 5-year age groups shows the most populous age group is the 15–19 year age group, followed by the 50–54 year age group. New Mexico's population age distribution is similar to that of the U.S. population, with a median age of 36.6 years in New Mexico, compared with 37.2 years in the United States.¹ (Figure 3)

Population by Race and Ethnicity

New Mexico's population distribution by race and ethnicity is strikingly different from that of the United States overall, with smaller proportions of persons who are Black and Asian, and larger proportions of persons who are American Indian and Hispanic.² White, non-Hispanic persons comprised a minority (41.4%) of the state's population in 2012.

New Mexico's American Indian population includes part of the Navajo Nation, 19 pueblos, and two Apache tribes (Jicarilla and Mescalero

Apache). Most of New Mexico's American Indian tribes have been located on their current lands since before Francisco Vásquez de Coronado arrived in 1541. Spanish settlers started arriving in 1598, and Santa Fe was settled by the Spanish in 1610 at about the same time the English, French, Dutch and Spanish were claiming colonies on the East and Gulf coasts of the U.S.

It was not until 1848 that the New Mexico territory was ceded to the United States, and in January of 1912, New Mexico became the 47th state of the Union. Many New Mexico Hispanic families trace their origins to Spanish colonists and still live on land that was granted to their ancestors by the king of Spain. (Figure 4)

Household Structure

New Mexico's household structure is similar to that of the U.S., with slightly fewer married couples with children and slightly more single males and females with children, and non-family households consisting of a single individual.³ New Mexico has a higher proportion of grandparents living in households with their own grandchildren, and a higher proportion of grandparents in that situation who are responsible for the care of those grandchildren (Figures 5 and 6).

Note: A family is defined as "a householder and one or more people living in the same household who are related to the householder by birth, marriage, or adoption."

Educational Attainment

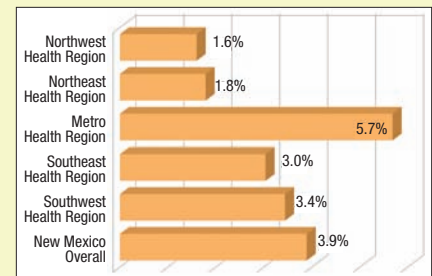
New Mexico is somewhat behind the U.S. in educational attainment, with a larger percentage of New Mexicans age 25 and older without a high school diploma and a smaller percentage with a bachelor's degree. (Figure 7)

Veteran Status

New Mexico has a higher proportion of the civilian population who have served in the military, with 11.4% having veteran status in New Mexico, compared with 9.1% in the U.S.

Note: "A 'civilian veteran' is a person 18 years old or over who has served (even for a short time), but is not now serving, on active duty in

FIGURE 1. 5-Year Population Change by Health Region, NM, 2008–2012



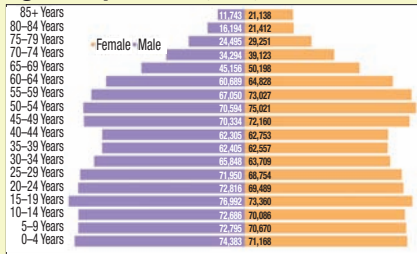
Source: University of New Mexico Geospatial and Population Studies (GPS) program, downloaded from <https://ibis.health.state.nm.us> on 12/30/2013

FIGURE 2. Percentage Population Change in Counties and Health Regions (HR) (Increase/Decrease), NM, 2008–2012

Health Region/ County	Year 2008	Year 2012	Percent Change
Northwest HR	225,972	229,584	1.6%
Northeast HR	290,365	295,552	1.8%
Metro HR	856,370	905,047	5.7%
Southeast HR	280,342	288,851	3.0%
Southwest HR	360,014	372,398	3.4%
Bernalillo County	641,740	675,550	5.3%
Catron County	3,709	3,745	1.0%
Chaves County	64,927	66,120	1.8%
Cibola County	26,928	27,353	1.6%
Colfax County	13,856	13,518	-2.4%
Curry County	47,744	49,596	3.9%
De Baca County	2,068	1,991	-3.7%
Dona Ana County	202,524	214,878	6.1%
Eddy County	53,477	54,815	2.5%
Grant County	29,849	29,389	-1.5%
Guadalupe County	4,692	4,664	-0.6%
Harding County	717	695	-3.1%
Hidalgo County	5,101	4,807	-5.8%
Lea County	63,025	66,322	5.2%
Lincoln County	20,310	20,578	1.3%
Los Alamos County	18,037	18,219	1.0%
Luna County	25,119	25,138	0.1%
McKinley County	72,212	73,426	1.7%
Mora County	4,947	4,822	-2.5%
Otero County	63,535	64,768	1.9%
Quay County	9,272	8,852	-4.5%
Rio Arriba County	40,482	40,257	-0.6%
Roosevelt County	19,519	20,577	5.4%
Sandoval County	123,471	135,950	10.1%
San Juan County	126,832	128,805	1.6%
San Miguel County	29,577	29,160	-1.4%
Santa Fe County	141,167	146,559	3.8%
Sierra County	12,251	11,908	-2.8%
Socorro County	17,927	17,764	-0.9%
Taos County	32,408	33,122	2.2%
Torrance County	16,508	16,187	-1.9%
Union County	4,482	4,535	1.2%
Valencia County	74,652	77,361	3.6%
NM Overall	2,013,064	2,091,432	3.9%

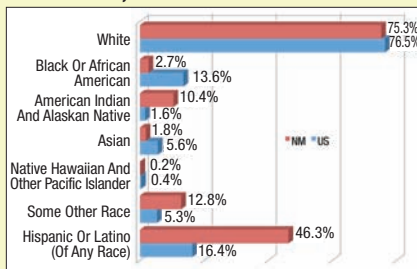
Source: University of New Mexico Geospatial and Population Studies (GPS) program, downloaded from <https://ibis.health.state.nm.us> on 12/30/2013

FIGURE 3. Estimated Population Size by Age Group and Sex, NM, 2012



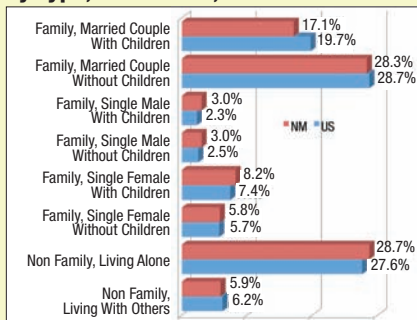
Source: University of New Mexico Geospatial and Population Studies (GPS) program, downloaded from <https://bis.health.state.nm.us> on 12/30/2013.

FIGURE 4. Race and Hispanic Ethnicity, NM and US, 2008–2012



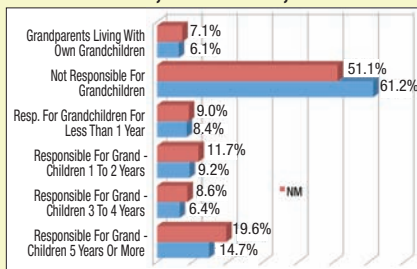
Source: U.S. Census Bureau, American Community Survey, DP05 5-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 1/6/2014.

FIGURE 5. Percentage of All Households by Type, NM and US, 2010–2012



Source: U.S. Census Bureau, American Community Survey, DP02 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 6. Grandparents Living in Households With Their Own Grandchildren, NM and US, 2010–2012



Source: U.S. Census Bureau, American Community Survey, DP02 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

the U.S. Army, Navy, Air Force, Marine Corps, or the Coast Guard, or who served in the U.S. Merchant Marine during World War II.”

Persons With a Disability

Among New Mexico’s civilian non-institutionalized population, 13.9% have a disability, compared with 12.1% in the United States. New Mexico saw higher rates of persons with disabilities in adults, but not among children age 0–17. (Figure 8)

Note: A disability is defined as “a long-lasting physical, mental, or emotional condition. This condition can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. This condition can also impede a person from being able to go outside the home alone or to work at a job or business.”

Place of Birth and Citizenship Status of Foreign-born Residents

Compared with the United States overall, New Mexicans are more likely to have been born in another U.S. state, and less likely to have been born outside the U.S. Among persons who were born outside the United States, those living in New Mexico are less likely to have received U.S. citizenship, compared with foreign-born persons in the U.S. overall. (Figure 9)

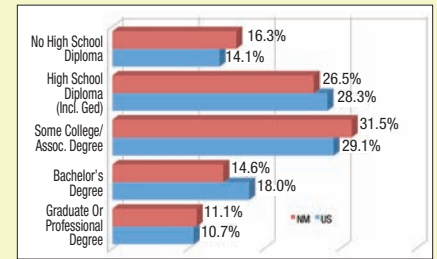
Mobility

New Mexicans are similar to other Americans in their tendency to move around. The proportion of New Mexicans age one and older who were living in the same house one year ago (85.4%) was similar to that of the U.S. (84.8%). Although, among those who did move, New Mexicans were more likely to have moved from a different state in the U.S. (Figure 10)

Language Spoken at Home and English Fluency

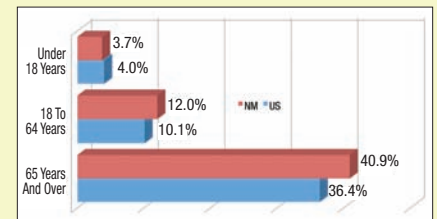
Compared with the United States, New Mexicans are more likely to speak a language other than English at home (36.3% vs.

FIGURE 7. Educational Attainment: Highest Level of Education Achieved, Age 25 and Over, NM and US, 2010–2012



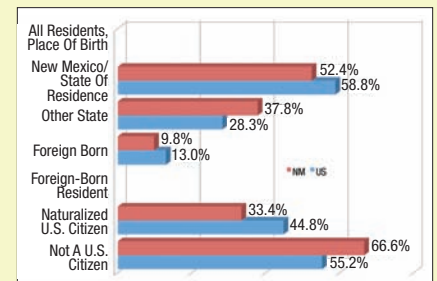
Source: U.S. Census Bureau, American Community Survey, DP02 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 8. Disability: Percentage of Civilian Non-Institutionalized Population With a Disability by Age Group, NM and US, 2010–2012



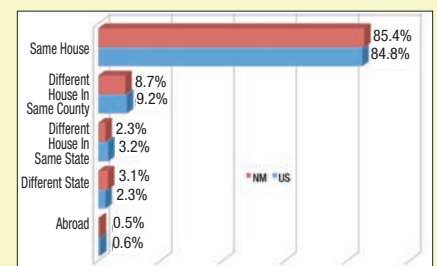
Source: U.S. Census Bureau, American Community Survey, DP02 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 9. Place of Birth and Citizenship Status of Foreign-born Residents, NM and US, 2010–2012



Source: U.S. Census Bureau, American Community Survey, DP02 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 10. Mobility: Percentage of Population Age 1 and Over by Where They Lived One Year Ago, NM and US, 2010–2012



Source: U.S. Census Bureau, American Community Survey, DP02 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

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20.8%). New Mexico also had more bilingual households. The proportion of persons who reported speaking some language other than English at home, and also speaking English well was 26.9% in New Mexico compared with 12.1% in the U.S. (Figure 11)

Employment

A higher proportion of New Mexicans age 16 and older were not in the labor force, compared with the U.S. overall. Among New Mexican civilians who were employed, higher proportions were employed in agriculture, construction, education and health care, and public administration, compared with the U.S. The proportion employed in manufacturing was higher in the U.S. (Figures 12 and 13).

Income and Poverty

Median household income was 19% higher in the U.S. (\$51,771) than in New Mexico (\$43,518). New Mexicans were also more likely to live in households with incomes below the U.S. poverty threshold (21.0% in New Mexico compared with 15.7% in the U.S.). The differences between New Mexico and the U.S. were greatest for children ages 0–17 years (Figures 14 and 15).

Health Insurance Coverage

New Mexicans were less likely to have either private or public health insurance coverage, and more likely to be uninsured (19.4%) compared to persons in the U.S. (15.1%). (Figure 16)

Housing and Home Ownership

There were an estimated 904,519 housing units in New Mexico from 2010–2012. 84.6% were estimated to have been occupied, for a total of 765,306 occupied housing units, or “households.”

About two-thirds of households in both New Mexico and the rest of the U.S. lived in single housing units. Among those who didn't, New Mexicans were more likely to live in mobile homes, whereas those in the U.S. were more likely to live in multi-unit apartment buildings.

About three-quarters of homes in New Mexico were heated by gas or electric provided by a public utility, compared with a little over half of homes in the U.S. Homes in the U.S. were

twice as likely to be heated by, “bottled, tank, or LP gas” (36.2% in the U.S. compared with 15.4% in New Mexico).

Although the overall prevalences were small, New Mexico homes were twice as likely to lack complete plumbing or kitchen facilities, and half as likely to have telephone service available.

New Mexicans were more likely to own their own homes (68.1% of housing units were owner-occupied) compared to families in the U.S. (64.7% owner-occupied). The median home value of owner-occupied homes in New Mexico was lower (\$159,300) than in the U.S. (\$174,600), as were monthly rents for renter-occupied housing units (\$744 in New Mexico, \$889 in U.S.). Monthly rent as a percentage of household income was slightly lower in New Mexico. Households where rent was equal to or greater than 35% of monthly income comprised 42.2% of New Mexican renter-occupied households, compared with 43.7% of in the U.S. (Figures 17–22).

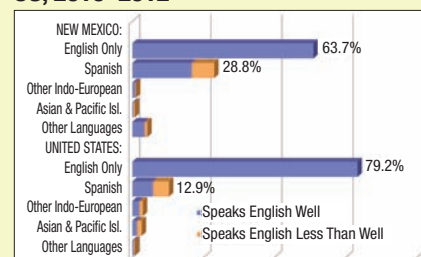
Conclusions

New Mexico is a diverse state, both geographically and by race and ethnicity. The state has relatively low education and income levels compared to the United States, overall, and a higher proportion of persons living in poverty, and a higher proportion lacking health insurance coverage. Education and income levels, poverty and health insurance coverage are all strongly related to population health status.

Here are some key findings from the comparison of New Mexico and U.S. demographic characteristics found in this section.

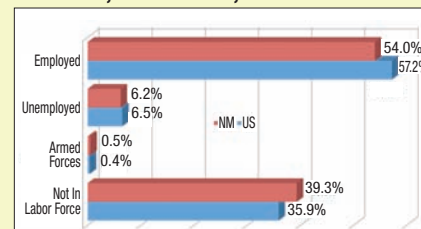
- New Mexico 2012 population densities range from 579.4 persons per square mile in Bernalillo County to fewer than 1 person per square mile in Catron, De Baca, and Harding counties.
- New Mexico's 2012 population distribution by age and sex was similar to that found in the U.S.
- New Mexico's racial and ethnic composition is unique among U.S. states, with many American Indian families currently living on lands that have belonged to the tribe since before European contact, and many Hispanic families tracing their origins to Spanish colonists who were granted their land by the

FIGURE 11. Language Spoken at Home and English Language Fluency, NM and US, 2010–2012



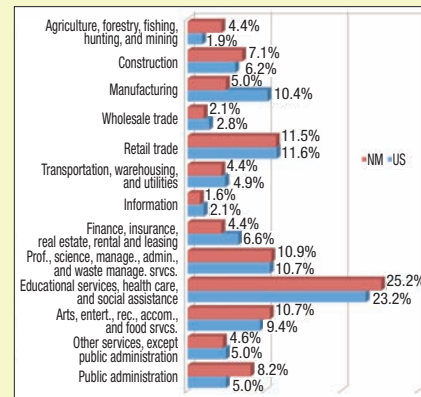
Source: U.S. Census Bureau, American Community Survey, DP02 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 12. Employment Status, Age 16 and Over, NM and US, 2010–2012



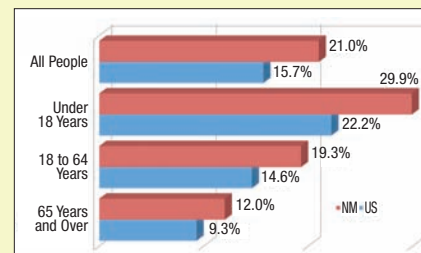
Source: U.S. Census Bureau, American Community Survey, DP03 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 13. Industry, Civilian Employed Population Age 16 and Over, NM and US, 2010–2012



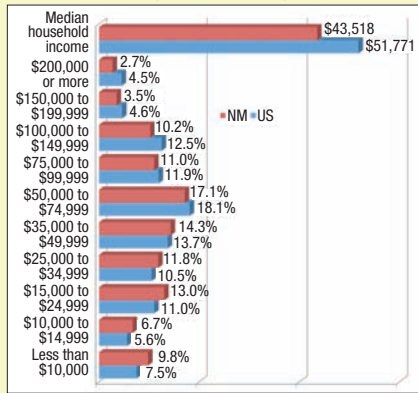
Source: U.S. Census Bureau, American Community Survey, DP03 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 14. Percentage of Persons in Poverty by Age Group, NM and US, 2010–2012



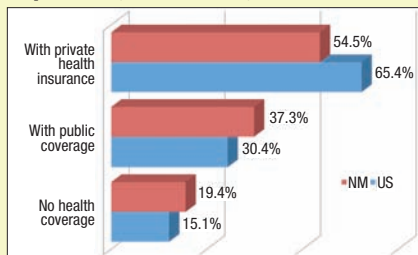
Source: U.S. Census Bureau, American Community Survey, DP03 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 15. Household Income, Population in Households, NM and US, 2010–2012



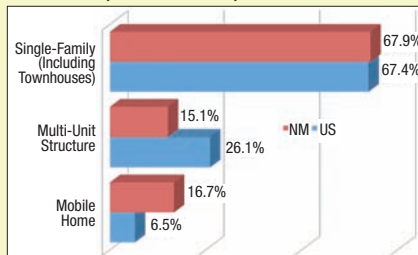
Source: U.S. Census Bureau, American Community Survey, DP03 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 16. Health Insurance Coverage, Civilian Non-institutionalized Population, NM and US, 2010–2012



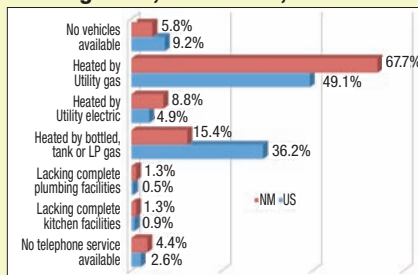
Source: U.S. Census Bureau, American Community Survey, DP03 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 17. Housing Type: All Housing Units by Number of Family Units per Structure, NM and US, 2010–2012



Source: U.S. Census Bureau, American Community Survey, DP04 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 18. Selected Features of Occupied Housing Units, NM and US, 2010–2012

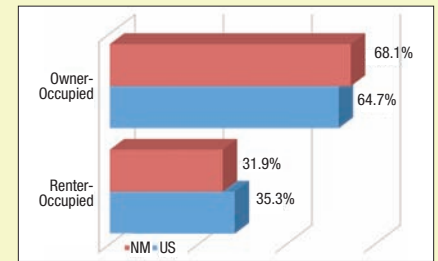


Source: U.S. Census Bureau, American Community Survey, DP04 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

king of Spain. White, non-Hispanic persons comprised a minority (41.4%) of the state's population in 2012.

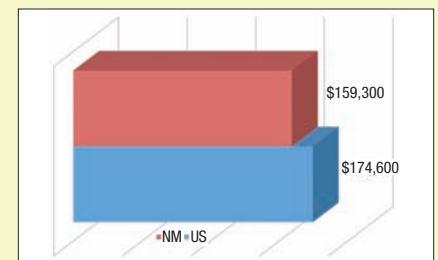
- Educational attainment during 2010–2012 in New Mexico was behind that of the U.S., with a higher proportion of New Mexicans lacking a high school diploma (16.3% in New Mexico versus 14.1% in the U.S.) and a lower proportion of New Mexicans with 4-year college degrees or higher (25.7% in New Mexico versus 28.7% in the U.S.).
- New Mexico had a higher proportion of bilingual households during 2010–2012. The proportion of persons who reported speaking some language other than English at home, and also speaking English "well" was 26.9% in New Mexico compared with 12.1% in the U.S.
- New Mexicans age 16 and older were more likely than their U.S. counterparts to be employed in agriculture and mining and public administration industries during the 2010–2012 time period, and less likely to be employed in manufacturing.
- The median income in New Mexico households in 2010–2012 was \$43,518, 84% of the U.S. median household income (\$51,771) during the same period.
- The percentage of persons in New Mexico 2010–2012 who were in households with incomes under the U.S. poverty threshold was 5.3 percentage points higher than the U.S. percentage (21.0% in New Mexico compared with 15.7% in the U.S., overall).
- New Mexicans were more likely to lack health insurance coverage: 19.4% of New Mexicans lacked coverage compared with 15.1% in the U.S.
- While New Mexicans were more likely to own their own homes (68.1% in New Mexico versus 64.7% nationally), the median value of those homes was lower (\$159,300 in New Mexico versus \$174,600 nationally). New Mexicans also had lower monthly rent bills (\$744) than in the U.S., overall (\$899).

FIGURE 19. Home Ownership: Occupied Housing Units by Owner- Versus Renter-Occupation, NM and US, 2010–2012



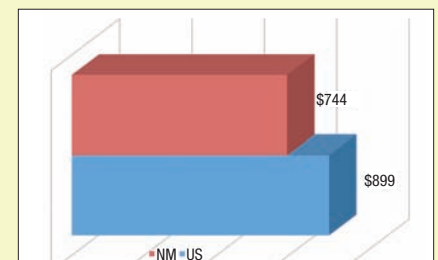
Source: U.S. Census Bureau, American Community Survey, DP04 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 20. Median Value of Owner-Occupied Housing Units, NM and US, 2010–2012



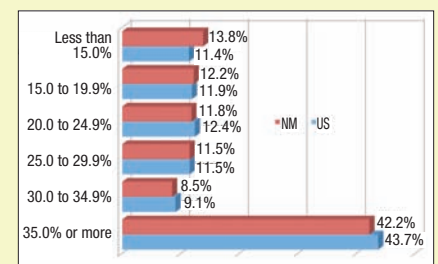
Source: U.S. Census Bureau, American Community Survey, DP04 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 21. Median Gross Rent, Renter-Occupied Housing Units, NM and US, 2010–2012



Source: U.S. Census Bureau, American Community Survey, DP04 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

FIGURE 22. Median Gross Rent as A Percentage of Income, Renter-Occupied Housing Units, NM and US, 2010–2012



Source: U.S. Census Bureau, American Community Survey, DP04 3-Year Summary File. Downloaded from <http://factfinder2.census.gov> on 12/30/2013

A Healthy Start Brings Newborns a

The mechanisms through which early life shapes an individual's health trajectory are just beginning to be understood. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, plays a role in determining health status throughout one's lifetime. By creating the conditions for babies and pregnant women to have adequate health care, nutrition, social support, and a safe environment free of exposure to infectious agents, toxic substances, injury hazards, and emotional and social distress, we are investing in the future health of the next generation of New Mexicans.

The majority of children born each year in New Mexico are born into young families with limited resources. In 2010, 47% of infants were born into poverty—their families earned less than 100% of the Federal Poverty Level (FPL) which was \$23,050 per year to support a family of four—and another 27% were born into low income families earning less than 235% of FPL. At this crucial developmental stage, these children are exposed to a confluence of coinciding neonatal risk factors that are more prevalent among those with lower incomes. New Mexico is also a rural state, with more than one-third of births to residents of rural and semi-rural areas, presenting challenges in service provision and transportation. Maternal and child health policy interventions provide a means to mitigate the harmful long-term health effects of being conceived and born into a low-resource environment.

Health Care

New Mexico has a relatively high proportion of unintended pregnancies. Overall nearly half (47%) of women with a live birth in 2010 said they wanted to be pregnant at a later time or never. Two-thirds (68%) of teen-aged mothers and over half (55%) of mothers 20–24 years old had unintended pregnancies, as did 51% of rural mothers. Access to effective family planning services allows individuals to achieve desired birth spacing and family size, and contributes to improved health outcomes for infants, children, and women. New Mexico has recently been successful at reducing the birth rate for adolescents 15–17 years of age among all racial/ethnic groups (Figure 1).

One-fifth (19%) of new mothers received inadequate prenatal care in 2010. This was



especially pronounced among American Indians (33%), teen-aged mothers (30%), mothers with incomes under 100% FPL (25%), and Medicaid recipients (20%).

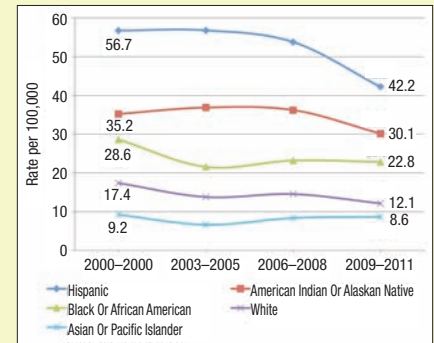
The New Mexico Newborn Screening Program is a universal program which currently screens all infants born in the state for 27 genetic and congenital conditions. Early diagnosis and treatment can result in normal growth and development and prevent permanent damage. Cases identified in 2011 include 216 hemoglobinopathies, 18 cases of congenital hypothyroidism, 5 cases of cystic fibrosis, and 17 cases of other disorders.

Nutrition

In New Mexico, 27% of mothers with a live birth in 2010 reported taking multivitamins or folic acid every day in the month prior to pregnancy. The Healthy People 2020 goal is 33%. Folic acid before pregnancy and in the first 12 weeks of pregnancy reduces the risk of neural tube birth defects.

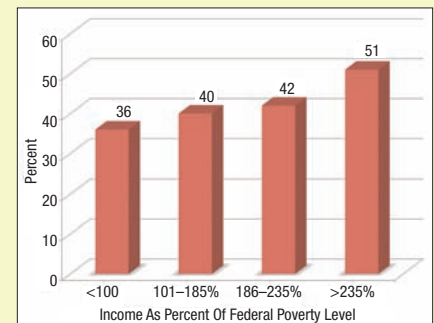
In 2010, 11% of mothers reported not having enough to eat at some point in the perinatal period when increased caloric and micronutrient intake is essential for healthy fetal development. Poor nutrition during pregnancy increases the risk of babies being underweight at birth, babies being delivered pre-term, stillbirth, as well as anemia and osteoporosis in the mother. One in five (20%) American Indian mothers reported not having enough to eat during or soon after pregnancy, as did 19% of those without a high school diploma, 18% of those with incomes below 100% FPL, and 14% of mothers living in

FIGURE 1. Adolescent Birth Rates by Race/Ethnicity, Ages 15–17, NM, 2000–2011



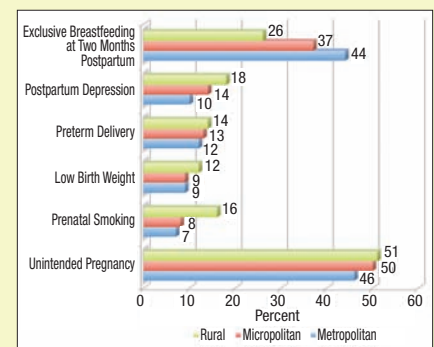
Source: NM Indicator Based Information System (IBIS), NM DOH.

FIGURE 2. Exclusively Breastfed at Two Months Postpartum by Family Income, NM, 2010



Source: NM PRAMS, NMDOH

FIGURE 3. Maternal Risk Factors by Urbanization of County of Residence, NM, 2010–2011



Sources: Unintended pregnancy, prenatal smoking, postpartum depression, exclusive breastfeeding: NM PRAMS; Low birth weight, preterm delivery: Vital Records and Health Statistics (VRHS), NMDOH

Lifetime of Good Health



semi-rural counties (counties with an urban area of 10,000–49,000 population).

The proportion of New Mexico mothers who breastfeed decreases as the level of family income decreases despite the fact that breastfeeding itself is essentially without cost. Sixteen percent of very low income mothers (<100% FPL) in 2010 never initiated breastfeeding after the birth of their child, and 12% of low income mothers (<185% FPL) never initiated breastfeeding, compared to 7% of mothers with incomes above 235% FPL. Similarly among mothers who do breastfeed, the length of time the baby is breastfed depends upon the level of family income. Exclusive breastfeeding is recommended for the first six months of the baby's life to reduce the risk of developing gastroenteritis, asthma, allergies, respiratory and ear infections, as well as obesity later in life. At two months postpartum, when the statewide New Mexico Pregnancy Risk Assessment Monitoring System (NMPRAMS) survey is administered, only 36% of very low income women were exclusively breastfeeding, compared to 51% of women with higher incomes (Figure 2).

Hazards

Sixty infants died in 2009–2011 from Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of infant death. One-third of these deaths were among children whose parents were not following the guidelines to place their infant on their back when put to sleep, one-half of deaths occurred in an adult bed, and 56% of the infants were sharing a bed with an adult or with other children at the time of death. According to the 2010 NMPRAMS survey, one-third of infants sleep in a bed with another person, over one-third of mothers usually place their baby to sleep with thick

blankets, bumper pads or toys, and one-fourth do not usually sleep in a crib. These sleep practices place the infant at risk of death from accidental strangulation or suffocation in bed and SIDS.

Substance Abuse

Maternal cigarette smoking during pregnancy causes a shortage of oxygen during fetal development and places the infant at risk of prematurity, low birth weight, congenital heart defects, stillbirth and SIDS. The Healthy People 2020 goal is to have 1.4% or fewer pregnant women smoking cigarettes. In New Mexico, 7.5% of women with a recent live birth reported smoking during pregnancy in 2010, with the highest prevalence among rural residents with one in six pregnant women smoking (Figure 3). A greater percentage of white non-Hispanic women smoked during pregnancy (9.5%) than Hispanic (7.2%) or American Indian women (5.2%). There is a gradient of smoking by income level: 10.5% of women at or under 100% FPL smoked during pregnancy, 6.5% of women at 101–185% FPL smoked, 4.8% of women at 186–235% FPL smoked, and 3.1% of women above 235% FPL smoked during pregnancy. The Healthy People 2020 goal for alcohol use during pregnancy is 1.7% or fewer. In 2010, 6.4% of women reported drinking alcohol in the last trimester of pregnancy, with the lowest percentages among teenagers (1.2%) and rural residents (3.0%), and the highest percentages among mothers 35 years of age and older (8.1%) and those with more than a high school education (8.1%).

Emotional and Social Environment

American Indian women reported the highest rates of physical abuse by a partner during pregnancy, with 10.8% reporting this experience in 2010, followed by teenage mothers with 7.9% reporting physical abuse. The lowest rates were found among women with higher income levels (0.5%). Eighteen percent of women living in rural counties report suffering from post-partum depression, compared to 14% of women in semi-rural counties (urban area of 10,000–49,999 population), and 10% of women in metropolitan counties (urban area of 50,000 population or greater)(Figure 3).

See Indicator Maps and Charts section, page 40, for additional data.

What's Being Done

- ☑ The Baby-Friendly Hospital Initiative is a global program to change hospital policies and maternity services to support breastfeeding. Twelve birth hospitals in New Mexico are currently working to meet the criteria necessary for the Baby-Friendly designation.
- ☑ The W.K. Kellogg Foundation has targeted four New Mexico counties for grant investments to improve birth outcomes, preconception health, and breastfeeding among the most vulnerable populations.
- ☑ Statewide DOH education series for case managers and home visitors on the Safe to Sleep campaign to reduce the risk for Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of infant death.

What Needs to be Done

- ☐ Improve reproductive health care and education among adolescents through school-based health centers.
- ☐ Expand newborn screening to include Severe Combined Immunodeficiency Syndrome (SCIDS) and lysosomal storage disorders.
- ☐ Improve accessibility to prenatal and birthing services in rural and smaller urban areas of the state.



Child Health Depends on Enhanced

In 2011 there were an estimated 395,907 children ages 1–14 in New Mexico—19% of the total population. The US Census Bureau reports that in 2010, 30% of New Mexico children lived in poverty, an increase of 4.7% from the previous year. Twenty-nine percent of children lived in a household that experienced food insecurity at some point during the year. Approximately 13% of New Mexico children do not have health care coverage.

Child Mortality

From 2009–2011, there were 254 deaths of New Mexico children ages 1–14, resulting in a rate of 21.2 deaths per 100,000 children. Boys had a higher death rate than girls (26.4 vs. 20.6). American Indian children died at nearly twice the rate of White children (32.7 vs. 16.7), and Hispanic children died at a rate of 20.6/100,000. During that same time period, mortality rates for children ages 1–14 were highest in Cibola, De Baca, Lincoln, Mora, Quay, San Juan and Sierra counties, and lowest in Bernalillo, Colfax, Los Alamos, Roosevelt, San Miguel, Santa Fe, and Taos counties.

The leading cause of death for New Mexico's youngest children (ages 1–4) was unintentional injury with a rate of 15/100,000 children. The second leading causes were assault and homicide, and congenital malformations at 3.4/100,000 children each. Specific causes of unintentional injury death were motor vehicle traffic crashes, drowning, and motor vehicle non-traffic injuries. For older children ages 5–14 the leading causes of death were unintentional injury

with a rate of 4.8/100,000, malignant neoplasm/cancer (1.4/100,000) and congenital malformations (1.3/100,000). The leading causes of unintentional injury deaths in this age group were motor vehicle traffic crashes (2.4/100,000), and suffocation (1.3/100,000).

Child Hospitalizations

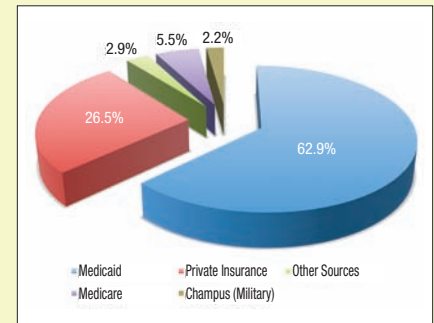
In 2011, there were 7,862 hospitalizations of children ages 1–14 for a rate of 198.6 hospitalizations per 10,000 children. For children ages 1–4, the rate was 298.7/10,000, and for those ages 5–14, the rate was 157.6/10,000. Medicaid paid for 4,948 of these hospitalizations, followed by 2,084 paid for by private insurance. The remaining were paid through other sources (Figure 1). In 2011, the majority of children in both age groups were hospitalized for respiratory problems at a rate of 60.8/10,000. The second and third major diagnoses for children ages 1–4 were injury and poisonings (22.4) and diseases of the digestive system (19.1). For children ages 5–14, mental disorders resulted in a hospitalization rate of 33.5, followed by digestive system diseases at 23.9.

Children with Special Health Care Needs

In 2010, there were approximately 71,000 children with special health care needs (CSHCN) in New Mexico. The highest proportion of CSHCN were Black/African-American (17.7%) followed by White (16.4%) and finally, Hispanic (15.1%). Most CSHCN reported 2–3 conditions (33.3%) followed by those with one condition

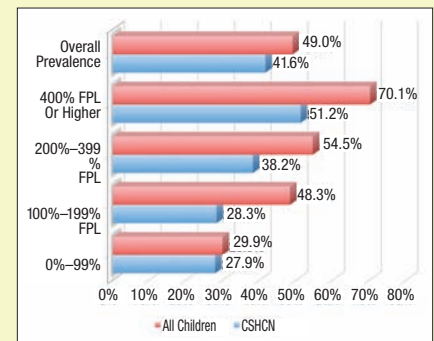


FIGURE 1. Child Hospitalizations by Payer of Care, NM, 2011



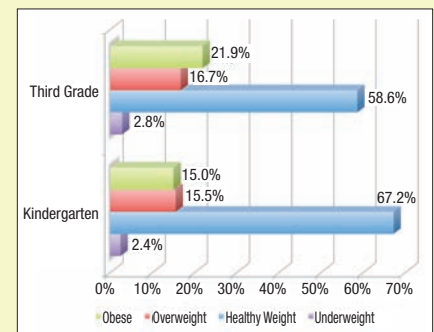
Sources: NM HIDD, NMDOH

FIGURE 2. Percent of Children with a Medical Home by Federal Poverty Level, NM, 2010



Source: National Survey of Children with Special Healthcare Needs

FIGURE 3. Percent of Students in Weight Categories by Grade, NM, 2011



Source: BMI Surveillance, NMDOH

Service Coordination



(25.8%) and those with four or more conditions (15.5%). Allergies, asthma, attention deficit/hyperactivity disorder, and developmental delays were the four most commonly reported conditions. Twenty-seven percent of parents surveyed reported that their special needs child's daily activities were "consistently affected, often a great deal," by his or her condition. A little over 70% reported that their child's condition caused difficulty with breathing, swallowing, circulation, pain, vision and/or hearing.

The Medical Home Model, first created by the American Academy of Pediatrics (AAP) in 1967, has been shown to be an excellent way of providing care for all children and especially for children with special health care needs (CSHCN). The Medical Home is not a physical location, but a model of care that is coordinated, accessible, compassionate, culturally sensitive, family centered and comprehensive. Having a usual source of care and receiving family-centered care are two essential components of a Medical Home. On the 2010 National Survey of CSHCN, 10.4% of CSHCN in New Mexico were reported to be without a usual source of care, compared to 9.5% nationally, and 9.7% of CSHCN in New Mexico have no personal doctor, compared to 6.9% nationally. New Mexico also has a higher proportion of CSHCN without family-centered care (40.0%), compared to the national 35.4%. The percentage of children in New Mexico with a Medical Home decreases with lower family income levels (Figure 2). This demonstrates a

need for more medical practices in New Mexico to become true Medical Homes.

Overweight and Obesity Threaten New Mexico's Children

In 2010, 13.2% of kindergarten students and 22.6% of third grade students in New Mexico were obese. In comparison, 18% of 6–11 year olds nationwide were obese. The average weight for kindergarten students in the obese category was 61.6 pounds, or about 20 pounds heavier than for those in the healthy weight category. The average weight for third grade students in the obese category was 98.9 pounds with some children weighing between 150 and 200 pounds. Two thirds of kindergarten students (67.2%) and nearly three-fifths of third grade students (58.6%) in New Mexico in 2011 were in the healthy weight category (Figure 3).

Obesity in children has serious consequences. The increase in childhood obesity has resulted in a dramatic increase in youth onset diabetes. Sixty percent of overweight children ages 5 to 10 years have at least one metabolic risk factor for heart disease and stroke, including elevated total cholesterol, triglycerides, insulin and high blood pressure. Obesity also leads to increases in non-alcoholic fatty liver disease in children that can lead to liver scarring and cirrhosis.

See Indicator Maps and Charts section, page 41, for additional data.

What's Being Done

- ☑ Families with newborns receive home visiting services that include injury prevention education.
- ☑ Medicaid redesign is emphasizing Medical Homes and care coordination.
- ☑ Many schools are implementing walking and rolling to school days, creating edible gardens or conducting fruit and vegetable tastings.

What Needs to be Done

- ☐ Increase the number of families with newborns and young children receiving effective home visiting services.
- ☐ Integrate existing care coordination programs with medical providers.
- ☐ Understand the knowledge, attitudes and perceptions surrounding healthful eating and physical activity among New Mexicans.
- ☐ Ensure that all New Mexicans have access to affordable healthy foods.



Healthy Behaviors Vital to Fostering

The future success and health of New Mexico youth is largely determined by the behaviors they engage in as young people. In 2011, the three leading causes of death among New Mexicans ages 15–19 were unintentional injury (predominantly motor vehicle crashes), suicide, and homicide.¹ These causes of death are associated with alcohol and drug use, suicidal ideation and attempts, physical violence, and other behaviors. The chronic diseases that are among the leading causes of death for New Mexicans are associated with risk behaviors often initiated during adolescence, such as tobacco use, alcohol use, inadequate physical activity and poor dietary practices. Unsafe sexual behaviors put young people at risk of unplanned pregnancy and sexually transmitted infections including HIV/AIDS. The 2011 New Mexico Youth Risk and Resiliency Survey (YRRS) examined all of these behaviors among high school and middle school students.

Fewer Suicide Attempts

Past suicide attempts are a leading risk factor for future suicides. Suicide attempts among high school students have decreased over the past several years from a high rate of 14.5% in 2003 to 8.6% in 2011. In 2011, 7.0% of middle school students reported ever trying to kill themselves.

Suicide attempts are far more likely among girls than boys. This is true in both middle school (9.7% vs. 4.4%) and high school (12.3% vs. 5.0%) (Figure 1). Among high school students, American Indian (10.5%) and Asian or Pacific Islander students (13.5%) had higher rates than Hispanic (8.6%) or White (6.4%) students. These disparities were not apparent among middle school students.

Suicide attempts varied with parent education, an indicator of socioeconomic status. Suicide attempts were reported by 12.3% of high school students whose parents did not graduate from high school, 7.3% of those whose parents graduated from high school but not college, and 6.6% of those whose parents completed college or professional school.

Alcohol, Tobacco, and Other Drug Use

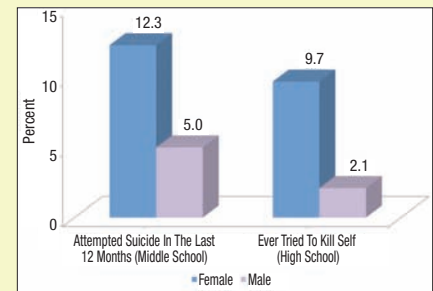
Alcohol use at an early age is associated with adverse outcomes later in life, such as alcohol dependence and abuse and chronic liver disease.² Alcohol use is also highly associated with traffic-related fatalities and other injuries. Most alcohol related behaviors have decreased in prevalence in recent years among New Mexico high school students. Current drinking (at least one drink in the past 30 days) decreased from 50.7% in 2003 to 36.9% in 2011; binge drinking decreased from 35.4% to 22.4%, and drinking and driving (19.1% to 9.3%). Among middle school students, 12.9% were current drinkers and 6.3% were binge drinkers.

High school students whose parents didn't finish high school had higher rates than those parents with a college or professional school education for drinking and driving (33.0% vs. 15.5%) and binge drinking (28.8% vs. 17.9%).

Illicit drug use among adolescents is associated with heavy alcohol and tobacco use, violence, and suicide.³ Among participating states in the national 2011 Youth Risk Behavior Survey, New Mexico high school students had the highest rates for marijuana use before age 13, current and lifetime cocaine use, current Ecstasy use, and the second highest rate for lifetime heroin use. There have been no significant changes in drug use since 2007.

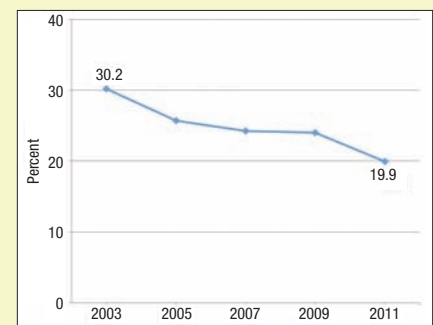
In descending order, drugs with the highest current use rates among high school students were marijuana (27.6%), painkillers to get high (11.3%), inhalants (6.7%), Ecstasy

FIGURE 1. Suicide Attempts by Gender, Grades 6–12, NM, 2011



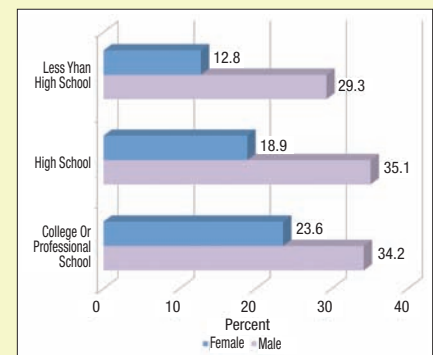
Sources: NM Youth Risk and Resiliency Survey (YRRS), NMDOH and PED

FIGURE 2. Current Cigarette Smoking by Year, Grades 9–12, NM, 2003–2011



Source: NM YRRS

FIGURE 3. Daily Physical Activity by Gender and Parent Education, Grades 9–12, NM, 2011



Source: NM YRRS

Healthy Youth

(6.4%), methamphetamine (3.9%), and heroin (3.2%). Among middle school students, lifetime use rates were 15.9% for marijuana, 11.8% for inhalants, 8.0% for prescription drug use without a doctor's prescription, 4.9% for painkillers to get high, and 3.6% for cocaine. In the case of every drug, students whose parents had a college or professional school education had a lower prevalence of use than students whose parents had less than a high school education.

Cigarette smoking increases the risk of several chronic diseases, such as heart disease, chronic obstructive pulmonary disease, acute respiratory illness, stroke, and various cancers.⁴ Spit tobacco (chewing tobacco, snuff, or dip), is associated with oral cancer and other oral conditions, heart disease, and stroke. The rate of current cigarette smoking among high school students decreased dramatically from 2003 (30.2%) to 2011 (19.9%) (Figure 2). 9.5% of high school students were current spit tobacco users (chewing tobacco, snuff, or dip), with no trend in recent years. Among middle school students, 6.8% were current cigarette smokers and 3.7% were current spit tobacco users. Among middle school students there were no differences between boys and girls for any tobacco use. Among high school students, boys were more likely than girls to be current cigarette smokers (23.2% vs. 16.5%) and spit tobacco users (14.8% vs. 3.9%). High school students whose parents had more education were less likely to smoke cigarettes or cigars than those whose parents had less education.

Physical Activity

Regular physical activity can reduce body fat, maintain body weight, and reduce the risk of chronic diseases.⁶ Obesity among adolescents is associated with a lack of physical activity and is a contributing factor for type 2 diabetes, hypertension, and adult obesity. At least 60 minutes of daily physical activity is recommended for children aged 6–17 years. In 2011, 26.3% of high school students and 31.2% of middle school students achieved this level of physical activity. In middle school, boys were 42% more likely than girls to attain recommended levels of physical activity (37.1% vs. 26.0%), while among high school students they were 83% more likely (33.8% vs. 18.5%). Higher levels of parent education were associated with a higher prevalence of daily physical activity among girls but not among boys.

At every level of parent education, boys were more likely than girls to exercise daily (Figure 3).

Sexual Behaviors

Adolescents who initiate sexual intercourse at an early age are less likely to use contraception, are at higher risk for unplanned pregnancy, and are likely to have a greater number of lifetime sexual partners than those who wait until later to engage in sex.⁷ In 2011, 47.8% of high school students and 10.4% of middle school students ever had sexual intercourse. Among those who ever had sex, middle school students had higher rates of condom use than high school students (69.1% vs. 54.4%). Among sexually active students in high school, condom use decreased with grade level (as students got older), while the prevalence of using reliable birth control methods (birth control pills, IUDs, or injectable birth control) increased. Among high school students, those whose parents had higher levels of education were less likely to engage in risky sexual practices such as having multiple sexual partners and initiation of sexual intercourse at an early age.

Although serious concerns remain, New Mexico has seen encouraging trends in health risk behaviors among youth in recent years. Rates for behaviors associated with mental health, alcohol use, tobacco use, and violence have decreased. Despite these improvements, rates for many of these same behaviors remain disturbingly high. Drug use rates were extremely high relative to the rest of the U.S. Disparities persist by gender, race/ethnicity, and parent education. Girls were less likely than boys to engage in daily physical activity, more likely to attempt suicide, and more likely to be victimized by sexual violence. Boys had higher rates than girls for tobacco use and physical fighting. American Indians and Asian or Pacific Islanders had relatively high rates for attempted suicide. For nearly every risk behavior discussed here, rates were higher among students whose parents had less education.

What's Being Done

- Trends in youth health statistics are being monitored with the NM Youth Risk and Resiliency Survey.
- Alcohol and drug prevention programs at the local level emphasize opioid use/misuse prevention.
- Seventy-nine school based health centers offer services and information throughout the state related to primary care, reproductive health, mental health, oral health and substance use.
- Comprehensive suicide prevention programs addressing depression, substance abuse and means restriction.
- Peer-to-peer mentoring that stresses positive youth development and engagement.

What Needs to be Done

- Increase positive youth development and leadership programs, with meaningful engagement of youth to develop, implement, and evaluate them.
- Increase and improve services available at school based health centers, including primary care and confidential health services, in areas such as reproductive and behavioral health.
- Increase healthy nutrition and physical activity interventions targeting middle school aged youth.



Aging Well Through Healthy Lifestyle,

With aging comes a higher risk for health problems, including chronic disease, disability and death. To stay disease- and disability-free as long as possible, we need to rely on healthy lifestyles along with early detection and management of chronic disease.

Hospitalization

Older adults use more health care than their younger counterparts. The top reasons for inpatient hospitalization in the 65-year-and-older age group are heart disease, influenza and pneumonia, and injury from falls.

Deaths

The leading causes of death among New Mexicans age 65 years or older (older persons) are heart disease, cancer, chronic lower respiratory diseases (COPD), stroke, diabetes, and unintentional injuries (Figure 1). Among unintentional injury deaths in older persons, the most common cause was falls with 66% of all unintentional injury deaths.

From 2009–2011, risk of death from various causes among older persons varied significantly by race/ethnicity. Heart disease death rates were highest among Whites and lowest for Asian and Pacific Islanders. The risk of death from cancer was highest among White, Black and Hispanic persons, and lower in American Indian and Asian/Pacific Islander groups. Risk of death from

COPD was highest among Whites, and risk of death from diabetes was highest in the American Indian population.

More than half of all heart attacks occur in people age 65 years or older. Modifiable risk factors include high blood pressure, high cholesterol, cigarette smoking, and physical inactivity. Heart disease deaths have been decreasing in New Mexico and elsewhere. While changes in lifestyle have played a role in reducing heart disease deaths, medical treatment, especially increased use of thrombolytic medications, has probably been a bigger factor.

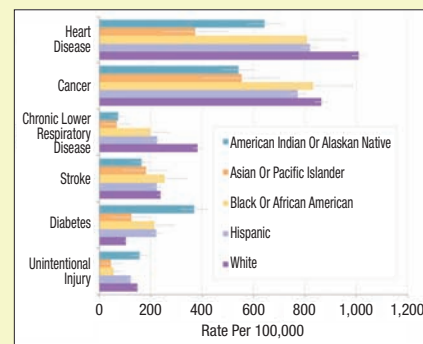
A stroke occurs when an artery in the brain is either ruptured or clogged. Nerve cells in the affected area of the brain die within minutes, potentially resulting disability or impairment. The risk factors for stroke are similar to those for coronary heart disease, including high blood pressure, cigarette smoking, and diabetes. Timely therapy with thrombolytic drugs is important for strokes caused by artery blockage.

Older adults who were hospitalized for injuries from falls were least likely to have a routine discharge, and had the highest likelihood of being transferred to another inpatient facility, such as a skilled nursing facility or an inpatient rehab facility (Figure 2). A decrease in bone density increases the likelihood of serious injury from falls. Bone density can be increased through weight-bearing exercise. In a study of risk factors for falls among elderly persons, sedative use was identified as a predisposing factor. Environmental hazards may also be a factor. Death from fall injuries increased markedly from 2000 to 2008, but in recent years has begun to decline.

Cancer was the second-leading cause of death from 2009–2011 for older New Mexicans. Preventing cancer is best accomplished by quitting smoking, improving one's diet, and limiting exposure to the sun. Early detection of cancer, with colonoscopy, mammography and Pap smear tests, is an important step in reducing death and disability from the disease.

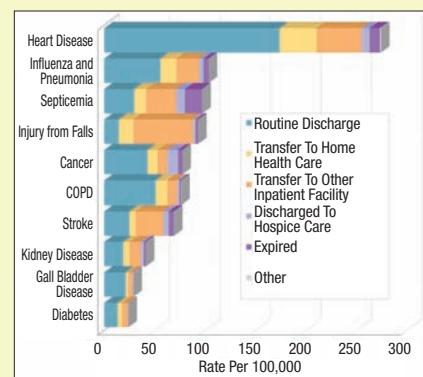
The risk of diabetes increases with age, and older adults are also more likely to suffer from complications of the disease. Diabetes can lead to heart disease, blindness, kidney failure, high blood pressure, nerve damage, and lower

FIGURE 1. Leading Causes of Death by Race/Ethnicity, Age 65+, NM, 2009–2011



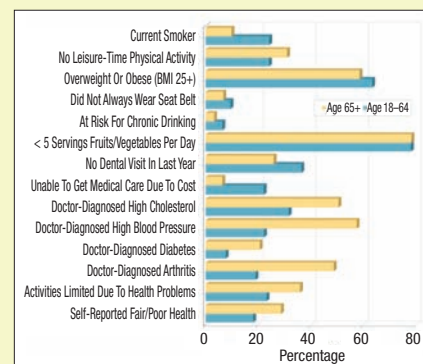
Source: Death Certificate Database, Vital Records and Health Statistics, NMDOH

FIGURE 2. Leading Reasons for Hospitalization by Discharge Status, Age 65+, NM, 2011



Source: NM HIDD, NMDOH

FIGURE 3. Health Risk from Selected Factors, Age 65+ and Age 18–64, NM, 2011



Source: New Mexico Behavioral Risk Factor Surveillance System, NMDOH



Early Disease Detection



extremity amputations. Diabetes incidence has increased in New Mexico, as in the rest of the US, primarily because of increases in type 2 diabetes, which increases with obesity and age. 20.5% of New Mexicans over 65 reported that they had been diagnosed with diabetes.

Influenza is highly contagious, as are most kinds of pneumonia. Older adults are more susceptible to complications if they become ill. The national goals for seasonal influenza and pneumococcal vaccination among adults age 65+ are each 90%. In New Mexico in 2011, 58.8% reported having an influenza vaccination in the last year and 69.2% reported ever having had a pneumococcal vaccination.

Risk Factors for Illness and Disease

Older adults are more likely to have chronic diseases, such as arthritis and diabetes, as well as certain risk factors, including high blood pressure and high cholesterol (Figure 3). But older adults also reported lower participation in leisure-time physical activity, and a high prevalence of obesity.

Cigarette smoking is a major risk factor for the leading causes of death and illness, including heart disease, stroke, cancer and chronic obstructive pulmonary disease. Older New Mexico adults were less likely to be current smokers than younger adults.

A 1996 Surgeon General's report suggested that the amount of physical activity required to

achieve health benefits was a daily expenditure of 150 calories from moderate or vigorous activities. Physical inactivity is associated with heart disease, diabetes, high blood pressure, and colon cancer. Regular activity also builds and maintains healthy bones, muscles and joints. Older New Mexico adults were more likely to be inactive than their younger counterparts: 30.9% of older adults were inactive.

A healthy diet, one that contains less fat and more fresh fruits and vegetables, is associated with a reduction in obesity, heart disease, diabetes, and some cancers. Older New Mexicans (30.9%) were more likely than younger adults (24.1%) to eat five fruits and vegetables a day.

Lower income and education levels put older adults at higher risk for a number of health problems. Older adults with annual incomes under \$15,000 were more likely to have diabetes and be physically inactive. They were three times more likely to smoke cigarettes, twice as likely to be physically inactive, and four times as likely to report that their health is "fair" or "poor" compared to those with incomes over \$50,000. Those with less than a high school education were more likely to have diabetes and more likely to be overweight or obese. They were more than twice as likely to smoke cigarettes, more than twice as likely to be physically inactive, and more than three times as likely to report that their health was "fair" or "poor" compared to those who were college graduates.

What's Being Done

- ✓ Offering evidence-based programs such as the Tai Chi: Moving for Better Balance program, the Enhance Fitness program, the Chronic Disease Self Management program, the Strong Women (and men) Strong Bones program.
- ✓ Increasing awareness about fall risks and fall prevention at health fairs and other venues where older adults participate.
- ✓ Influenza and pneumonia surveillance and vaccination programs.

What Needs to be Done

- Improved clinical management of high blood pressure, high cholesterol, diabetes, arthritis, and other chronic diseases.
- Coordination of care between multiple health care providers.
- Create a comprehensive coordinated approach to using evidence-based healthy aging programs and services statewide.
- Identify mechanisms for reimbursement for fall screening and prevention activities.



Some New Mexicans at Greater Risk

Remarkable progress has been made toward the control of infectious diseases since the beginning of the 20th century, primarily due to effective vaccines, behavioral prevention strategies and improved medical care. But many infectious diseases, both old and emerging, continue to evade efforts at control and elimination. The epidemiology of the following infectious diseases in New Mexico demonstrates that some groups continue to be affected disproportionately. Distinct racial and ethnic disparities continue to exist for these infectious diseases in New Mexico, and the reasons behind these disparities are not always clear.

HIV/AIDS Affects Men Who Have Sex with Men

When Acquired Immunodeficiency Syndrome (AIDS) was first reported in the United States, gay, bisexual, and other men who have sex with men (MSM) played a key role in the Human Immunodeficiency Virus (HIV) epidemic. When screening tests for HIV antibodies were first made available, MSM accounted for 65% of new diagnoses. Now rates of new diagnoses have declined dramatically, but MSM still account for over 60% of new diagnoses.^{1,2}

From 2007–2011, 64% of new HIV diagnoses among men in New Mexico were attributable to MSM (Figure 1). MSM with a history of injection drug use (MSM/IDU) comprised an additional 6% of new diagnoses, making MSM and MSM/IDU the groups at highest risk for HIV infection among men. Young MSM are at especially high risk for HIV infection. Among New Mexicans under 35 years of age, MSM and MSM/IDU accounted for 65% of new diagnoses from 2007 through 2011, as compared to 54% among persons age 35 and older.

American Indian, Black, and Hispanic New Mexicans are also disproportionately affected by HIV. In New Mexico, those groups account for just over half the total population, yet from 2007 through 2011, they accounted for 70% of new HIV diagnoses. Among MSM and MSM/IDU, American Indian, Black, and Hispanic New Mexicans comprised 67% of all new HIV diagnoses.

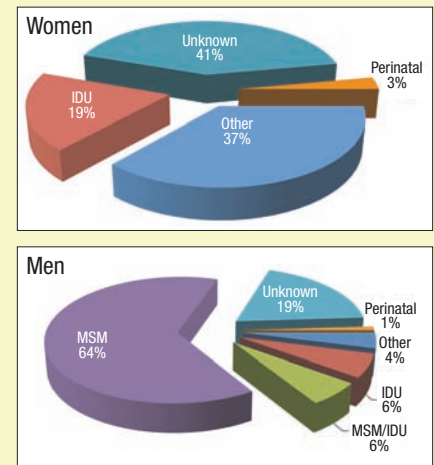
Pertussis (Whooping Cough) in the Hispanic Community

New Mexico is in the midst of a statewide pertussis outbreak. In 2011, 277 pertussis infections were reported to the New Mexico Department of Health, which represented more cases in a single year than in any year going back to the 1980s. In 2012, over 874 pertussis infections were reported. The Centers for Disease Control and Prevention (CDC) predict that the United States will experience more whooping cough in 2012 than in any year since 1959.³

The reasons for the dramatic rise in pertussis in New Mexico and nationally are not completely understood. Evidence suggests that a change in childhood pertussis vaccine formulation that occurred in the 1990s may be partially responsible for recent events.⁴ Improvements in pertussis testing and diagnosis may have contributed to an increase in diagnoses. Also, the number of school-aged children receiving vaccination exemptions has increased in the last 15 years, a trend that has been associated with increased risk of contracting pertussis.⁵

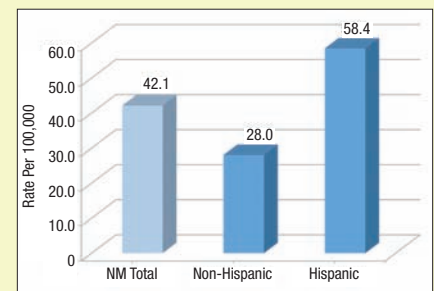
A key feature of the outbreak in New Mexico is the distribution of cases by ethnicity. Approximately 42% of the New Mexico

FIGURE 1. Diagnosis of HIV Infection Among Adults and Adolescents by Gender and Transmission Category, NM, 2007–2011



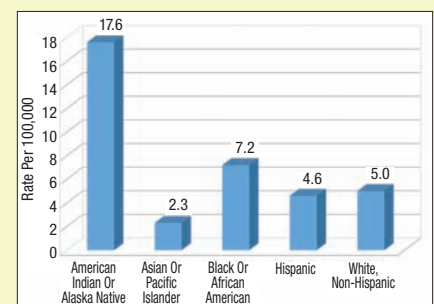
Source: Enhanced HIV/AIDS Reporting System, NMDOH

FIGURE 2. Pertussis Rates by Ethnicity, NM, 2012



Source: NEMEDSS, NMDOH

FIGURE 3. Invasive Pneumococcal Disease Rates by Race/Ethnicity, NM, 2006–2011



Source: Emergency Infection Program, NMDOH



of Infectious Disease

population is Hispanic (U.S. Census). During 2012, approximately 60% of New Mexico pertussis cases have occurred among Hispanics. Overall, the rate of pertussis among Hispanics is twice the rate among non-Hispanic New Mexicans (Figure 2).

Evidence from investigations in New Mexico suggests that household size plays an important role in pertussis transmission. For 2012, the mean household size among pertussis cases is 4.5 persons, compared to a statewide mean of 2.6 persons per household. Pertussis cases of all races and ethnicities in New Mexico tend to have larger household sizes than average, so household size alone does not explain the ethnic disparity that exists. Within the 6 counties with the highest pertussis rates, the average household size of pertussis cases who are Hispanic exceeds the average county household size and the average household size of Hispanics in the county.

What exactly is driving the higher household size of Hispanic cases is not known, but may be influenced by income or other factors, such as the size of extended family groups. Notably, Hispanic pertussis cases tend to have more identified contacts requiring antibiotic prophylaxis than cases of other races and ethnicities. The median number of contacts per case for 2012 is 2, but 69% of Hispanic cases had 4 or more identified contacts requiring antibiotic prophylaxis. Additional investigation is being conducted to explain why Hispanics appear to be at greater risk of pertussis infection in New Mexico.

Invasive Pneumococcal Disease

Invasive pneumococcal disease (IPD) is caused by the bacterium *Streptococcus pneumoniae*. The infection is considered invasive when the bacteria invade a normally sterile body site, such as blood or cerebrospinal fluid. IPD is a vaccine-preventable disease. The national estimate of IPD between 2006 and 2009 was approximately 14.1 cases per 100,000 U.S. population per year. According to 2006–2009 estimates from the Centers for Disease Control and Prevention (CDC), 11.1% of IPD infected persons died.

Certain groups are at higher risk of IPD infection. This includes the elderly, children under two years of age, immune compromised persons, and certain racial and ethnic groups.⁶ The American Indian population has historically experienced



higher rates of IPD compared with the non-Indian population in the U.S. and in New Mexico.⁶ From 2006–2011, the rate of IPD in New Mexico was highest in the American Indian population.

From 2006–2010, the number of cases and percentage of deaths was highest among those aged 65 years and older. New Mexico IPD rates were higher among infants (42/100,000) than the national estimate of 37 infections/100,000 people. With the introduction of a new vaccine for children that targets 13 types of the pneumococcal bacteria (PCV13, available since February 2010), overall IPD rates may decrease.^{7,8} This might result in an overall decrease in the burden of IPD resulting from increased immunity in the population; however, other types of pneumococcal bacteria not included in the vaccine may emerge to replace the types found in the vaccine.^{7,9}

Further investigation regarding factors contributing to IPD infection among New Mexicans is ongoing. New Mexico is participating in a vaccine efficacy evaluation with a number of other states. As the PCV13 vaccine becomes more widely used, it is important to continue to monitor the annual burden of IPD and detect infections caused by pneumococcal bacteria that are not in the vaccine. This information is useful to determine if new vaccines are needed.

See Indicator Maps and Charts section, page 42, for additional data.

What's Being Done

- Behavioral intervention strategies, such as those targeting sexual risks or substance misuse, to reduce transmission of HIV.
- Interventions to increase pertussis vaccination rates.
- Evaluation of vaccine effectiveness and development of treatment guidelines for invasive pneumococcal disease.

What Needs to be Done

- Increase HIV testing and linking those newly diagnosed with HIV to care.
- Better understand the reasons for higher rates of pertussis in Hispanics and use the information to target prevention efforts.
- Identify factors contributing to invasive pneumococcal disease infection among New Mexico subpopulations.



The Changing Tobacco Environment

Tobacco use, the leading cause of death, results in about 2,100 deaths in New Mexico annually. Also, an estimated 42,000 New Mexicans are afflicted with tobacco-related diseases.¹ Cigarette smoking has a harmful impact on nearly every organ in the human body and is linked to conditions such as chronic bronchitis, heart disease, emphysema, stroke, pneumonia, and cancers of the lung, stomach, pancreas, cervix, and kidney.² The leading causes of smoking-related death in New Mexico are chronic obstructive pulmonary disease and lung cancer.³ New Mexico has some of the lowest rates of smoking-related death in the nation, however, the burden of death related to smoking is much greater than that of alcohol and other drugs.

In addition to the disease and death burden, smoking is estimated to cost New Mexico \$461 million in direct health care costs and \$493 million in lost productivity.⁴ In 2012, the state excise tax per pack of cigarettes was \$1.66, while the average retail price of a pack of cigarettes is \$6.06.⁵ Each pack of cigarettes sold in New Mexico costs the state about \$14.00 in smoking-related medical and lost productivity costs.⁶

Who is Using and Being Affected by Tobacco

In 2011, 21.5% of New Mexico adults smoked cigarettes, comparable to the national rate of 21.2%.⁷ This translates into about 335,000 adult smokers in the state. Some adults use other tobacco products, including chew or spit tobacco, cigars, or tobacco in a hookah (water pipe), often in combination with cigarettes.



Among New Mexico high school youth, 30.1% reported using any form of tobacco in the previous month. Cigarette smoking was reported by 19.9% of youth, compared to 18.1% in the US (Figure 1). There has been a significant decline in New Mexico youth smoking since 2003 when 30.2% of youth smoked. Declines in spit tobacco and cigar use were also seen in 2011 compared to previous years.

There are specific population groups who smoke at higher rates than the general population, which may result from complex factors, including social stressors, targeted marketing, and inadequate access to a variety of health and economic resources. For example, there are significant differences in adult smoking prevalence based on socioeconomic characteristics such as education, income, employment, and insurance status (Figure 2). Other groups with elevated smoking include lesbian, gay, and bisexual New Mexicans, people with disabilities, African Americans, and American Indians (Figure 3).

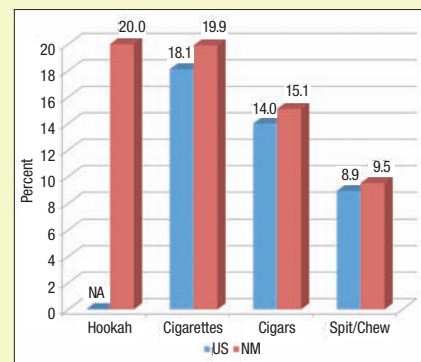
Differences in smoking can also be seen among different groups of high school youth. For example, smoking is highest among 12th graders and American Indians; and boys are more likely to smoke than girls. Students whose parents had less than a high school education were more likely to smoke than those whose parents were college graduates. Another important difference is that youth who earned mostly C, D or F grades were significantly more likely to smoke than youth earning mostly A or B grades.⁸

Smoking-related deaths can also differ by group. For example, death rates for males are about double those of females across all racial/ethnic groups.³ Among both males and females, Whites have the highest rates, followed by African Americans. Counties with the highest smoke-related death rates include Torrance, Sierra, Quay, Valencia, and Socorro counties.

Preventing Tobacco Use and Exposure to Secondhand Smoke

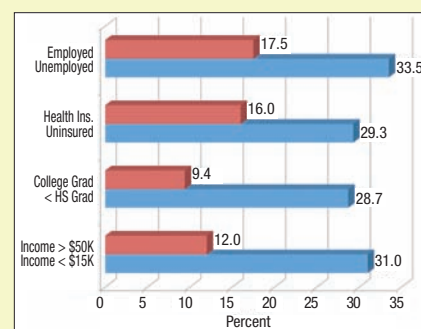
According to a 2012 Surgeon General's Report, nearly 90% of adult smokers tried their first cigarette before age 18 and about three of every four high school smokers continue to smoke well into adulthood.⁹ In addition, there is evidence that the younger individuals are when they start using tobacco, the more likely they are to become

FIGURE 1. Youth Tobacco Use in Past 30 Days, Grades 9–12, NM and US, 2011



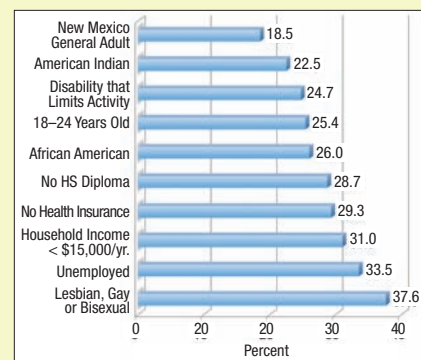
Sources: NM Youth Risk and Resiliency Survey (YRRS), NMDOH and CDC Youth Risk and Behavior Surveillance (YRBS)

FIGURE 2. Adult Smoking Prevalence by Socioeconomic Factors, NM, 2008–2010



Source: NM Behavioral Risk Factor Surveillance System (BRFSS), NMDOH

FIGURE 3. Smoking, by Selected Population Groups, NM, 2008–2010



Source: NM Behavioral Risk Factor Surveillance System (BRFSS), NMDOH

in New Mexico



addicted and the more heavily addicted they will become. In New Mexico, there are an estimated 23,100 high school youth who smoke, making prevention of tobacco use a critical issue.

Key strategies for preventing young people from starting to use tobacco include mass media campaigns, higher tobacco prices, and smoke-free laws and policies. New Mexico's most recent cigarette tax increase (\$0.75) became effective in 2010, which may be partially responsible for recent declines in youth smoking. The state has a clerk-assisted tobacco sales law and also prohibits the sale of tobacco products to minors. Another policy likely to have impacted youth smoking by changing social norms is the Dee Johnson Clean Indoor Air Act (2007), which made most non-tribal indoor workplaces and public places in the state smoke-free.

Statewide mass media campaigns continue to focus on preventing smoking initiation, promoting and facilitating cessation, and shaping social norms related to tobacco use. Innovative media initiatives are also in place to reach and engage young people in tobacco education and promoting awareness of issues. Other complementary activities in the state include supporting the development of voluntary smoke-free policies in multi-unit housing complexes, school and work campuses, and homes and vehicles.

Supporting People in Quitting Tobacco

Among New Mexico smokers, about half have tried quitting in the past year. To support tobacco users in quitting, the State uses mass media statewide to promote its free tobacco cessation services. Current services include a telephone

helpline (1-800-QUIT NOW), with a personalized quitting plan, a trained quitting coach, and multiple calls per enrollee. Web-based cessation services such as www.QuitNowNM.com are also available stand-alone or in combination with the telephone helpline. Additional services include free nicotine patches or gum and text-messaging support. Web-based training is being developed to reach health care providers statewide to teach them how to screen patients for tobacco use, provide brief interventions, and to refer them to the statewide QUIT NOW services.

Emerging Issues in Tobacco Use and Environment

Although cigarette smoking remains at the forefront and results in the greatest health and economic burden, the introduction and use of emerging tobacco products requires attention. In New Mexico, one in five high school youth report smoking tobacco or flavored tobacco in a hookah (waterpipe) in the past month (Figure 1). Among adults in the state, about 14% report ever having tried smoking tobacco in a hookah.¹⁰ A recent national study showed that 13.6% of adults have tried at least one emerging tobacco product, including snus, waterpipe, dissolvable tobacco products, or electronic nicotine delivery systems (i.e., e-cigarettes).¹¹ The tobacco prevention community will need to track the use and impact of these emerging products to inform efforts related to public health policy and interventions.

Another developing issue is the impact of the 2009 Family Smoking Prevention and Tobacco Control Act, which gives the Food and Drug Administration authority to regulate the manufacture, distribution, and marketing of tobacco products to protect public health.¹² The Tobacco Control Act seeks to prevent and reduce tobacco use by young people through activities such as requiring age and identification verification at retailers, restricting the sale of single cigarettes, a ban on certain candy and fruit-flavored cigarettes, and prohibiting false or misleading labeling and advertising. The Act also requires bigger, more prominent warning labels of tobacco product packaging, but this and other parts of the law continue to be challenged in the legal system. The full implementation and public health impact of the Tobacco Control Act will likely take many years to unfold.

See Indicator Maps and Charts section, page 43, for additional data.

What's Being Done

- ✔ QUIT NOW telephone- and web-based cessation services, including quit coaching, free nicotine patches, and text messaging support are available to NM tobacco users.
- ✔ Statewide priority population networks are in place to help maximize the reach, involvement, and mobilization of people in greatest need of tobacco-related services.
- ✔ Youth are being reached with tobacco use prevention approaches, including mass media and cutting edge social media and marketing.

What Needs to be Done

- Encouraging tobacco users to quit altogether instead of switching to lower priced tobacco products.
- Exploration of interventions allowable under the Family Smoking Prevention and Tobacco Control Act, such as protecting young people by regulating the time, place, and manner in which tobacco can be advertised and sold.
- Extending protections from secondhand smoke exposure to people in places not covered by the Dee Johnson Clean Indoor Air Act.



Burden of Substance Abuse Affects

The consequences of substance abuse are severe in New Mexico. Substance abuse is one of the state's leading causes of death (Figure 1), and New Mexico consistently ranks among the worst in the nation for death from drugs and alcohol. The devastation caused by substance abuse is also associated with domestic violence, crime, poverty, motor vehicle crashes, chronic liver disease, infectious diseases, mental illness, and other medical problems.

In 2006, the cost of excessive alcohol consumption in the U.S. was \$223.5 billion dollars, including the costs of medical care, treatment services, criminal justice, and lost productivity.¹ In 2007, the estimated cost of excessive alcohol consumption in New Mexico was more than \$2.8 billion, or \$1,400 per person.² This economic burden falls heavily on New Mexico, since it is one of the nation's poorest states—with the second highest percentage of people living in poverty in 2010–2011 (20.2%)³—and has among the highest rates of health problems associated with substance abuse. Vulnerable populations who experience considerable negative consequences from substance abuse include youth, pregnant women, injection drug users, and prison inmates.

Higher Rates of Substance Abuse Among Youth in NM Compared to US

Substance abuse prevention among adolescents is critical considering the negative long-term consequences of early substance use.^{4,5} In the 2011 New Mexico Youth Risk and Resiliency Survey, 37% of high school students reported that they had a drink of alcohol in the past month while 22% reported having at least five drinks on one occasion, similar to U.S. rates (39% and 22%, respectively). However, a larger proportion of students reported having their first drink

before age 13 years (27%) compared to students nationwide (21%).

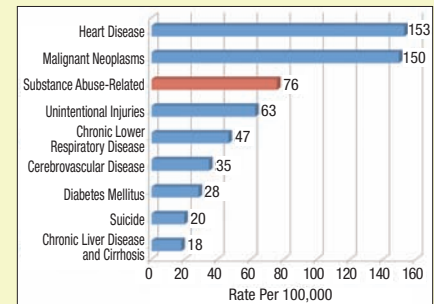
Rates of illicit drug use among New Mexico youth are also relatively high. Marijuana use in the past month was reported by 28% of students, compared with 23% nationwide. New Mexico students also reported higher use of cocaine, heroin, methamphetamine and Ecstasy than students nationally. Prescription drug abuse among youth has emerged as a concern in New Mexico. In 2009, 14% of New Mexico high school students reported current nonmedical use of prescription painkillers, which decreased to 11% in 2011. The prevalence of nonmedical use of prescription painkillers is higher among high school students whose parents have less than a high school education (Figure 2).

Alcohol-Related Death Rates Remain High Despite Decreases in DWI-Related Death

Alcohol-related health problems result from excessive alcohol consumption, either chronic heavy drinking or acute binge drinking. Heavy drinking, defined as drinking more than two drinks per day for men and more than one drink per day for women, is often associated with alcoholism or alcohol dependence, and can cause or contribute to a number of diseases, including alcohol-related chronic liver disease.

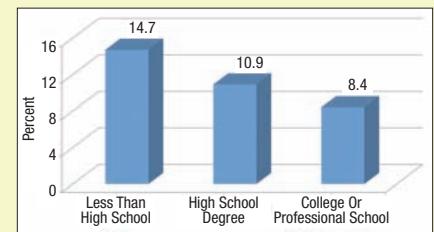
For the past 15–20 years, New Mexico's death rate from these diseases has consistently been first or second in the nation, and 1.5 to 2 times the national rate. Furthermore, while the national death rate from alcohol-related chronic diseases fell during this period, New Mexico's rate increased.⁶ Rio Arriba and McKinley counties have death rates for diseases associated with heavy drinking that are 4–5 times the national rate.

FIGURE 1. Leading Causes of Death, Primary and Substance Abuse-Related, NM, 2007–2011



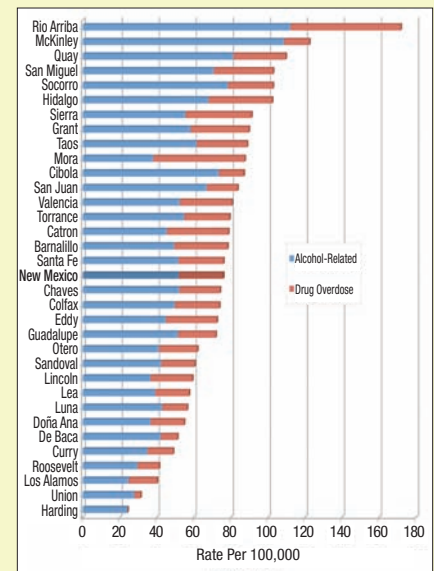
Sources: BVRHS, NMDOH, UNM-GPS

FIGURE 2. Percent of High School Students (Grades 9–12) Who Used Painkillers to Get High in Past 30 Days by Parents' Education, NM, 2011



Sources: YRRS, NMDOH and PED

FIGURE 3. Alcohol-Related and Drug Overdose Death Rates by County, NM, 2007–2011



Sources: BVRHS, NMDOH, UNM-GPS



All New Mexicans

Acute binge drinking, defined as having five drinks or more on an occasion for men and four drinks or more on an occasion for women, is a high-risk behavior associated with numerous injury outcomes, including motor vehicle crash fatalities, homicide, poisoning, and suicide. New Mexico's death rate for alcohol-related injury also has consistently been among the worst in the nation, ranging from 1.4 to 1.8 times the national rate over the past 15–20 years. While New Mexico's alcohol-impaired motor vehicle crash death rate has declined almost 70% during this period, death rates from other alcohol-related injuries have remained stable or increased.

Overdose Death Rate Increases

New Mexico has one of the highest drug overdose death rates in the nation. In 2011, the age-adjusted drug overdose death rate in New Mexico was 25.9 deaths per 100,000 persons.⁷ Since 2007, the rate has increased 15%. Deaths due to prescription drugs now outnumber illicit drug deaths. In 2010, the most common drug types causing overdose death in New Mexico were prescription opioids (e.g., oxycodone, methadone, morphine), heroin, cocaine, tranquilizers (e.g., Diazepam, Alprazolam), muscle relaxants (e.g., Carisoprodol) and antidepressants.⁸ Prescription drug deaths have been fueled by the increase in sales of Schedule II and III prescription opioids, which have increased 144.7% since 2001.⁹ Rio Arriba County had the highest 2007–2011 drug overdose death rate at 59.5—a rate more than twice the state rate. Combined alcohol-related and drug overdose death rates by county are shown in Figure 3.

How Do We Tackle the Problem of Substance Abuse?

Given the tremendous burden from substance abuse problems, prevention and treatment is of critical importance in New Mexico. Primary prevention attempts to stop a problem before it starts. In New Mexico, primary prevention of alcohol-related health problems has focused on regulating access to alcohol and altering the alcohol consumption behavior of high-risk populations. Regulatory efforts have included increasing the price of alcohol—which is effective in deterring alcohol abuse,¹⁰ establishing and enforcing a minimum legal drinking age, regulating the density of liquor outlets, and increasing penalties for buyers and

servers of alcohol to minors. Efforts to reduce drug overdose death are currently focused on reducing prescription drug overdoses by requiring more medical provider training in the area of pain management and promoting use of the Prescription Monitoring Program database to detect and reduce prescription drug misuse and inappropriate prescribing. DOH is also working with various community groups to provide naloxone (a drug which reverses respiratory depression during an overdose) to at-risk patients who are prescribed opioid painkillers.

Secondary prevention efforts try to detect and treat emergent cases before they cause harm. In New Mexico, screening and brief intervention (SBI) could be more widely used to identify at-risk drinkers and address problem drinking before it causes serious harm.

Tertiary prevention involves the treatment of individuals diagnosed with substance use disorders so they can recover to the highest state of health while minimizing the long-term effects of the disease. There are 141 facilities in New Mexico that provide substance abuse treatment services, including eight facilities that offer substitution therapy such as methadone and buprenorphine.¹¹ Roughly 141,000 New Mexicans abused or were dependent on alcohol during the past year while approximately 50,000 abused or were dependent on illicit drugs.

Only a small portion, approximately 6%, of current substance abusers received treatment for their substance abuse or dependence in the past year.¹² Nationally, the most common reasons that people who need treatment do not receive it are because they are not ready to stop using, have no health insurance and can't afford the cost, or are concerned about the possible negative effect on their job.¹³

Harm reduction is another important part of the substance abuse prevention model. Syringe exchange, which prevents the transmission of blood-borne pathogens among injection drug users, is one such strategy. Harm reduction programs in New Mexico deliver disease and overdose prevention education, acute-detox, health promotion, social service and treatment referral, and, in some locations, primary medical care to injection drug users.

See Indicator Maps and Charts section, pages 44 and 45, for additional data.

What's Being Done

- More than \$15 million is spent each year to help fund local DWI programs.
- Roughly 15,000 people were enrolled in substance abuse treatment in 2009, including a mix of mental health services, in outpatient, inpatient and residential settings.
- The New Mexico Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council consisting of DOH and the healthcare provider licensing boards and professional associations is tightening regulations and requirements and promoting the use of Prescription Monitoring Program data to reduce the misuse of prescription drugs.
- Trainings on guidelines for effective and safe opioid prescribing among pain patients and those who are opioid dependent.

What Needs to be Done

- Increase support in adult primary care settings for screening and brief interventions (SBI) to address potential alcohol-related problems. Promote wider implementation of alcohol electronic SBI (e-SBI).¹⁴
- Expand the existing DOH overdose prevention program to include distribution of naloxone to persons with high risk opioid prescriptions.
- Support ongoing and new evidence-based programs for substance abuse prevention, treatment and recovery, ensuring thorough program evaluation.
- Educate the general population about the importance of safe medication use, secure storage in the home and proper disposal of leftover medicine.



Multiple Chronic Conditions Present

Chronic diseases such as heart disease, cancer, emphysema, stroke, and diabetes account for five of the leading six causes of death in New Mexico.¹ Another common chronic disease, arthritis, is a leading cause of disability among adults. Public health efforts to prevent and manage chronic diseases have traditionally been funded and organized to focus on a specific disease or risk factor. There has been growing recognition, however, that this disjointed approach may not best serve populations that are particularly burdened by multiple risk factors and chronic diseases. The reality is that many chronic diseases share potentially modifiable risk factors such as physical inactivity, tobacco use, unhealthy eating, and excess weight, which tend to cluster in communities and individuals. These shared chronic disease risk factors, in turn, are strongly related to potentially modifiable social determinants such as poverty, unsafe neighborhoods, discrimination, and low educational attainment.²

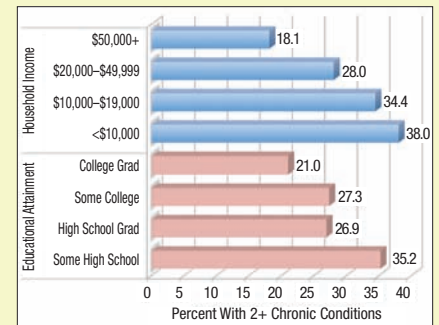
Over one in four adults in NM ages 45 years and older has been diagnosed with two or more chronic diseases.³ Not surprisingly, multiple chronic conditions are more common in communities and individuals with more risk factors and adverse social determinants of health, such as lower income and education levels (Figure 1). While learning to live with any chronic disease takes skills and resources, it is particularly

challenging to manage multiple chronic diseases and risk factors at the same time. This means that many New Mexicans living with the challenge of multiple chronic conditions may not have the health literacy skills, income, community resources, and access to healthcare services that they need to successfully take care of themselves.

Arthritis and cardiovascular disease (CVD, i.e., heart disease, heart attack or stroke) are common conditions that often co-exist. Physical activity, such as moderate aerobic exercise and strength training, is important in the management of both arthritis and CVD by improving physical function, controlling weight, lowering blood pressure and improving cholesterol levels. However, NM adults with arthritis or CVD are more likely to be physically inactive than those with neither condition. This is especially true for persons who have both arthritis and CVD (Figure 2). These results are consistent with a national study that found arthritis might be a barrier to increased physical activity among persons with heart disease, perhaps due to arthritis-associated joint pain and fear of further joint damage.⁴ The authors recommended several specially tailored self-management programs that can help adults learn to manage arthritis pain and safely increase physical activity. They concluded that greater integration of heart disease and arthritis intervention efforts by health-care providers, payers, and health departments might better address the effects of these co-occurring conditions.



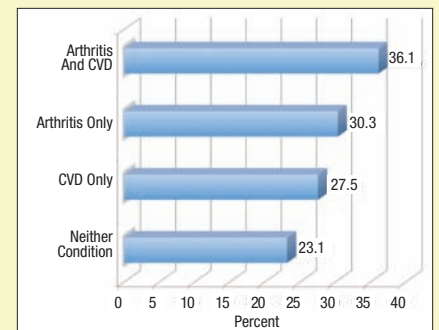
FIGURE 1. Prevalence of Multiple Chronic Conditions by Annual Income and Educational Level, Age 45+, NM, 2011



Source: NM Behavioral Risk Factor Surveillance System, NMDOH

Note: Multiple Chronic Conditions include two or more of the following: Cardiovascular disease (heart attack, coronary heart disease, and/or stroke), current asthma, cancer (excluding skin cancer), COPD, arthritis, kidney disease, or diabetes.

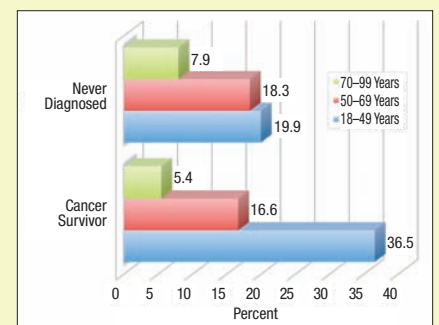
FIGURE 2. Prevalence of Physical Inactivity Among Adults by Disease Status, NM, 2011



Source: NM Behavioral Risk Factor Surveillance System

Notes: Physical inactivity is defined as no leisure time physical activity or exercise in past 30 days. Arthritis is defined as diagnosed with some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; CVD is defined as diagnosed with one or more of the following: heart attack, coronary heart disease, and/or stroke.

FIGURE 3. Current Smoking Among Adult Cancer Survivors vs Adults Never Diagnosed with Cancer, NM, 2009–2010



Source: NM Behavioral Risk Factor Surveillance

Note: "Cancer" excludes non-melanoma skin cancer.

Challenges for NM



Cancer survivors face a number of challenges, including increased risk for future cancer (either recurrent or a second type). Unfortunately, many cancer survivors are chronically addicted to nicotine, further increasing their risk for future cancer and other tobacco-related illnesses by continuing to smoke cigarettes.⁵ Among NM cancer survivors in the 18 to 49 year age group, smoking rates are significantly higher than among their peers who have never been diagnosed with cancer (Figure 3). This suggests missed opportunities by clinicians and the public health community to encourage all cancer survivors who use tobacco to quit and to connect them to affordable evidence-based cessation services.

The Four Key Domains

In support of coordinated chronic disease efforts, the Centers for Disease Control and Prevention (CDC) is encouraging state chronic disease programs to work collaboratively by sharing basic functions such as data management, communication, partnership development, and implementation of a statewide chronic disease plan. CDC has provided funding to a number of states, including New Mexico, to maximize the reach of chronic disease programs by working with statewide partners across the following four key domains:⁶

- Achieving policy and environmental changes that support healthy communities.

- Achieving improvements to the way that health care systems detect, manage and control chronic diseases and risk factors through early detection and clinical preventive services.
- Enhancing clinic-community linkages so that people at high risk can better take charge of their health through self-management programs and other community supports.
- Providing data and information for decision making at the state level through a strong foundation in surveillance and epidemiology.

The goal of using shared resources to address overlapping chronic conditions, risk factors, and social determinants of health is the delivery of more efficient and effective chronic disease prevention and management efforts that will benefit all New Mexicans.

As chronic disease prevention and management activities become more strongly coordinated in our state, it will be crucial to evaluate whether improvements in the health and quality of life of our residents are actually being realized. This will be especially important to determine for those communities and individuals most heavily burdened by chronic disease risk factors, adverse social determinants of health, and multiple chronic conditions.

See Indicator Maps and Charts section, page 46, for additional data.

What's Being Done

- ☑ The NM Chronic Disease Prevention Council, a statewide coalition, is working with diverse partners to implement the NM Shared Strategic Plan for Chronic Disease Prevention and Control 2012–2016.
- ☑ Community and health care system partners throughout NM are delivering the Stanford University-developed Chronic Disease Self-Management Program in English and Spanish, providing skill building crucial to managing one or more chronic conditions.
- ☑ The National Diabetes Prevention Program is being piloted in a number of NM worksites and communities to help individuals with pre-diabetes avoid or delay getting diabetes.
- ☑ Chronic disease public health data are readily available to stakeholders and policy makers through queryable websites such as the DOH Indicator-Based Information System (IBIS).

What Needs to be Done

- Creating sustainable funding mechanisms for chronic disease self-management programs, such as their incorporation into health plan networks and covered benefits.
- Assessing the potential public health benefits and dangers of all proposed policies and legislation to make decisions that best support the long term health of New Mexicans.
- Increasing access to affordable, healthy foods and safe places to be physically active in New Mexico's rural and frontier areas.



Injuries Affect New Mexicans Across

Unintentional injury is the leading cause of death among 1 to 44 year olds in New Mexico. It is the third leading cause of death among the total population in New Mexico and accounts for 68% of all injury deaths. New Mexico's unintentional injury death rate of 59.3 per 100,000 population in 2010 was 1.6 times higher than the national rate of 37.9/100,000. Poisoning was the leading cause of unintentional injury death in 2011. In 2007, poisoning surpassed motor vehicle traffic crash injury as the leading cause of unintentional injury death. The other leading causes of unintentional injury death, in order, were motor vehicle traffic crash injuries, fall-related injuries and suffocation. The leading causes of unintentional injury death vary by age group. In 2011, suffocation was the leading cause of unintentional injury death among infants less than one year of age, motor vehicle traffic crash injury was the leading cause among 1–24 year olds, poisoning was the leading cause among 25–64 year olds and fall-related injury was the leading cause among 65+ year olds.

The unintentional injury death rate among males (83.0/100,000 population) was almost double the rate among females (43.3/100,000 population) in 2011. Poisoning (319 deaths) was the leading cause of unintentional injury death among males in 2011, followed by motor vehicle traffic crash injury (219) and fall-related injury (140). For females, poisoning (184 deaths) was the leading cause of unintentional injury death, followed by fall-related injury (156) and motor vehicle traffic crash injury (82).

During 2010–2011, American Indians had the highest unintentional injury death rate at 82.2/100,000 population, followed by

Hispanics (61.5/100,000 population) and Whites (56.0/100,000 population). African-Americans and Asians had the lowest unintentional injury death rates (43.9/100,000 population and 31.4/100,000 population, respectively). The leading causes of unintentional injury death varied by race/ethnicity. Motor vehicle traffic crash injuries were the leading cause of unintentional injury death among American Indians and Asian/Pacific Islanders. Poisoning was the leading cause of unintentional injury death among Hispanics, Whites and African Americans.

Fall-related injury was the leading cause of unintentional injury hospitalizations and emergency department visits in 2010. Poisoning was the second leading cause of unintentional injury hospitalization. Motor vehicle traffic crash injury was the third leading cause of unintentional injury emergency department visits.

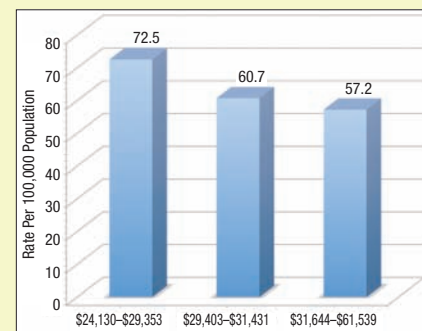
Poverty is a risk factor for unintentional injuries. The unintentional injury death rate was 1.3 times higher among counties with the lowest average county income compared to counties with the highest average county income in 2010 (Figure 1). The unintentional injury hospital discharge rate was also higher among counties with the lowest average county income (36.4/100,000) compared to counties with the highest average county income (31.3/100,000) in 2010.

Suffocation Among Infants

From 2007 through 2011, 20 infants less than one year of age died of suffocation in NM. The United States suffocation death rate (22.3/100,000) from 2006–2010 was two times higher than the rate in NM (11.6/100,000). Suffocation accounted for 36% of infant deaths due to unintentional injuries. Another 40% of unintentional injury deaths among infants was due to other specified and unspecified injuries. Males accounted for 70% of the infant suffocation deaths.

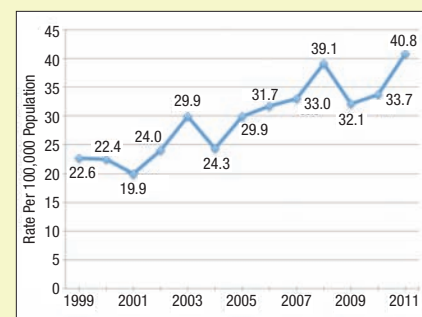
Suffocation deaths among infants have been increasing in NM. During 2002–2006 there were eight infant deaths due to suffocation in NM compared to 20 in the 2007–2011 period. Infants are most at risk for suffocation while sleeping. Infants should sleep in safe cribs, alone, on their backs, with no loose bedding or soft toys.

FIGURE 1. Unintentional Injury Death Rate by County Income, NM, 2010



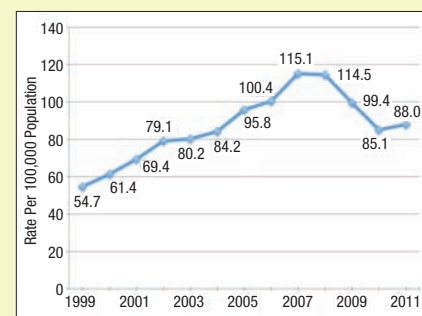
Source: VRHS, NMDOH

FIGURE 2. Unintentional Poisoning Death Rate, Aged 25–64, NM, 1999–2011



Source: VRHS, NMDOH

FIGURE 3. Fall-Related Injury Death Rate, Aged 65+, NM, 1999–2011



Source: VRHS, NMDOH



Entire Lifespan

Motor Vehicle Traffic Injury Among 1–24 Year Olds

From 2007 through 2011, 468 children and young adults died in a motor vehicle crash. Motor vehicle traffic injury deaths have decreased 46% from 2002 through 2011 among 1–24 year olds. The rate in 2011 was 11.7/100,000. The highest motor vehicle traffic death rate during 2007–2011 occurred among 15–24 year olds (26.7/100,000). The motor vehicle traffic death rate among males was two times higher than the rate among females. For this age group, American Indians had the highest motor vehicle traffic injury death rate (23.8/100,000) followed by Hispanics (13.2/100,000) and Whites (11.2/100,000).

The success in the reduction in motor vehicle traffic injury deaths can be attributed to several factors. Improvements continue to be made in roadway design and vehicle safety. New Mexico has invested in seat belt and child safety seat laws and set tighter penalties against drinking while driving. Graduated drivers licensing policies for teenage drivers have helped bring the number of teen crash deaths down.

Poisoning Among 25–64 Year Olds

From 2007 through 2011, 1,875 adults 25 to 64 years of age died of unintentional poisoning. Poisoning deaths increased 81% from 1999 to 2011 (Figure 2). The poisoning death rate during 2007–2011 was highest among 35–44 year olds (42.7/100,000) and 45 to 54 year olds (42.4/100,000). The male poisoning death rate was two times higher than the female rate. Hispanics had the highest unintentional poisoning death rate (41.0/100,000) followed by Whites (32.1/100,000) American Indians (30.6/100,000) and Blacks (29.6/100,000).

About 90% of unintentional poisoning deaths are due to drug overdose. Deaths due to unintentional drug poisoning can result from drug misuse such as taking too much of a drug for medical reasons and drug abuse. The American Association of Poison Control Centers has developed safety tips for the public to follow while using prescription drugs. People should follow the directions on the label, only take prescription drugs that were prescribed to them by a health care provider, never take larger or more frequent doses of their medication and never share or sell their prescriptions.

Falls Among 65+ Year Olds

From 2007 through 2011, 1,348 older adults 65+ years of age died of unintentional fall-related injuries. Fall-related injury deaths increased dramatically among older adults from 1999 through 2007 (115.1/100,000), increasing 110% during this period (Figure 3). The death rate decreased 24% from 2007 through 2011 (88.0/100,000). The dramatic increase in the fall-related death rate from 1999 through 2007 may be linked to increased life expectancy that results in a larger proportion of older adults living with chronic diseases that cause them to be at increased risk and vulnerability to fall-related injuries.¹

Another possible explanation for the dramatic increase in the fall death rate in older adults is the effect of improved reporting quality after updating the International Classification of Disease-9 (ICD-9) to ICD-10.² However, the fall-related death rate among older adults in NM decreased in 2009 and 2010 for unknown reasons.

The fall-related injury death rate increased dramatically with age. From 2007–2010 the fall-related death rate among 85+ year olds (484.3/100,000) was 20 times higher than the rate among 65–74 year olds (23.6/100,000) and five times higher than the rate among 75–84 year olds (95.8/100,000). The female fall-related death rate was slightly higher than the male rate. Whites had the highest fall-related death rate (114.2/100,000) followed by American Indians (79.6/100,000) and Hispanics (79.3/100,000).

For many older persons, injuries due to falls, such as a hip fracture or traumatic brain injury, are so disabling that they never return to independent living in the community. Falls also have psychological consequences. Many people who fall, even those who are not seriously injured, develop a fear of falling. This fear can result in depression, isolation and reduced mobility, which lead to a decline in physical function and an increased risk of falling. The most effective strategies for prevention of older adult falls include home safety improvements, physical activity that focuses on maintenance of strength and balance, and medication safety.

See Indicator Maps and Charts section, page 47, for additional data.

What's Being Done

- ☑ The Safe Sleep Campaign involves educating parents about ways to reduce the risk for Sudden Infant Death Syndrome and other sleep-related causes of infant death, including avoiding having the baby co-sleep with parents or siblings, avoiding breast feeding in bed and keeping the crib free of all accessories.
- ☑ The New Mexico Safe Kids Coalition teaches parents on the correct use of seat belts, car seats and booster seats for children, as well as use of rear facing car seats until age 2.
- ☑ Implementation of evidence based adult falls prevention programs in various communities.

What Needs to be Done

- ☐ Increase provision of evidence-based Early Childhood Home Visiting programs to include at-risk families with other children.
- ☐ Provide training regarding safety protocols of the “Safe Sleep” and “Cribs for Kids” campaign to all home daycare providers, home visitors, parents and other caregivers of infants.
- ☐ Increase the availability of free car seats and booster seats, as well as “fitting stations” and clinics for inspection, replacement and parent training regarding proper and safe fitting.
- ☐ Incorporate adult fall risk assessment and proven interventions into clinical practice.



New Mexico's Violence Rate Second

Violence is a public health problem of epidemic proportions, both nationally and in New Mexico. In 2010, violence accounted for more than 55,000 deaths in the United States. New Mexico had the second highest violent death rate in the nation, 28.5 deaths per 100,000 population.¹

Violence may have lasting harmful effects on individuals, families, and communities. The health effects may remain for years following the initial injury, accounting for significant, permanent disabilities such as spinal cord and brain injuries and limb loss. Victims of violence are also at an increased risk for psychological and behavioral problems, such as depression, anxiety, post-traumatic stress disorder, substance use disorders, and suicidal behaviors; and reproductive health problems, such as unwanted pregnancy and sexually transmitted infections.

Violence related injuries and deaths include both intentional, self-harming injuries due to suicidal behaviors, and intentional, interpersonal injuries, such as intimate partner violence, child maltreatment, and sexual assault. Although mortality data are the most collected and available source of violence related data, deaths represent only a fraction of the health and societal impact of violence. Apart from deaths, there were an estimated 1,484 inpatient hospital discharges and 8,557 visits to emergency departments for violence related injuries in NM during 2010.^{2,3} According to recent NM survey data results, 8.6% of high school students reported making a suicide attempt in the past 12 months, and 5.9% of adults 18 years and older reported a suicide attempt during their lifetimes.^{4,5}

Suicide

Over the past 15 years, suicide rates in NM have consistently been more than one and a half times greater than U.S. rates. In 2010, NM had the fourth highest suicide rate among the 50 states and the District of Columbia.¹ From 1999–2011, the NM suicide rate increased 13.4%, from 17.9 per 100,000 to 20.3 per 100,000, mirroring a similar increase (15%) in suicides at the national level.

In 2011, suicide was the eighth leading of cause of death in New Mexico, accounting for a total of 419 deaths.⁶ The majority of suicides (52.5%) were caused by firearm injuries.⁷ However, there were differences in the causes of death between

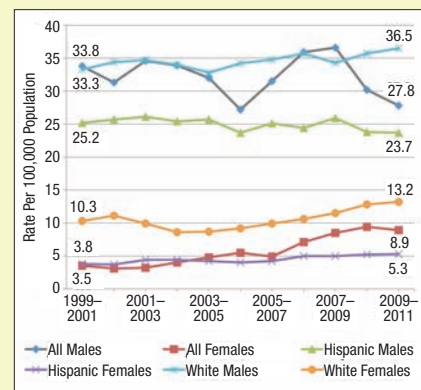
male and female suicide victims. The majority of male suicides were due to firearm injuries (59.9%), followed by hanging/suffocation (23.6%) and poisoning (9.9%). In contrast, the most common cause of death among female suicide victims was poisoning (41.9%), followed by firearms (30.5%) and hanging/suffocation (22.9%).

Male suicide rates in NM have traditionally been 4–5 times higher than female suicide rates. However, recent increases in female suicides have narrowed the rate disparity between the sexes to three to one. White males have the highest suicide rates, followed by American Indian (AI) males, although AI male suicide rates have recently been declining (Figure 1).⁷ In contrast, female suicide rates have increased among the three most common racial/ethnic groups, with the AI female suicide rate more than doubling from 3.5 per 100,000 in 1999–2001 to 8.9 per 100,000 in 2009–2011.

According to results from the 2010 NM Violent Death Reporting System (NM–VDRS), the most common circumstances associated with female suicides were current mental health problems (56.5%) and current treatment for mental illness (54.6%).⁸ Among male suicide victims, the most common circumstance was a current depressed mood (42.1%). Male victims were more likely to disclose their intent to commit suicide (39.6%) than female victims (24.1%). Intimate partner problems were more frequent among male (33.3%) compared to female (24.1%) suicide victims, whereas physical health problems were more common among females (37.0%) than males (24.5%). Substance use, particularly alcohol use, was common among suicide decedents. More than a third (37.2%) of suicide victims who were tested for blood alcohol tested positive; and almost one quarter (23.2%) of suicides were alcohol related, or had a blood alcohol concentration (BAC) greater than or equal to 100 mg/dl or 0.10%.

A previous suicide attempt is a risk factor for completed suicide, and suicide attempts may also result in injuries serious enough to merit inpatient hospitalizations or emergency department (ED) visits for medical attention. In 2010, there were 1,010 inpatient hospitalizations for suicide attempt.² In contrast to completed suicides that are more common among males, hospital discharges for suicide attempt were more common among females

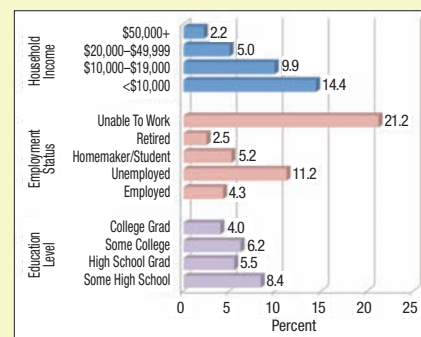
FIGURE 1. Suicide Rates by Gender and Race/Ethnicity, NM, 1999–2011



Source: VRHS, NMDOH

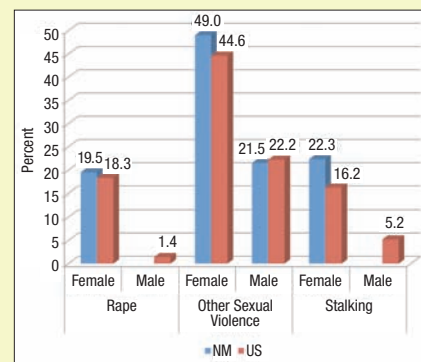
Note: Suicide rate defined as 3-year rolling average rates, age-adjusted to the 2000 US standard population

FIGURE 2. Lifetime Prevalence of Suicide Attempt Among Adults Aged 18+ by Socioeconomic Status Indicators, NM, 2011



Source: NM BRFSS, NMDOH

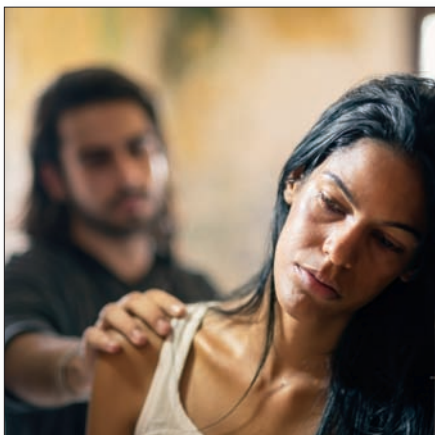
FIGURE 3. Lifetime Prevalence of Sexual Violence by Gender, NM and US, 2010



Source: CDC.

Note: State estimates of rape among men not available due to small numbers; state-level stalking estimates for men were not reported.

Highest in America



(63.6%). The majority of the 2,148 ED visits for suicide attempt were also female patients (56.3%).³ New Mexican adults 18 years and older with lower household income, lower levels of employment, and less education reported higher rates of having ever attempted suicide during their lifetimes (Figure 2).⁵

Homicide

Homicide, or death caused by an intentional assault of another person, is a significant public health problem in New Mexico. In 2011, homicide was the third leading cause of death among persons 15–34 years.⁶ In 2010, the latest year for which state comparison data are available, NM's homicide rate was the sixth highest in the nation (7.6 per 100,000).¹

In 2011, there were 146 assault deaths in New Mexico, an age-adjusted homicide rate of 7.4 per 100,000.⁷ From 2009–2011, the male homicide rate (12.5 per 100,000) was 4 times higher than the female rate (3.2 per 100,000). American Indian (26.1 per 100,000) and Black (24.8 per 100,000) males had the highest homicide rates, followed by Hispanic males (14.0 per 100,000); the White male homicide rate (6.2 per 100,000) was significantly lower compared to male rates in the other racial/ethnic groups. Homicide rates were highest among males between the ages of 15–44 years; males in the age group 35–44 years (21.2 per 100,000) had the highest rate.

Firearm was the leading cause of death among homicide victims, accounting for 51.8% of all homicide deaths in NM during 2009–2011.⁷ Firearm deaths were more common among male homicide victims (55.3%) compared to

female homicide victims (38.8%). Overall, 9.3% of homicides in NM were intimate partner violence related, i.e. the victims were either the current or former intimate partner of the suspect; or the deaths were associated with intimate partner conflict or violence, but were not deaths of the intimate partners themselves.⁸ The most common circumstance related to homicide deaths among males was an argument over something besides intimate partners/jealousy, or money, property or drugs (46.9%). In contrast, almost a third (31.3%) of female homicides were related to intimate partner violence.

In 2010, there were 474 inpatient hospitalizations for assault related injuries, an age-adjusted hospital discharge rate of 24.0 per 100,000.² Infants less than one year had the highest assault hospitalization discharge rate of 92.1 per 100,000. There were also 6,842 ED visits for assault, an overall age-adjusted rate of 348.2 per 100,000.³

Sexual Violence

Sexual violence is a major public health problem with serious long-term physical and mental health consequences. In New Mexico, nearly one in five (19.5%), or 149,000 adult women, reported being raped at some time in their lives (Figure 3).⁹ In addition, 49.0% of women and 21.5% of men 18 years and older have experienced some form of sexual victimization other than rape during their lifetimes.

Among women in NM who experienced rape, physical violence, and/or stalking by an intimate partner during their lifetimes, 29.9% reported an impact on their lives, including being fearful, having safety concerns, experiencing symptoms of posttraumatic stress disorder (PTSD), being injured, needed housing, legal or victim's advocate services, and missing school or work.⁹ Twenty-two percent of these victims had symptoms of PTSD, and 20.0% reported an injury or need for medical care.

Sex crimes in NM go largely unreported. In 2010, the number of rapes that came to the attention of law enforcement represented about one-fifth of the estimated rapes that occurred.¹⁰ According to these reports, the offender was known by the victim in an average of 72% of rapes perpetrated; and, of known offenders, 24% were family members.

What's Being Done

- The New Mexico Human Services Department is developing a statewide suicide prevention plan to inform suicide prevention programming across the lifespan.
- The NM Department of Health was awarded a three-year grant from the Substance Abuse and Mental Health Services Administration to implement and evaluate youth suicide prevention programs.
- The Coalition for Suicide Prevention and Survivor's Support in Las Cruces was established in December 2011 to address public health and community concern about suicide and attempted suicide in southern New Mexico.
- The NM Department of Health funds community-based sexual violence prevention programs that target caretakers, school personnel, and law enforcement officials serving persons with disability statewide; and youth and young adults, including LGBT, Spanish speaking, and youth of color, in select counties.

What Needs to be Done

- Promote and implement effective clinical care practices to assess, treat and refer persons at high risk for suicide, focusing on primary care and emergency department settings.
- Develop suicide prevention programs targeted towards adult populations in NM with the highest suicide rates, especially veterans and White males ages 45 years and older.
- Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk through counseling by health care professionals, community-based health promotion, and mass media campaigns.
- Raise awareness and promote safe gun storage practices in the home, particularly the use of a lockbox or gun safe; and encourage parents to remove firearms from the homes of adolescents, especially adolescents with a high risk of suicide.

Burden of Mental Illness Touches All

Mental illness is common in the United States and around the world. According to the U.S. Surgeon General, mental disorders are health conditions characterized by “alterations in thinking, mood or behavior (or some combination thereof) associated with distress and/or impaired functioning.”¹

Approximately 1 in 4 adults in the U.S. has a mental disorder of some kind in any given year. 13 million (5.8%) suffer from serious, debilitating disorders that are associated with suicide attempts, significant role impairment or lost work productivity.² Mental disorders are also common in childhood and adolescence. Approximately one in 5 children has a mental illness diagnosis associated with some impairment.¹ Adult mental illness is commonly preceded by psychiatric conditions that begin during childhood. The various types of mental disorders are defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).³

Mental illness affects not only the mental and physical health and well being of the individual, but also has a tremendous impact on families and communities. According to the latest update of the Global Burden of Disease Report, mental illness is one of the main causes of years of healthy life lost to disability (YLD).⁴ Individuals

with serious mental illness have higher mortality rates and die earlier than the general population. The overall burden among females is 50% higher than among males. Psychiatric conditions contributing to the higher burden in females include anxiety disorders and senile dementias. In contrast, one quarter of the male burden is due to alcohol and drug use disorders—six times higher than the burden of these conditions among females.

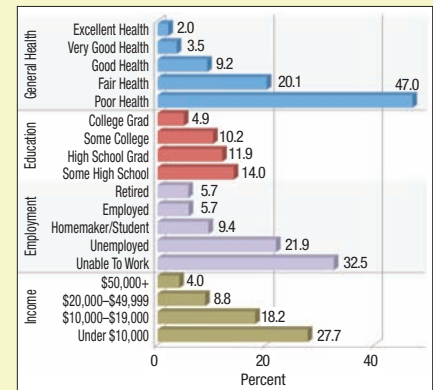
Treatment of mental illness can reduce the level of disability and improve quality of life. However, only 41% of U.S. adults with a 12-month mental health disorder defined in the DSM-IV used mental health services in the prior year.⁵ Barriers to receiving treatment include cost and insurance issues, not feeling a need for treatment or thinking that the problem can be handled without treatment, and stigma associated with mental illness.

Depression

Major depression is a mental disorder characterized by an all-encompassing low mood accompanied by low self-esteem and by loss of interest or pleasure in normally enjoyable activities.³ Depression is one of the most prevalent and treatable mental disorders. Unipolar depression was the third leading cause of disease

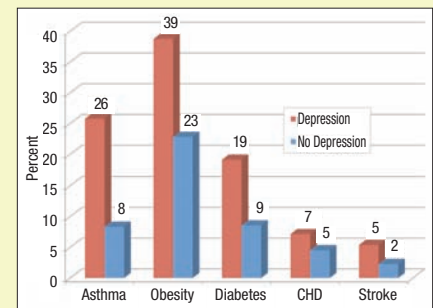


FIGURE 1. Prevalence of Depression by Selected Sociodemographic Characteristics, NM, 2010



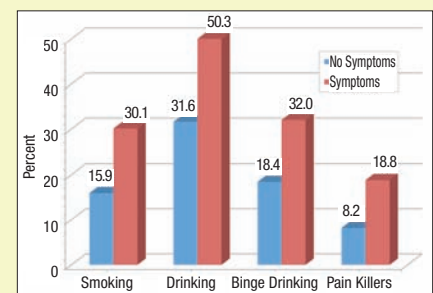
Source: NM Behavioral Risk Factor Surveillance System, NMDOH

FIGURE 2. Chronic Health Conditions and Depression, NM, 2010



Source: NM Behavioral Risk Factor Surveillance System, NMDOH

FIGURE 3. Youth Substance Abuse Behavior and Symptoms of Depression, High School, NM, 2011



Source: NM Youth Risk and Resiliency Survey, NMDOH

NM Residents

burden globally according to the Global Burden of Disease Report, and the number one cause of YLD.⁴ Depression accounted for 65.5 million disability-adjusted life years (DALYs), or 4.3 percent of the total DALYs.⁴ The DALY is a summary measure of population health that combines years of life lost from premature death and years of life lived in less than optimal health due to disease and injury.

Major depression is often associated with co-morbid mental disorders, such as anxiety and substance use disorders. It is also a risk factor for suicide and has been associated with an increased prevalence of chronic medical conditions such as heart disease, stroke, asthma, diabetes and obesity.⁷

Estimates of the prevalence of mental disorders in the general population come from both national and state surveys that use both screening and diagnostic measures to quantify mental illness. According to results from the 2009–2010 National Survey of Drug Use and Health, 8.6% of New Mexico youth 12–17 years had a major depressive episode in the last 12 months, along with 7.7% of young adults 18–25 years and 5.5% of adults over 26.⁶

Depression Among Adults

The New Mexico Behavioral Risk Factor Surveillance System survey estimated 9.1% of NM adults were suffering from depression in 2010. There were no significant differences in current depression by gender or age group. The prevalence among Native Americans (15.1%) was considerably higher than that among Whites (7.3%) and Hispanics (9.8%). The prevalence of depression was strongly and inversely related to reported general health (Figure 1) with almost half of those reporting poor overall health afflicted with depression compared to only 2% among those in excellent health.

Depression is also strongly related to education, employment and income (Figure 1). College graduates suffered from depression at less than half the rate of people with lower levels of education. The prevalence of depression was 4.9% for college graduates, compared to 10.2% for those with some college, 11.9% for high school graduates and 14.0% for those who did not complete high school. People who are employed or retired had much lower rates of

depression (5.7%) than those who are unemployed (21.9%) or unable to work (32.5%). Depression was much less common among adults with household incomes of \$50,000 or more (4.0%) than among those with household incomes of \$10,000 or less (27.7%).

Depression is strongly associated with other chronic health conditions. Adults with one or more chronic medical conditions were much more likely to suffer from depression than adults without these conditions (Figure 2). Rates of health care provider diagnoses of asthma (25.8%), diabetes (19.1%), coronary heart disease (7.1%), and stroke (5.4%) were much higher in those suffering from depression. In addition, adults with depression were much more likely to be obese than those who were not.

Depression Among Youth

Persistent feelings of sadness and hopelessness are criteria for and predictors of clinical depression for youth. Results from the 2011 NM Youth Risk and Resiliency Survey indicated that 29.1% of high school students reported feeling sad or hopeless every day for two weeks or more in the previous year. This is essentially the same as the national rate of 28.5%. NM female students (37.3%) were more likely to report persistent feelings of sadness or hopelessness than male students (21.2%).

Persistent feelings of sadness and hopelessness were also associated with other risky behaviors. High school students who reported sadness and hopelessness were more likely to report substance use (Figure 3), including cigarette smoking, current alcohol use, binge drinking, using painkillers to get high and a variety of other behaviors. They also reported involvement in physical fights and being victims of intimate partner violence and sexual violence more often than students without these feelings.

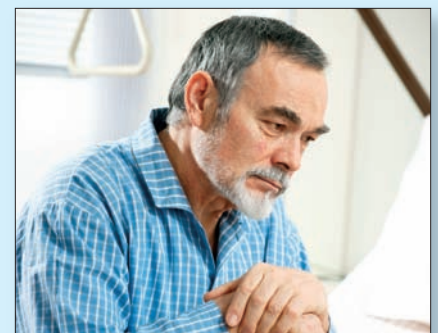
Mental health problems are common in New Mexico. They affect individuals of all ages and racial/ethnic backgrounds. Depression is a serious, common and treatable disease. It was most prevalent among adults with lower socioeconomic status. These health disparities, along with higher rates of chronic disease, lack of social and emotional support, and substance use, contribute to poorer outcomes among adults with mental health conditions.

What's Being Done

- The New Mexico Health Care Reform Leadership Team is aligning with national health care reform legislation to include behavioral health services in essential benefits packages provided through health insurance exchanges.
- Behavioral health services for middle and high school students are offered at 59 school-based health centers throughout New Mexico.
- Core service agencies in local collaborative areas coordinate the continuum of mental health and substance abuse treatment for people with serious mental health needs.
- The NM Behavioral Health Collaborative implemented “Talk About It,” an anti-stigma and wellness campaign to raise public awareness about prejudices surrounding mental illness and its treatment.

What Needs to be Done

- Continue to improve youth and adult access to services through braided funding strategies.
- Implement collaborative care for the management of depressive disorders as recommended by the U.S. Preventive Services Task Force.
- Increase the capacity to provide mental health and substance abuse assessment, crisis intervention and early intervention services at school-based health centers.
- Expand early recognition and intervention programs for young people with early signs of serious mental illness.
- Expand the continuum of the behavioral health workforce and provide incentives for providers to work in rural, frontier and tribal areas.



Reducing Health Disparities Benefits

Health Disparity and Health Equity

“Health disparities” are defined as “differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups in the United States.” Health disparities are relative and are identified by comparing health status, access to services, and/or health outcomes of population groups. Health equity is defined as “the attainment of the highest level of health for all people.” Although there have been national efforts at reducing health disparities and achieving health equity during the past two decades (e.g., Healthy People 2000, 2010, 2020 and the National Partnership for Action to End Health Disparities), the 2011 National Healthcare Disparities Report states that the quality of care is improving but access to care and disparities in care are not improving particularly for minority groups and low-income individuals.

Socioeconomic Characteristics Associated with Health Disparities

Characteristics such as race or ethnicity, limited English proficiency, disabilities, sexual orientation, age, economic status and geographic location may affect one's ability to achieve good health. Unfortunately health data systems have not routinely collected sufficient

data to allow for the monitoring of the association between a characteristic such as limited English proficiency or economic status and health status or access to care.

The Patient Protection and Affordable Care Act passed in 2010 not only addresses access to care, but also addresses the need for improved data collection to identify significant health differences that often exist between segments of the population. As a result, the Office of Minority Health in the United States Department of Health and Human Services has released new minimum data standards for race/ethnicity, sex, primary language and disability status. Improved data collection will assist in efforts to prioritize affected populations and monitor efforts to reduce health disparities.

New Mexico's Population and Health Disparities

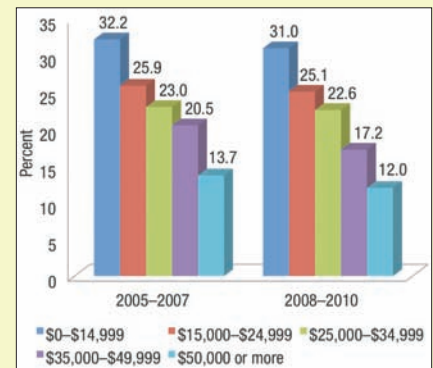
New Mexico's diverse population exhibits many of the social and economic characteristics associated with health disparities. New Mexico is a minority-majority state with Hispanics constituting the largest segment of the population (46.7% in 2011), followed by Whites at 40.2%. American Indians are the third largest population in New Mexico (10.1%) with African-Americans constituting 2.5% and Asians 1.6% of the

population. In addition 36% of the population over the age of four speaks a language other than English at home and nearly one-fifth of the population lives below the poverty level.

Tobacco Use and Economic Status

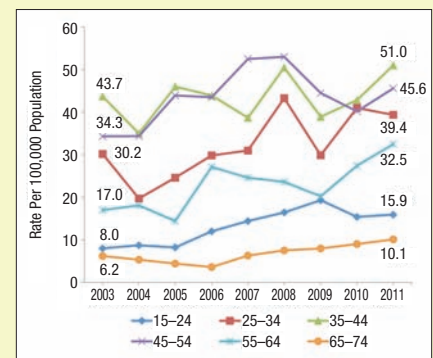
There is a clear association between economic status and smoking among adults both in New Mexico (Figure 1) and nationally. Low income adults have the highest rates which represents a reversal from the situation prior to the release of the first Surgeon General's Report

FIGURE 1. Adult Smoking by Income Level, NM, 2005–2010



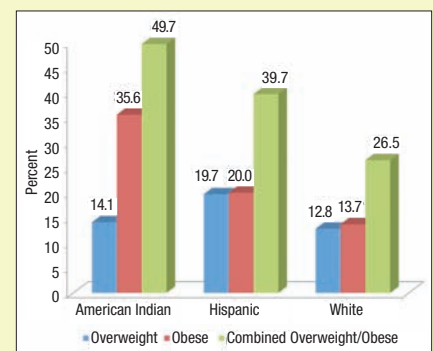
Source: NM Behavioral Risk Factor Surveillance System, NMDOH

FIGURE 2. Drug Overdose Death Rates by Age Group, NM, 2003–2011



Source: Death Certificate Database, Vital Records and Health Statistics, NMDOH

FIGURE 3. Percent of Third Grade Students Overweight and Obese by Race/Ethnicity, NM, 2011



Source: BMI Surveillance, NMDOH



All New Mexicans



actually decreasing but this decrease is not a positive trend because it is due to the fact that rates for all groups are increasing. The highest rates of drug overdose deaths are found among adults ages 35–44 followed by the age group adults 45–54 (Figure 2). These two age groups have rates more than four times that of the age group 65–74 and nearly three times that of youth ages 15–24.

Child and Youth Obesity and Race/Ethnicity

Obesity is an increasing problem nationally and in

New Mexico, where it is occurring among the very young, particularly in our American Indian children. Data from the Youth Risk and Resiliency Survey (YRRS) have indicated that obesity is a problem for American Indian youth as this group exhibits the highest obesity rates each survey. In 2010 New Mexico instituted an obesity surveillance system for elementary students and the results were similar to the data from the YRRS with White students having the lowest rates of obesity and American Indians having the highest rates. Nearly 1 of 2 American Indian children in the third grade in 2011 was overweight or obese compared to 1 of 4 White children (Figure 3).

on Smoking in 1964, at which time higher income individuals smoked more than lower income individuals.

Smoking rates have decreased at all income levels, but smoking rates for the lowest income group (\$0–14,999) were 2.6 times higher than for the highest income group (\$50,000 and above) during the 2008–2010 time period. One of the components associated with the higher smoking rates among low income individuals is that low income smokers are less likely to quit smoking than higher income smokers, which may be due to difficulty in accessing tobacco cessation materials and programs.

The 2010 Patient Protection and Affordable Care Act contains a number of provisions expanding access to tobacco cessation through requiring Medicaid and private health plans to offer cessation coverage.

Drug Overdose Deaths and Age

New Mexico has the second highest drug overdose death rate in the nation. Historically in New Mexico fatal overdoses have been linked to illicit drugs such as heroin and cocaine. Recently prescription drugs, particularly opioid pain relievers, have caused more overdose deaths. Drug overdose deaths are an example of an issue for which the differences between groups is

What's Being Done

- ☑ A standard set of small areas have been developed for New Mexico to provide health status information at the community level and better permit the study of the relationship between place and health disparity.
- ☑ The U.S. Office of Minority Health has released new minimum data standards for Race and Ethnicity, Sex, Primary Language, and Disability Status. Improved data will assist in efforts to target affected populations and to monitor efforts to reduce health disparities.
- ☑ By selecting a limited number of health priorities the Department of Health is better able to enlist partners in addressing persistent health disparities and targeting resources to the populations most affected by these issues.

What Needs to be Done

- ☐ More multi-sector and collaborative approaches are needed to address the underlying risk factors that contribute to health disparities.
- ☐ Improved dissemination of evidence-based and promising practices from state-level organizations to local communities for implementation in high-risk populations.
- ☐ Increasing Geographic Information System (GIS) capacity to allow for combining or layering data from various data systems in order to associate social, environmental or economic data with health outcomes or access to health services and more precisely identify populations experiencing disparities.



Many Environmental Factors Affect

A healthy environment is essential to the health of New Mexicans. Environmental health addresses the interaction between human health and the chemical, physical, and biological agents found in both our natural and human-made surroundings. The environment can include the indoor and outdoor air we breathe; water we use for drinking, cooking, and bathing; food we eat; products we use; buildings we work in; and recreational areas we use.

Determining Environmental Exposures

Exposure to many toxic substances can be determined through biological samples, such as blood, urine, or hair. As part of New Mexico's notifiable disease surveillance, laboratory reports that indicate exposure to mercury, arsenic, uranium, lead, pesticides, and nitrates are collected and investigated. Lead exposure, for example, can be determined through blood testing.

Lead comes from a variety of sources, including older lead-based paints, ceramics with lead-based glazes, some imported toys and jewelry, fishing weights and bullets. In recent years, the percent of children tested for lead has increased (from 3.5 % of children under age 6 years of age tested in 2006 to 8.5% of children tested in 2011) while the rate of children found to have high blood lead levels has fallen (from 2.2 children per 1,000 screened in 2006 to 1.9 per 1,000 screened in 2011).

The northwestern and southwestern regions of the state had the highest rates of elevated lead levels in young children. Even small amounts of lead can affect brain development in fetuses, infants, and children, while high levels in adults can cause high blood pressure and other health problems. Thus, the collection and analysis of lead testing data combined with case management for lead-poisoned children and adults are very important. One of the main challenges is getting physicians to comply with the mandatory requirement that all children receiving Medicaid be tested for lead.

Air Quality and Health

Particulate matter pollution refers to particles suspended in air, such as dust, dirt, soot and smoke, and little droplets of liquid. Some

particles are large or dark enough to be seen, like soot or dense smoke. Other particles are too small to be seen.

Air quality for the state is generally good, but some areas (e.g., parts of southern New Mexico and San Juan County) have relatively high levels of air pollutants. Industries adversely affecting air quality include power plants, oil and gas development, and confined animal feeding operations.

Short-term exposure to high particle pollution contributes to increased mortality from cardiovascular events and also can result in increased hospital admissions for several cardiovascular and pulmonary diseases, including heart attacks, congestive heart failure, stroke, asthma, and chronic obstructive pulmonary disease. The heart attack death rate is greatest in the northwestern and southeastern regions of the state and particle pollution may play a role.

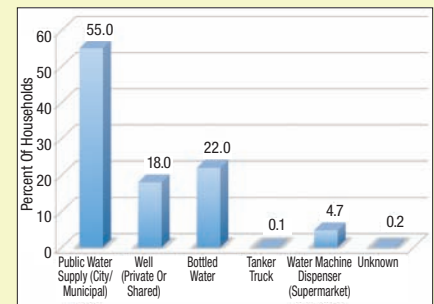
Long-term exposure to high levels of particle pollution can reduce overall life expectancy by a few years.¹ Research indicates exposure to air pollution can increase the rates of infant mortality.² Because there are not air quality monitors in every county, methods to forecast episodes of poor air quality including high ozone and dust concentrations are being developed. Air quality health advisories can then be developed to notify potentially affected communities so that they can take action to protect themselves.

Water Quality and Health

Polluted and unhealthy water can contribute to gastrointestinal illness, various cancers, birth defects, and developmental problems in children. Routine sampling and analysis of the state's water reveals that the quality is generally good, but problems can occur. One such problem arises from bacteriological contamination, which may lead to boil-water advisories. In 2011, there were eleven boil-water advisories issued by the New Mexico Environment Department's Drinking Water Bureau. When a boil-water advisory is issued, the Department of Health provides educational materials for the public and advises public health officials to be on alert for cases of gastrointestinal illness.

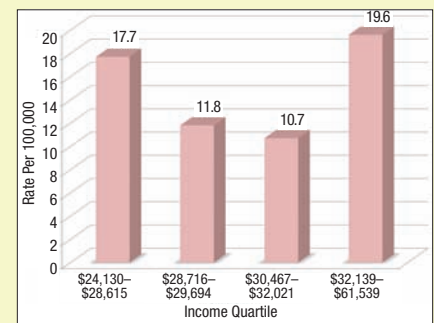
Nitrates from fertilizers, animal waste, or improperly maintained septic tanks can contaminate drinking water sources. Most of our drinking water (about

FIGURE 1. Main Source of Drinking Water, NM, 2007



Source: NM Behavioral Risk Factors Surveillance Survey, NMDOH

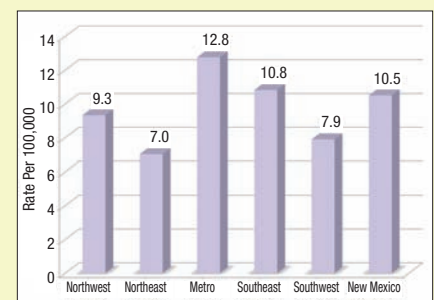
FIGURE 2. Asthma Hospitalization Rates Among Children (<15) by County Income, NM, 2010



Sources: Hospital Inpatient Discharge Database, NM Department of Health

Note: These data include hospital inpatient discharges where asthma is the first-listed diagnosis. They include state residents who were discharged from a non-federal hospital. Because many American Indians are admitted to federal IHS hospitals, they are not included in these rates.

FIGURE 3. Cleft Lip with or without Cleft Palate by Region, NM, 2008-2010



Source: NM Birth Defects Surveillance Database, NMDOH

Ability to be Healthy

90%) comes from groundwater; therefore, monitoring groundwater quality in New Mexico is important. An estimated 18% of state residents, or roughly 350,000 people, get their water from untested private wells (Figure 1).

Arsenic is one naturally-occurring contaminant of our groundwater. Exposure to high arsenic levels in drinking water is associated with bladder and other internal organ cancers. The relatively new Environmental Protection Agency (EPA) drinking water standard for arsenic of 10 ug/L requires that water systems modify their source water supplies and/or install arsenic removal technology, such as reverse osmosis. Exposure prevention measures continue to be promoted by creating and disseminating fact sheets and other educational materials among potentially exposed New Mexicans.

Homes and Health

Housing affects health both directly, through physical, chemical and biological exposures, and indirectly, through psychological effects. Young children spend about 70% of their time in homes, and elderly people are at home 90% of the time. Lower quality housing can increase asthma exacerbation, lead poisoning and radon and mold exposure.

Housing and health assessments determined the areas where resources should be focused. Health conditions included asthma hospitalizations and lead poisoning. Lea and Doña Ana counties had the most overlap of housing and health risk factors. For example, in Hobbs, 72% of all housing was built before 1979; therefore, there is a lead paint risk. Hobbs resides in Lea County, which had one of the highest rates of asthma emergency department visits among children under age 15. In Portales, 60% of renters are cost-burdened, indicating renters pay more than 30% of income toward rent. Colonias most at risk were along the Rio Grande Valley, in farming communities, and those outside the Las Cruces city limits.

Asthma

About 150,000 adults and 42,000 children in New Mexico had asthma in 2010. To reduce the burden of asthma we collect and analyze health surveillance data and work with partners to develop effective and sustainable public health actions.

One primary goal of state and local agencies, physician groups, and non-profit organizations is to reduce the rates of asthma emergency room visits, hospitalizations, and deaths in southeastern New Mexico where the rates are highest. Income plays a role in asthma hospitalizations among youth, where rates tend to decrease as per capita income increases, with the exception of the highest quartile (Figure 2). When the three southeastern counties with the highest asthma rates (Curry, Lea, Eddy) are removed from the highest income quartile, the rate decreases from 19.6 to 12.0 per 10,000 population.

Efforts to address these rates include increasing: 1) health care provider training on the latest National Heart, Lung, and Blood Institute asthma guidelines, 2) asthma education in elementary schools and, 3) indoor air quality education in grades K–12. The indoor air quality education components highlight potential asthma triggers on school campuses.

Tracking Environmentally-Related Disease

Linking environmental hazard or human exposure data with health data is needed to determine if and how the environment may affect health. Examples include the connections between air quality and asthma emergency room visits, or between arsenic levels in drinking water and bladder cancer incidence.

Prevalence rates for major birth defects have been tracked in New Mexico since 1998. For some birth defects, doctors and public health scientists know how they happen and in some cases they can help women prevent some of these.

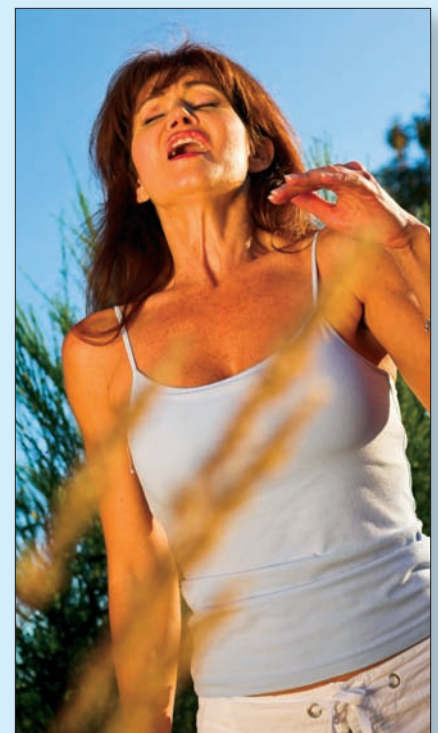
For many birth defects, however, there are no clear causes. It is likely that most birth defects happen for many reasons, not just one reason, and the environment might contribute. Differences in the prevalence of cleft lip with or without cleft palate by health region from 2008 to 2010 may be connected to a variety of risk factors, including air pollution (Figure 3). The Environmental Public Health Tracking website has been developed to disseminate this type of information to New Mexicans. This information can help residents avoid potentially harmful exposures.

What's Being Done

- Asthma self-management education in a clinical setting is being provided in order to reduce hospital admissions.
- The Environmental Public Health Tracking Web data query system has publicly available New Mexico environmental and health data and continues to be updated and expanded.
- Lead exposure is being assessed, and individuals with high blood lead levels receive education and home visits, if necessary with the goal of eliminating the source of exposure.

What Needs to be Done

- Increase collaboration to implement evidence-based asthma curricula in elementary schools
- Educate communities at risk for adverse environmental exposures so that they can protect themselves.
- Develop environmental health advisories, such as when increased ozone and dust concentrations occur.
- Increase evidence-based awareness of environmental conditions that may affect the health of New Mexicans through timely dissemination of data and information.



Healthy Workplaces Provide Benefits

Injuries and illnesses due to work are costly to workers, employers and society, both economically and in terms of human suffering. In New Mexico almost \$277 million or \$384 for each covered worker was paid out in benefits for workers' compensation insurance in 2010. This likely represents a fraction of the costs of work-related illness and injury as costs are shifted to insurance systems other than workers' compensation.

Furthermore, not all employees are covered by Workers' Compensation. Laws in New Mexico exclude employers with fewer than three employees, domestic workers; farm and ranch laborers and real estate salespersons are exempt from mandatory workers' compensation coverage. The average annual cost of worker compensation per worker has risen in both New Mexico and the United States but the gap between the cost per worker in New Mexico appears to be rising faster than for the U.S. overall (Figure 1).

Illnesses Due to Work

Since the passing of the Occupational Health and Safety (OSH) Act in 1970, diseases due to work exposures have decreased, but have not been eliminated. Many of the OSHA standards were passed within the first 10 years of the act but the pace of standards setting has decreased sharply in recent years. Only one standard (for

hexavalent chromium) has been established in the last 10 years.

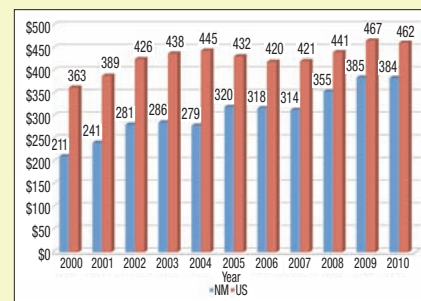
Certain occupational illnesses that are almost always associated with workplace exposure, such as coal workers pneumoconiosis (CWP) or mesothelioma, a rare cancer associated with asbestos exposure, are reportable to the NMDOH. In 2011, there were 15 persons discharged from New Mexico acute care hospitals with CWP (age-standardized rate of 9.2 per million NM residents over 16 years of age); 39 discharges with asbestosis (22.3/million); and 19 persons discharged from hospitals with silicosis (10.8/million).

According to the New Mexico Tumor Registry, there were 16 incident cases of mesothelioma in 2009, or an age standardized rate of 9.2 per million residents aged 15 and over. Other reportable occupational illnesses include hypersensitivity pneumonitis, noise-induced hearing loss, occupational asthma and occupational pesticide poisoning.

Non-Fatal Injuries on the Job

The United States Department of Labor, Bureau of Labor Statistics collects data annually from employers on occupational illness and injury, as recorded on OSHA 300 logs. This Annual Survey of Occupational

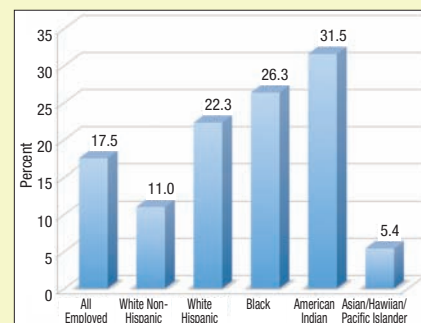
FIGURE 1. Workers' Compensation Costs, NM and US, 2000–2010



Source: Total amount and average benefits paid, National Academy of Social Insurance

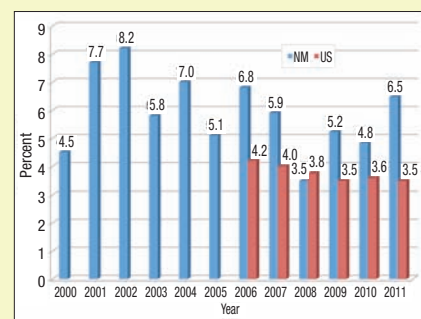
Note: All workers who are eligible for compensation should they sustain work-related injuries or illnesses are considered "covered" workers

FIGURE 2. Relative Percentage of Employment by Race in High-Morbidity Risk Occupations, NM, 2008–2010



Source: Bureau of Labor Statistics (BLS) Current Population Survey

FIGURE 3. Occupational Injury Death Rates, NM and US, 2000–2011



Sources: Deaths from BLS Census of Fatal Occupational Injury, Denominator from BLS Current Population Survey



for Everyone



Illness and Injury (SOII) is the basis of many of the health and safety statistics that are reported on workplaces in America. Injuries or illnesses with lengthy onsets or long latency periods, such as hearing loss and carpal tunnel syndrome, are less likely to be captured on OSHA logs and reported in the SOII than easily identifiable traumatic work injuries, such as lacerations or fractures. This is, in part, due to the timely nature of SOII data, which are collected shortly after the calendar year.

In 2010, private employers in New Mexico reported an estimated 5,540 traumatic injuries, or 1,098 per 100,000 FTEs, that required one day or more days away from work. Traumatic injuries comprised about 93% of all reported conditions, both illness and injury. The estimated rate for the U.S. overall was 1,007 per 100,000 FTEs.

According to the SOII, there were an estimated 60 amputations from work in New Mexico or 11 per 100,000 FTEs in 2010 while the rate for the US overall was 6 per 100,000. In 2012, the NMDOH added traumatic amputations and work-related burns requiring hospitalization to the list of notifiable conditions.

Disparities in Occupational Illness and Injury

In New Mexico, certain racial and ethnic groups are over-represented in occupations at high risk

for non-fatal occupational illness and injury (Figure 2). For example, 11.0% of Whites are employed in occupations at high risk for morbidity, but 31.5% of American Indians work in a high-risk occupation. Furthermore, many of these occupations, such as construction laborers, janitors, and home health aides, are in the lower end of the earnings bracket.

Occupations considered high-risk are those with at least twice the average rate of illness and injury and are based on Bureau of Labor Statistics “days away from work” cases and employment estimates for private sector workers for the year 2008 from the SOII.

Workplace Injury Fatalities

While the rate of occupational fatalities in New Mexico appears to be declining, New Mexico’s rate remains well above the US rate (Figure 3). In 2010 there were 38 deaths of which 31.6% were transportation-related. The second most frequent cause of death was homicide, comprising 26% of deaths; half of those were the five employees who died during the July 2010 shooting at Emcore in Albuquerque. Falls were noted as the cause in 15.8% of deaths. Construction was the single industry with the largest percentage of fatalities with 26% of deaths. The NMDOH added occupational injury fatality to the list of reportable conditions in 2012.

What’s Being Done

- ✓ Guidelines have been formulated for health care providers on occupational exposures, such as lead.
- ✓ Surveillance is focused on industries that national and state data indicate have high health hazards, such as healthcare.
- ✓ Collecting respondents’ occupation and industry in New Mexico health and behavior survey data.
- ✓ Partnering with employers and regulators to disseminate worker exposure prevention messages.

What Needs to be Done

- Improve dissemination of worker health and safety information to workers, employers and health care providers through website development.
- Continue cooperative efforts between state agencies and the National Institute of Occupational Safety and Health (NIOSH) on prevention programs.
- Evaluate occupational health programs to determine effectiveness.



Health Care Availability Essential to

In 1978, nearly all nations of the world signed the World Health Organization Declaration of Alma Ata,¹ proclaiming the right of all people to primary care. Primary care is defined as basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. In 2010, 34% of the total NM population resided in designated primary care Health Professional Shortage Areas (HPSA). All or part of thirty-one of the thirty-three counties were designated a primary medical HPSA.

Important health maintenance information and tools, such as mammograms, PAP tests, measurements of blood cholesterol, and many others, are only available through health care providers. For most individuals and families, the high cost associated with accessing health care can only be managed through some form of health care plan, be it private health insurance, employer-provided insurance, or some form of public-sponsored coverage such as Medicare.

Lack of health care coverage has been associated with delayed access to health care and increased risk of late stage diagnosis of chronic disease and mortality.² Individuals without health care coverage are much less likely than those with coverage to receive recommended preventive services, are less likely to have access to regular care by a personal physician, and are less able to obtain needed medication or health care services. Consequently, the uninsured are more likely to succumb to preventable illnesses, more likely to suffer complications from those illnesses, and are more likely to die prematurely.^{2,3}

The New Mexico Department of Health routinely monitors health care coverage. Throughout the past decade, New Mexicans were less likely than

those living in the rest of the country to have any form of health care coverage (Figure 1). Adults sixty-five years of age or more qualify for federally-sponsored Medicare. Nearly all adults in this age group have access to health care. In 2011, among children under the age of 19, 9.9% of New Mexico children and 9.4% of U.S. children were without any form of health care coverage.⁴ This represented an improvement over 2010 figures.

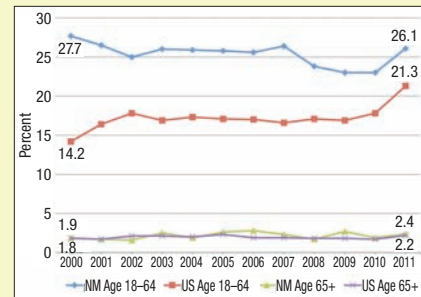
For each preventive measure or health screen, the percentage of adults who have received the given service varied by health care coverage status (Figure 2). For example, 69.7% of adults age 65 or older who had coverage had received the recommended pneumococcal vaccination while only 49.3% of those without coverage had received the vaccination. Adults who were covered by a health plan were significantly more likely to have received each form of potentially life-saving service by the recommended age and within the recommended time frame than those without coverage. In 2011, nearly forty-four percent (43.9%) of adults without coverage experienced a time in the previous 12 months in which they needed medical care but could not get it because of the cost, while cost prevented only twelve percent (12.2%) of adults with coverage from obtaining needed medical care.

Demographic Disparities in Accessing Health Care

Ideally, all individuals would have effective access to health care. However, access to health care varies by gender, race/ethnicity, education level, annual household income, employment status, and region of residence (Figure 3). In 2011, adult men were slightly less likely than adult women to have health care coverage (74.9% vs. 81.3%). However, cost was slightly more likely to have prevented adult women from getting necessary medical care during the previous year (20.3% vs. 18.0%). White (85.4%) and Asian or Native Hawaiian/Pacific Islander (92.0%) adults were more likely than American Indian (81.9%), Black or African American (74.1%), and Hispanic (67.7%) adults to have health care coverage. Hispanic adults were least likely of all racial/ethnic groups to have health care coverage.

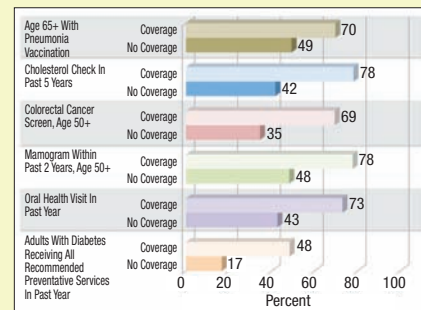
Adults with greater education levels or living in households with annual incomes of greater than \$20,000 were significantly

FIGURE 1. Lack of Healthcare Coverage Age 18–64 and 65+, NM and US, 2000–2010



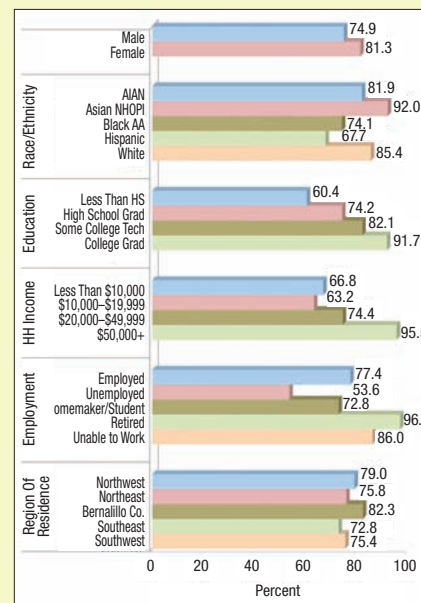
Source: NM Behavioral Risk Factor Surveillance System (BRFSS), NMDOH

FIGURE 2. Access to Important Preventive Health Care by Health Care Coverage Status, NM, 2010–2011



Source: NM Behavioral Risk Factor Surveillance System (BRFSS), NMDOH

FIGURE 3. Demographic Disparities in Health Care Coverage, NM, 2011



Source: NM Behavioral Risk Factor Surveillance System (BRFSS), NMDOH



Health Care Use



more likely to have health care coverage. At each level of completed education, the prevalence of health care coverage was significantly higher. Adults who were employed were significantly more likely to have coverage than adults who were unemployed (77.4% vs. 53.6%). Retired adults were most likely to have coverage (96.8%). Of course, most retired adults are 65 or older and qualify for Medicare.

Adults living in the southeastern region of New Mexico (72.8%) were significantly less likely to have coverage than adults living in other regions. Adults living in Bernalillo County (82.3%) had the highest coverage of any region.

Community-Based Primary Care

For more than 20 years, there has been an effort to build a system of community-based primary care centers for New Mexico's underserved. This has been a collaborative effort, linking federal, state, and local programs with community groups and non-profit agencies. The impact has been considerable; there are primary care centers in 97 communities serving more than 300,000 patients through more than 1 million visits each year. Roughly 88% of these patients have annual incomes below 200% of the Federal Poverty Level and approximately 43% are without any form of health care coverage.

Primary care centers are serving a significant portion of the unmet need in New Mexico, making clear the necessity of continuing to build the primary care center sector. Under the Federal Primary Care Cooperative Agreement, the Office of Primary Care & Rural Health (OPCRH) of the NMDOH will continue its work facilitating the expansion of primary care centers by providing support to the NM Primary Care Association and individual community groups and primary care centers seeking to initiate or expand

community-based primary care centers in underserved parts of the state. The OPCRH will develop and disseminate information about areas of highest need and will promote coordinated planning to meet local needs, including coordination between primary care centers, rural hospitals, local health councils and public health offices.

While the focus of these centers is on medical services, there is an increased emphasis on expansion of dental services in the primary care setting. Fewer than half of primary care clinic sites have dental service capacity. But even with this limited capacity, primary care centers provide more than 21% of all Medicaid dental services in New Mexico.

The community-based primary care sector in New Mexico is a major public health success story. Few other states have such a widespread system caring for such a large percentage of the state's underserved population.

Affordable Care Act

The recently approved Affordable Care Act (ACA) will have some important benefits for residents of New Mexico.⁵ ACA includes a small business tax credit designed to support small businesses in providing health care coverage to employees. An estimated 25,700 businesses in New Mexico will be eligible for this tax credit. Frequently, adults who retire early will lose employer-provided coverage but will be too young to receive coverage through Medicare. Through ACA, the Early Retiree Reinsurance Program will provide support to employers to ensure continuation of coverage of employees who retire early. ACA will allow children to be covered through their parent's plan through age 26. ACA makes available to New Mexico \$37.5 million to provide coverage for uninsured residents with pre-existing medical conditions through a new transitional high-risk pool.

Additionally, the ACA includes many consumer protections, including: elimination of lifetime limits on coverage; restrictions against denial of coverage based on pre-existing conditions; regulation of use of annual limits to coverage; requirement of appeals processes to ensure pathways to dispute denial of medical claims; and, increased flexibility in choice of physician.

See Indicator Maps and Charts section, page 48, for additional data.

What's Being Done

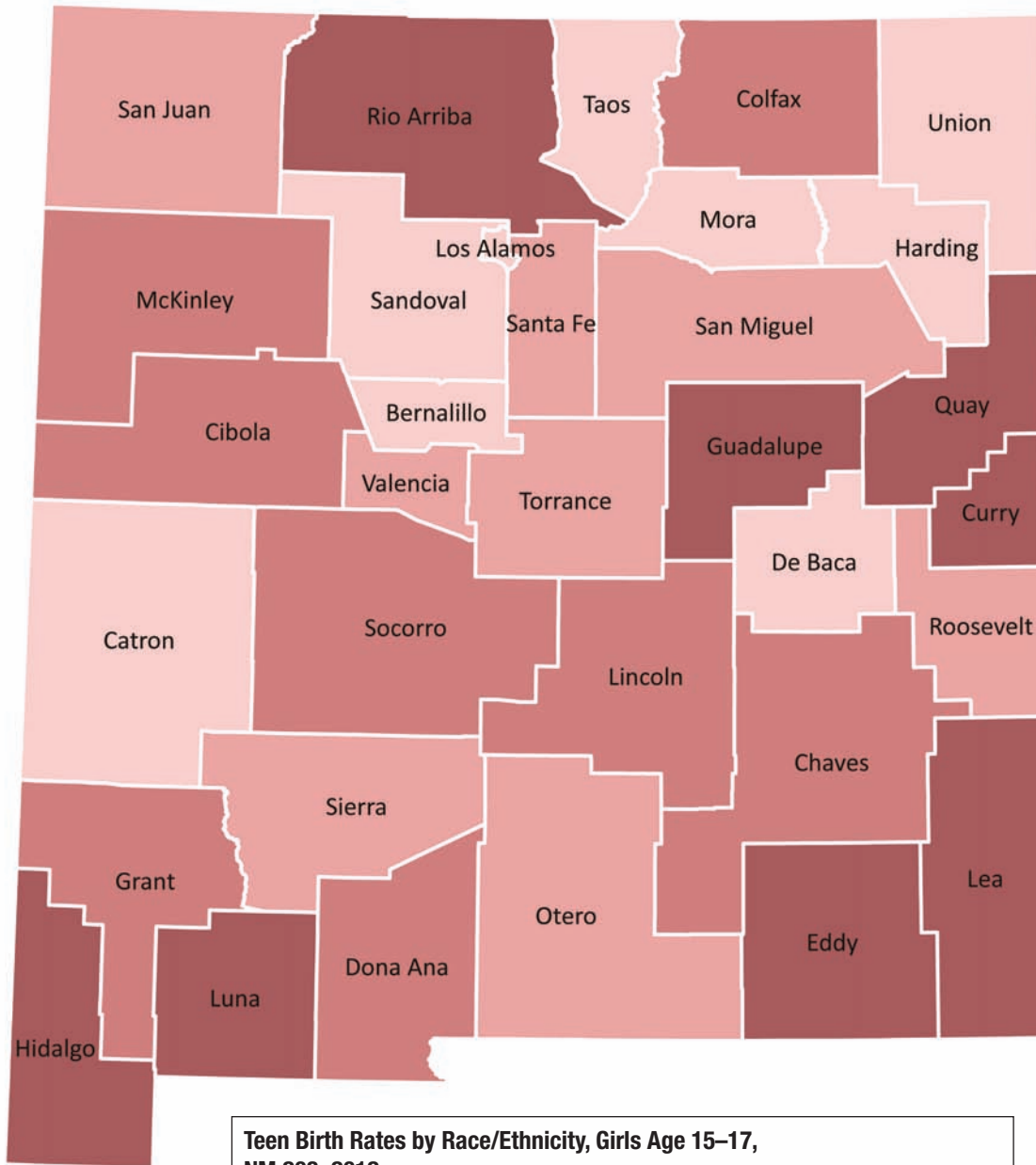
- Preparations are underway for the initiation of the new federal Affordable Care Act.
- \$1.38 million from U.S. Department of Health & Human Services to the NM Medical Insurance Pool to support coverage of those who have been denied coverage due to pre-existing conditions.
- Supplemental questions on health care access will be added to the 2013 New Mexico Behavioral Risk Factor Surveillance System to provide baseline data that will serve to assess the impact of the Affordable Care Act in future years.
- Planning assistance and low-interest loans are being given to community groups and agencies developing or expanding community-based primary care centers.
- Tax incentives and education loan repayment programs encourage medical professionals to settle and work in under-served areas.

What Needs to be Done

- Careful study of and integration of New Mexico primary care and other medical resources with the federal Affordable Care Act.
- Monitor distribution of medical professionals and services across the state to identify geographic areas of need.
- Expansion of primary care centers to meet the needs of more underserved people.
- Expansion of services provided by primary care centers to include dental services, behavioral health services, health promotion and disease prevention services, and chronic disease management.
- Continue, and expand, monitoring of access to and utilization of health care across the entire population of New Mexico.



Teen Birth Rate Girls Age 15–17, NM, 2008–2012



Teen Birth Rates by Race/Ethnicity, Girls Age 15–17, NM 2008–2012	
New Mexico, Overall	29.5
American Indian/Alaska Native	31.5
Asian/Pacific Islander	7.4
Black/African American	17.6
Hispanic/Latino	40.8
White	12.1

Number of births per 1,000 girls in the population

County	Births per 1,000 Girls Age 15–17
NM, Overall	29.5
Catron	0.0*
Los Alamos	5.0*
De Baca	12.1*
Union	15.6*
Sandoval	18.6
Mora	20.5*
Harding	22.0*
Bernalillo	22.8
Taos	23.9
San Miguel	24.2
Torrance	25.2
Otero	26.1
Santa Fe	26.1
Valencia	27.4
Sierra	29.9
San Juan	30.3
Roosevelt	30.4
McKinley	31.1
Colfax	31.3
Lincoln	34.1
Dona Ana	34.9
Chaves	36.8
Grant	37.1
Cibola	37.2
Socorro	37.3
Eddy	38.9
Rio Arriba	39.4
Hidalgo	40.6
Guadalupe	45.4
Curry	49.1
Quay	49.2
Lea	52.0
Luna	63.3

Source: Birth Certificate Data, Bureau of Vital Records and Health Statistics (BVRHS), New Mexico Department of Health. Population Data: Geospatial and Population Studies Program, University of New Mexico.

*Data are not stable and may not represent population risk.

This information on this page complements the **Maternal and Infant Health** chapter, page 10.

New Mexico Department of Health Family Planning Program, P.O. Box 26110, Santa Fe, NM 87502. Susan Lovett, Program Manager, (505) 476-8882, susan.lovett@state.nm.us. Kate Daniel, Epidemiologist, (505) 476-8890, katharine.daniel@state.nm.us.

Childhood Obesity Prevalence Trends NM, 2010–13

TABLE 1. Percentage of Students Overweight or Obese by Grade, NM, 2010–13

	Kindergarten				Third Grade			
	2010	2011	2012	2013	2010	2011	2012	2013
Obese	13.2%	15.0%	14.6%	13.7%	22.6%	21.9%	21.4%	19.9%
Combined Overweight/Obese	30.3%	30.5%	28.1%	27.7%	38.7%	38.6%	36.8%	34.7%
Number in Sample	1,800	1,885	2,116	3,928	1,642	1,768	1,833	3,803

TABLE 2. Percentage of Kindergarten Students Overweight or Obese by Race/Ethnicity, NM, 2010–13

	American Indian				Hispanic				White			
	2010	2011	2012	2013	2010	2011	2012	2013	2010	2011	2012	2013
Obese	25.5%	20.6%	23.8%	21.6%	12.9%	17.7%	14.2%	14.6%	8.8%	8.7%	11.8%	9.3%
Combined Overweight/Obese	41.0%	42.7%	36.8%	39.6%	31.8%	31.5%	29.2%	28.6%	24.8%	21.9%	22.1%	22.2%
Number in Sample	232	369	222	339	927	842	1,279	2,417	466	532	505	1,018

TABLE 3. Percentage of Third Grade Students Overweight or Obese by Race/Ethnicity, NM, 2010–13

	American Indian				Hispanic				White			
	2010	2011	2012	2013	2010	2011	2012	2013	2010	2011	2012	2013
Obese	36.6%	35.6%	30.0%	29.5%	22.6%	20.0%	22.7%	22.7%	17.8%	13.7%	15.2%	12.8%
Combined Overweight/Obese	55.4%	49.7%	50.0%	47.3%	39.4%	39.7%	39.3%	38.8%	31.7%	26.5%	26.5%	25.1%
Number in Sample	194	342	201	291	983	802	1,038	2,262	369	460	495	1,086

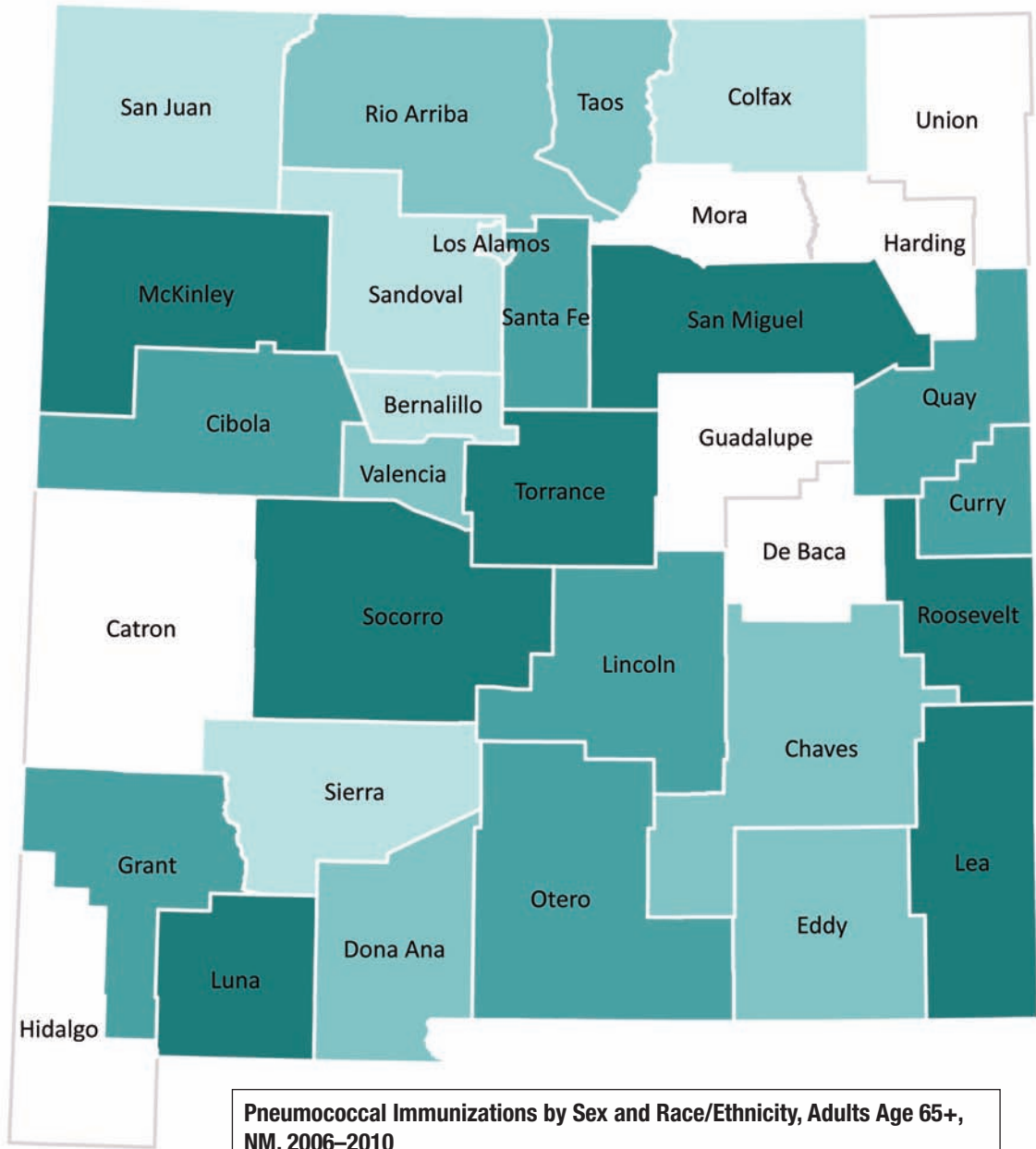
TABLE 4. Percentage of Students Overweight or Obese by Gender, NM, 2010–13

	Female				Male			
	2010	2011	2012	2013	2010	2011	2012	2013
Obese	16.8%	17.0%	15.4%	15.6%	19.0%	19.5%	20.3%	17.7%
Combined Overweight/Obese	33.6%	32.9%	29.9%	30.1%	35.4%	35.8%	34.6%	31.9%
Number in Sample	1,757	1,776	1,977	3,733	1,685	1,877	1,972	4,001

This information on this page complements the **Healthy Youth** chapter, page 12.

Healthy Kids New Mexico Community Transformation Program, NMDOH, Chronic Disease Bureau, Suite 800, Albuquerque, NM 87108. Katharine VonRueden, Program Epidemiologist, (505) 476-7624, Katharine.VonRueden@state.nm.us.

Adults Age 65+ Who Have Ever Had a Pneumonia Vaccination NM, 2006–2010



County	Percentage of Adults 65+
NM, Overall	66.0%
Los Alamos	73.9%
Sierra	72.5%
Bernalillo	71.5%
Sandoval	71.4%
Colfax	70.5%
San Juan	69.5%
Taos	68.4%
Valencia	67.5%
Eddy	66.6%
Rio Arriba	64.5%
Dona Ana	64.2%
Chaves	64.1%
Santa Fe	63.6%
Curry	62.0%
Grant	61.6%
Cibola	61.3%
Quay	60.8%
Otero	59.8%
Lincoln	59.1%
McKinley	59.0%
Socorro	58.4%
Luna	56.3%
Roosevelt	56.0%
Lea	54.5%
Torrance	54.4%
San Miguel	48.3%
Catron	**
De Baca	**
Guadalupe	**
Harding	**
Hidalgo	**
Mora	**
Union	**

Source: Behavioral Risk Factor Surveillance System survey data, New Mexico Department of Health, Injury and Behavioral Epidemiology Bureau.

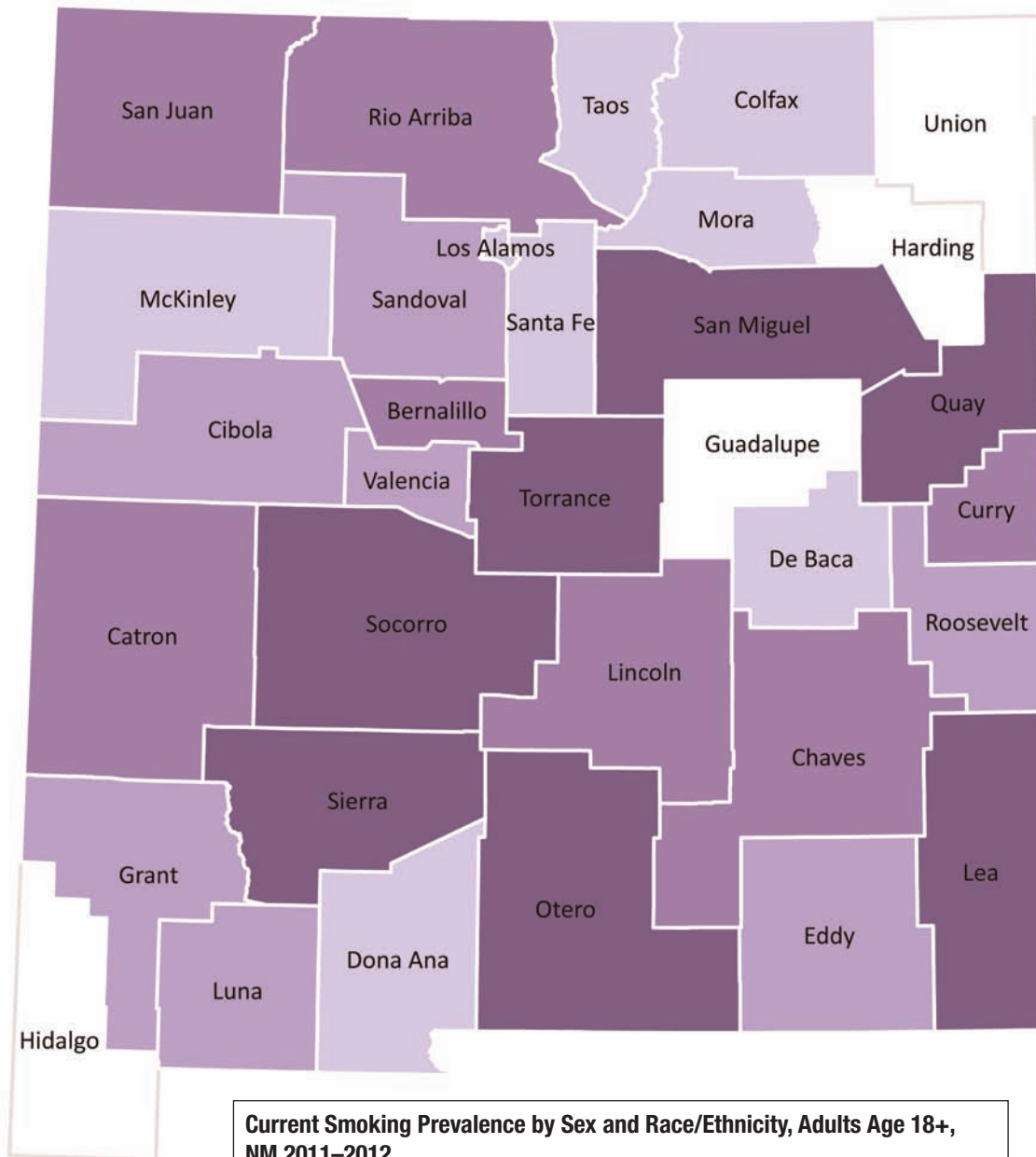
**Sample sizes were insufficient to generate reliable estimates.

**Sample size was insufficient to generate a reliable estimate.

This information on this page complements the **Infectious Diseases** chapter, page 18.

New Mexico Immunization Program, NMDOH, 1190 St. Francis Drive, S-1264, Santa Fe, NM 87505. Contact: Cynthia Rawn, MPH, (505) 827-0196, cynthia.rawn@state.nm.us. NM Immunizations Practices Advisory Council/Adult Immunization Coalition. Indicator Lead: Dan Burke (505) 827-2463, dan.burke@state.nm.us.

Adult Smoking Prevalence by County NM, 2011–2012



County	Percentage of Adults 18+
NM, Overall	20.4%
Los Alamos	11.8%
Taos	13.7%
McKinley	13.8%
Mora	15.2%
Colfax	15.5%
Santa Fe	16.8%
Dona Ana	17.0%
De Baca	17.4%
Sandoval	17.8%
Cibola	18.8%
Roosevelt	19.2%
Luna	19.7%
Grant	20.2%
Eddy	20.8%
Valencia	20.9%
Bernalillo	21.0%
San Juan	22.6%
Chaves	22.8%
Lincoln	23.0%
Curry	23.5%
Rio Arriba	23.5%
Catron	24.0%
Otero	24.7%
Socorro	24.8%
Lea	27.4%
Quay	27.6%
Sierra	28.8%
San Miguel	29.4%
Torrance	31.0%
Guadalupe	**
Harding	**
Hidalgo	**
Union	**

Current Smoking Prevalence by Sex and Race/Ethnicity, Adults Age 18+, NM 2011–2012	
Male	23.5%
Female	17.4%
New Mexico, Overall	20.4%
American Indian/Alaska Native	17.6%
Asian/Pacific Islander	16.4%
Black/African American	22.9%
Hispanic/Latino	19.2%
White	19.5%

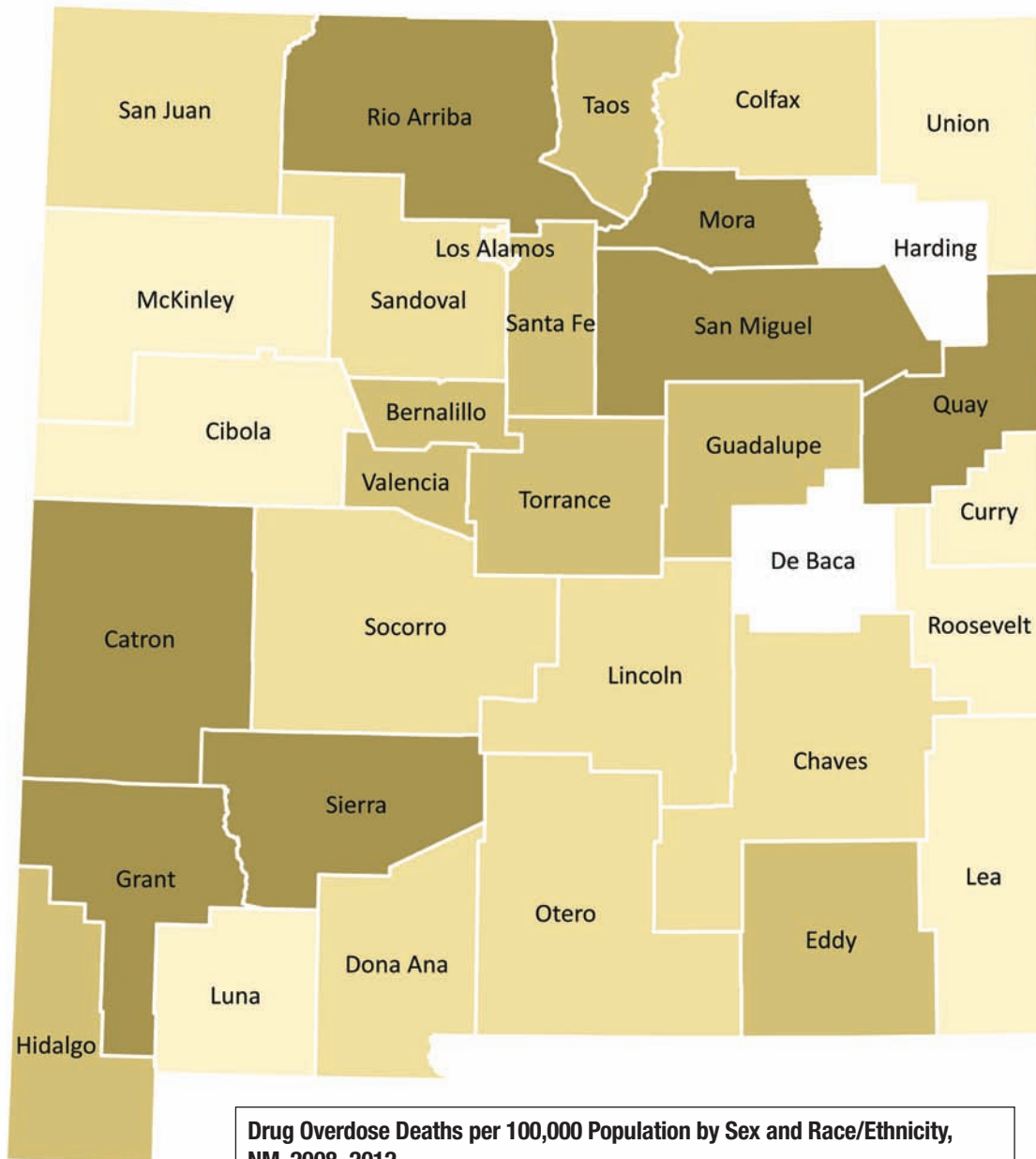
Source: Behavioral Risk Factor Surveillance System survey data, New Mexico Department of Health, Injury and Behavioral Epidemiology Bureau.

**Sample sizes were insufficient to generate reliable estimates.

This information on this page complements the **Tobacco Use** chapter, page 20.

Tobacco Use Prevention and Control Program, NMDOH, 5301 Central Ave NE, Suite 800, Albuquerque, NM 87108. James Padilla, Tobacco Program Epidemiologist, (505) 841-5839, james.padilla@state.nm.us.

Deaths Due to Drug Overdose NM, 2008–2012



County	Deaths per 100,000 Pop.
NM, Overall	24.3
Union	3.2*
Cibola	10.1
Curry	10.7
McKinley	13.8
Roosevelt	13.8
Luna	14.4
Los Alamos	15.8
Lea	15.9
San Juan	18.1
Dona Ana	18.6
Sandoval	18.7
Otero	22.0
Chaves	22.2
Lincoln	22.4
Socorro	22.8
Colfax	23.6
Torrance	24.7
Valencia	24.7
Santa Fe	25.1
Eddy	25.9
Guadalupe	26.0*
Bernalillo	28.9
Hidalgo	29.4*
Taos	29.7
Grant	31.2
San Miguel	33.6
Quay	37.2
Sierra	40.0
Catron	42.5*
Mora	61.0
Rio Arriba	67.7
De Baca	**
Harding	**

Male	29.6
Female	18.9
New Mexico, Overall	24.3
American Indian/Alaska Native	14.2
Asian/Pacific Islander	7.3
Black/African American	20.3
Hispanic/Latino	25.4
White	25.2

Age adjusted to the U.S. 2000 standard.

Source: Death Certificate Data, Bureau of Vital Records and Health Statistics (BVRHS), New Mexico Department of Health. Population Data: Geospatial and Population Studies Program, University of New Mexico.

Age adjusted to the U.S. 2000 standard

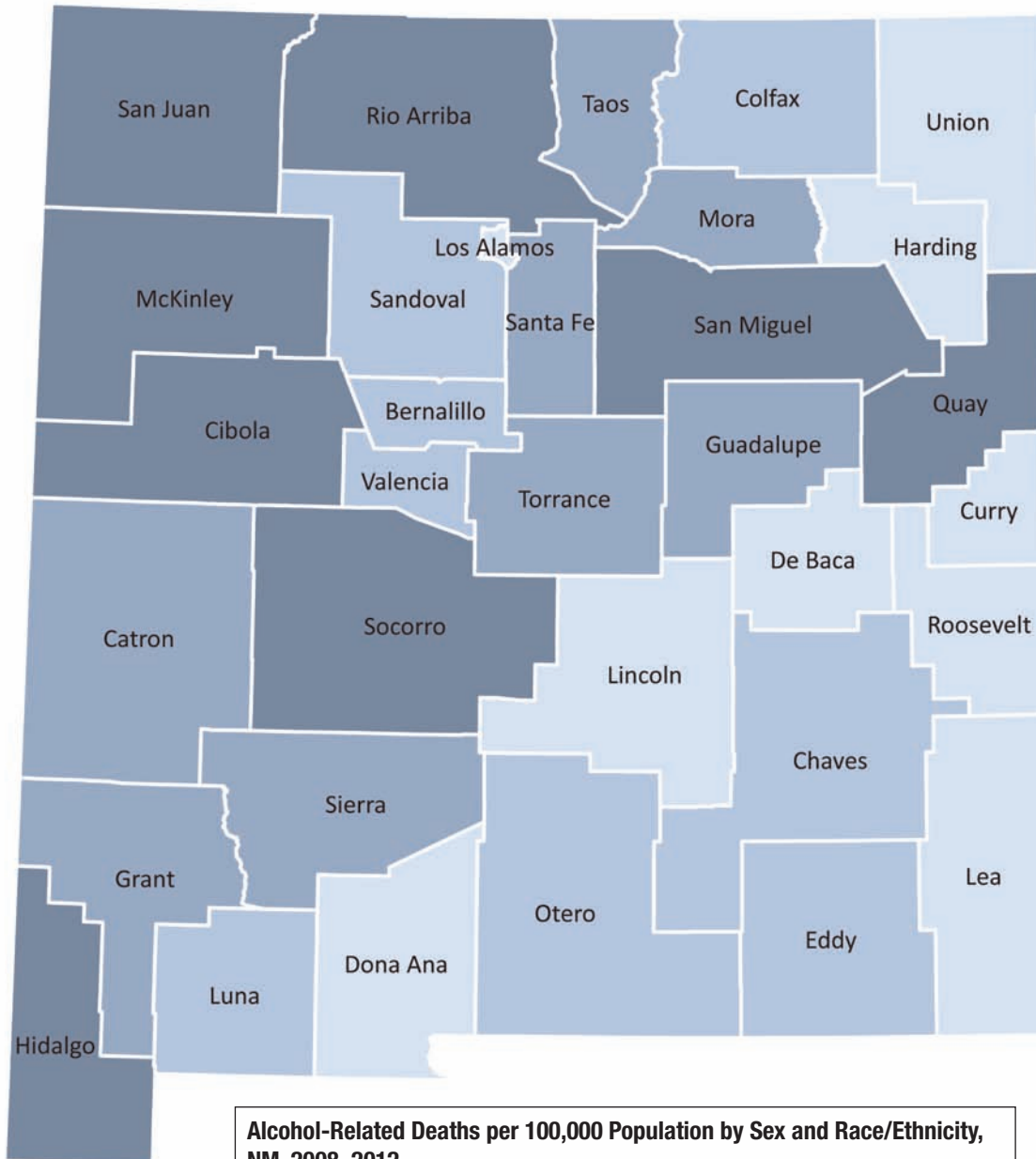
*Data are not stable and may not represent population risk.

**Population size and number of deaths were insufficient to generate reliable estimates.

This information on this page complements the **Substance Abuse** chapter, page 22.

Substance Abuse Epidemiology, Epidemiology and Response Division, NMDOH, 1190 St. Francis Dr., Room N-1103, Santa Fe, NM, 87502. Contact Laura Tomedi, Alcohol Epidemiologist, (505) 476-1757 or Laura.Tomedi@state.nm.us. Injury Prevention Program, Melissa Heinz, (505) 476-3541, melissa.heinz-bennett@state.nm.us. Hepatitis Harm Reduction Program Manager, Dominick V. Zurlo, (505) 827-2507, Dominick.Zurlo@state.nm.us.

Alcohol-Related Deaths NM, 2008–2012



County	Deaths per 100,000 Pop.
NM, Overall	52.3
Harding	8.9*
Los Alamos	25.8
Roosevelt	30
Union	32.6*
Lincoln	34.3
Curry	35.4
Dona Ana	36.4
Lea	39.7
De Baca	40.1*
Luna	42.8
Sandoval	43.4
Eddy	44.9
Otero	45.4
Colfax	46.5
Bernalillo	49
Valencia	50.4
Chaves	51
Santa Fe	52.8
Guadalupe	53.7
Catron	55.4*
Mora	55.6
Grant	56
Sierra	57.1
Torrance	57.5
Taos	61.7
Hidalgo	63.4
San Juan	68.8
San Miguel	70.9
Socorro	76.2
Cibola	76.9
Quay	80.5
McKinley	110.3
Rio Arriba	116

Alcohol-Related Deaths per 100,000 Population by Sex and Race/Ethnicity, NM, 2008–2012	
Male	75.6
Female	30.2
New Mexico, Overall	52.3
American Indian/Alaska Native	120.1
Asian/Pacific Islander	14.6
Black/African American	36.3
Hispanic/Latino	53.0
White	41.1

Age adjusted to the U.S. 2000 standard.

Source: Death Certificate Data, Bureau of Vital Records and Health Statistics (BVRHS), New Mexico Department of Health. Population Data: Geospatial and Population Studies Program, University of New Mexico. Attributable fractions: CDC ARDI, SAES.

Age adjusted to the U.S. 2000 standard

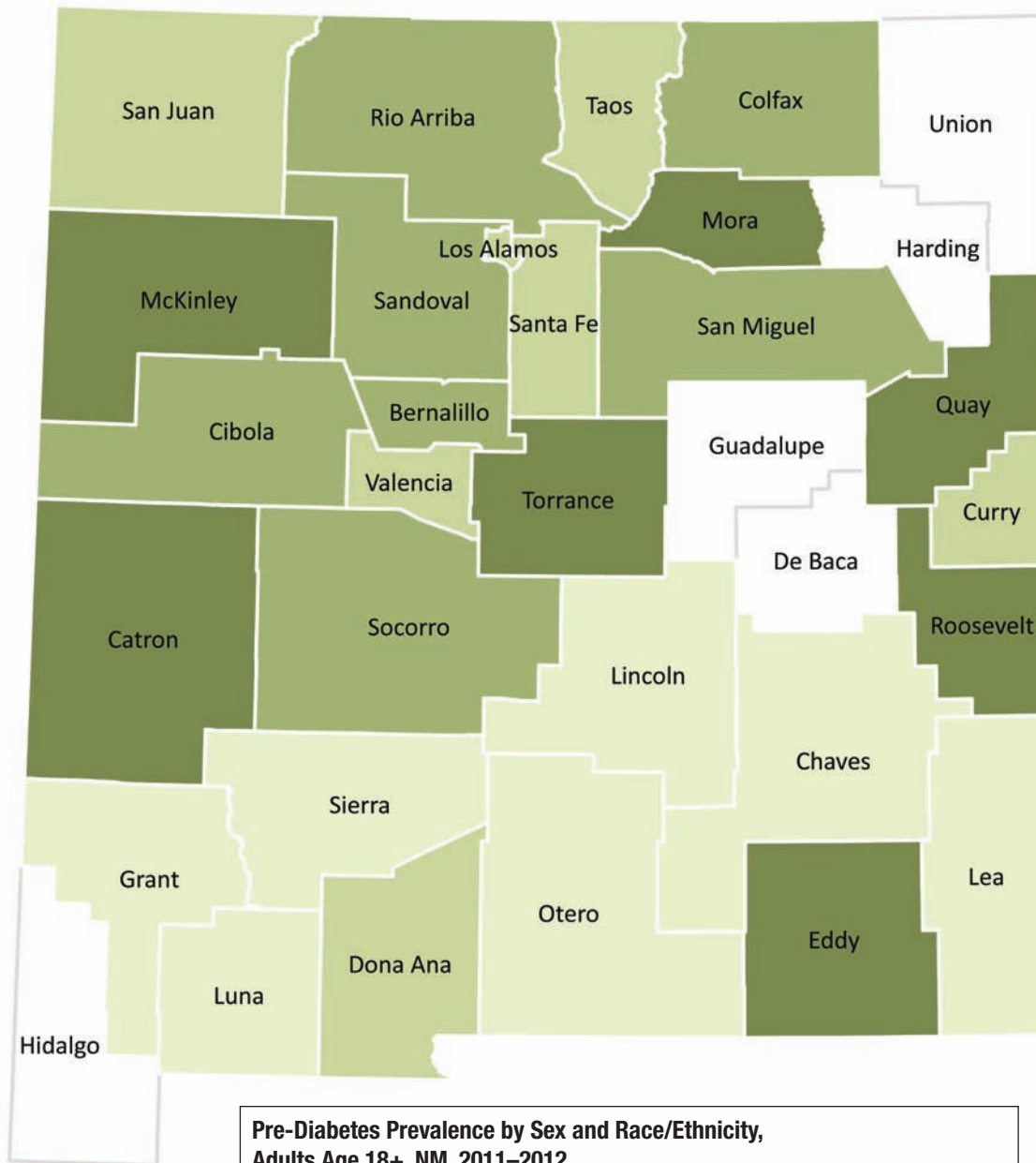
*Data are not stable and may not represent population risk.

This information on this page complements the **Substance Abuse** chapter, page 22.

Substance Abuse Epidemiology, Epidemiology and Response Division, NMDOH, 1190 St. Francis Dr., Room N-1103, Santa Fe, NM, 87502.

Contact Laura Tomedi, Alcohol Epidemiologist, (505) 476-1757 or Laura.Tomedi@state.nm.us.

Diagnosed Pre-Diabetes Prevalence NM, 2011–2012



County	Percentage of Adults 18+
NM, Overall	7.7%
Luna	2.8%*
Sierra	3.7%*
Lincoln	4.8%*
Lea	5.9%
Otero	6.3%
Grant	6.5%
Chaves	6.6%
Taos	6.7%
Santa Fe	6.8%
Curry	6.9%
San Juan	7.3%
Dona Ana	7.6%
Los Alamos	7.7%
Valencia	7.7%
Bernalillo	7.8%
Socorro	7.8%*
San Miguel	8.1%
Sandoval	8.5%
Colfax	8.5%
Cibola	8.9%
Rio Arriba	9.2%
Catron	9.5%*
Torrance	9.9%
Roosevelt	10.1%
McKinley	10.2%
Quay	11.1%*
Eddy	13.2%
Mora	17.3%*
Harding	**
DeBaca	**
Union	**
Guadalupe	**
Hidalgo	**

Male	8.0%
Female	7.4%
New Mexico, Overall	7.7%
American Indian/Alaska Native	12.5%
Asian/Pacific Islander	6.3%*
Black/African American	10.5%*
Hispanic/Latino	8.7%
White	6.3%

Age adjusted to the U.S. 2000 standard.
*Data are not stable and may not represent population risk.

Source: Behavioral Risk Factor Surveillance System survey data, New Mexico Department of Health, Injury and Behavioral Epidemiology Bureau.

Age adjusted to the U.S. 2000 standard.

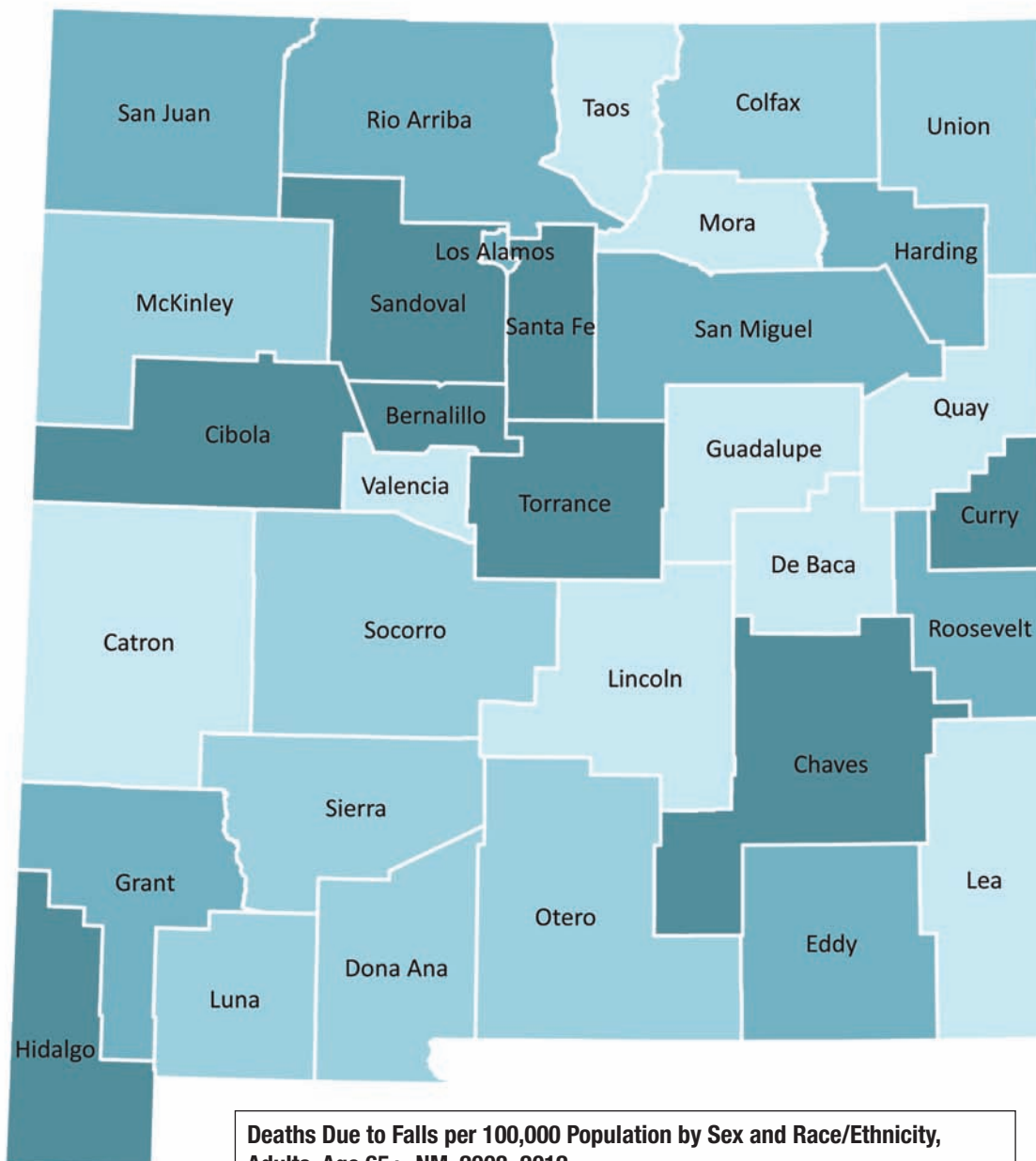
*Data are not stable and may not represent population risk.

**Sample sizes were insufficient to generate reliable estimates.

This information on this page complements the **Chronic Disease** chapter, page 24.

Diabetes Prevention and Control Program, NMDOH, 810 W. San Mateo Road, Suite 200E, Santa Fe, NM 87505, Judith Gabriele, Program Manager, (505) 476-7613 judith.gabriele@state.nm.us; Corazon Halasan, Epidemiologist, (505) 476-7617 corazon.halasan@state.nm.us. Toll free: 1 (888) 523-2966

Fall-Related Deaths Among Adults 65+ Years of Age NM, 2008–2012



County	Deaths per 100,000 Pop.
NM, Overall	93.7
Valencia	0*
Catron	19.1*
De Baca	42.6*
Quay	42.6*
Mora	43.4*
Lincoln	44.1*
Guadalupe	54.8*
Lea	56.8
Taos	59.7
Socorro	62.7*
Otero	66.2
Union	69.1
Dona Ana	76
Luna	77.1
McKinley	77.6
Colfax	79.4*
Sierra	81
San Miguel	84.2
San Juan	87.6
Grant	88.2
Eddy	91.6
Rio Arriba	94.4
Harding	96.3*
Roosevelt	100.6
Los Alamos	103.3
Curry	104
Sandoval	105.1
Cibola	108.4
Santa Fe	110.4
Bernalillo	111.3
Chaves	121.8
Torrance	136.2
Hidalgo	146.1*

Male	88.9
Female	97.6
New Mexico, Overall	93.7
American Indian/Alaska Native	81.8
Asian/Pacific Islander	23.3*
Black/African American	37.1*
Hispanic/Latino	76.9
White	105.4

*Data are not stable and may not represent population risk.

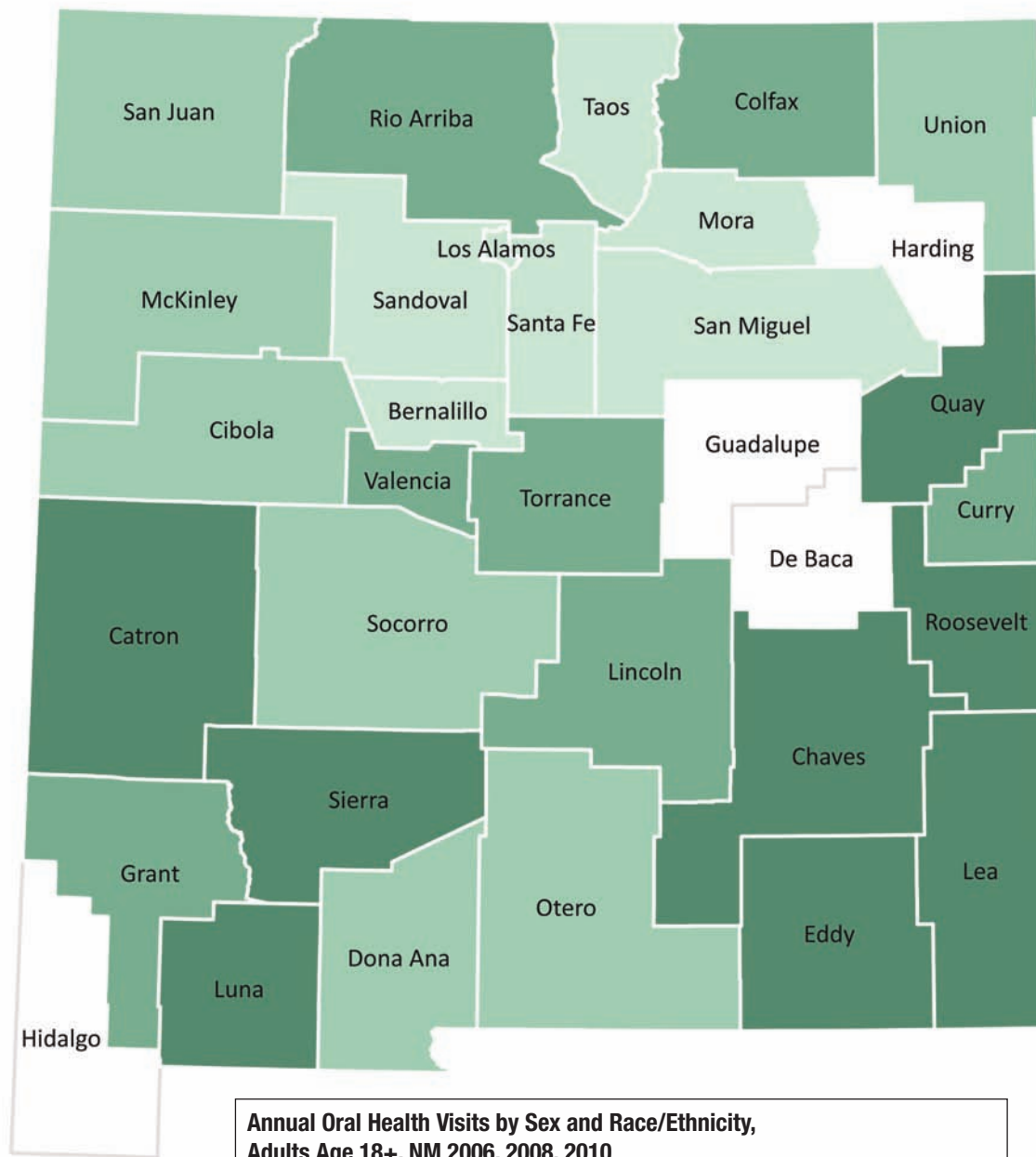
Source: Death Certificate Data, Bureau of Vital Records and Health Statistics (BVRHS), New Mexico Department of Health. Population Data: Geospatial and Population Studies Program, University of New Mexico.

*Data are not stable and may not represent population risk.

This information on this page complements the **Unintentional Injury** chapter, page 26.

Injury Epidemiology Unit, Epidemiology and Response Division, NMDOH, 1190 St. Francis Dr., Room N1105, P.O. Box 26110, Santa Fe, NM, 87502. Contact Glenda Hubbard, Epidemiologist, (505) 476-3607 or Glenda.Hubbard@state.nm.us.

Adults Who Had a Dental Visit in the Past 12 Months NM, 2006, 2008, 2010



County	Percentage of Adults 18+
NM, Overall	66.0%
Los Alamos	84.4%
Santa Fe	72.3%
Bernalillo	71.2%
Sandoval	70.3%
Mora	68.1%
San Miguel	67.4%
Taos	64.8%
Socorro	64.5%
Otero	64.4%
Dona Ana	64.1%
McKinley	64.1%
San Juan	63.3%
Cibola	62.9%
Union	62.7%
Lincoln	62.6%
Colfax	62.5%
Rio Arriba	61.8%
Valencia	61.6%
Grant	61.1%
Torrance	60.7%
Curry	60.2%
Eddy	58.6%
Sierra	57.3%
Lea	56.1%
Chaves	54.3%
Luna	51.3%
Catron	51.0%
Quay	49.5%
Roosevelt	49.1%
De Baca	**
Guadalupe	**
Harding	**
Hidalgo	**

Male	63.9%
Female	68.1%
New Mexico, Overall	66.0%
American Indian/Alaska Native	63.4%
Asian/Pacific Islander	72.3%
Black/African American	62.0%
Hispanic/Latino	60.6%
White	70.2%

Source: Behavioral Risk Factor Surveillance System survey data, New Mexico Department of Health, Injury and Behavioral Epidemiology Bureau.

**Sample sizes were insufficient to generate reliable estimates.

This information on this page complements the **Access to Health Care** chapter, page 38.

Office of Oral Health, NMDOH, Health Systems Branch, 1190 St. Francis Drive, Room 1054-B, P.O. Box 26110, Santa Fe, New Mexico 87502. Contact Rudy F. Blea, Telephone: (505) 827-0837, Cell: (505) 795-3260, FAX: (505) 827-0021, Email: rudy.blea@state.nm.us. Website: www.health.state.nm.us/PHD/OOH/.

New Mexico Department of Health

Harold Runnels Building
1190 S. St. Francis Drive
Santa Fe, NM 87505
505-827-2613
<http://nmhealth.org>

Public Health Offices and Clinics

New Mexico Department of Health has 57 public health offices throughout the state. For a complete list of public health offices and services provided, please visit <http://nmhealth.org/location/public/>, or call your regional health office.

Northeast Regional Office

(Rio Arriba, Taos, Colfax, Union, Los Alamos, Santa Fe, Mora, San Miguel, Guadalupe, and Harding Counties)

605 Letrado Street
Santa Fe, NM 87505
505-476-2600

Northwest Regional Office (Midtown)

(San Juan, McKinley, Cibola, Bernalillo, Sandoval, Torrance, and Valencia Counties)

2400 Wellesley Dr NE
Albuquerque, NM 87107
505-841-4100

Southeast Regional Office

(Quay, De Baca, Curry, Lincoln, Roosevelt, Chaves, Eddy, and Lea Counties)

9 East Challenger Street
Roswell, NM 88203
575-347-2409

Southwest Regional Office

(Catron, Socorro, Grant, Sierra, Hidalgo, Luna, Doña Ana and Otero Counties)

1170 N. Solano Drive
Las Cruces, NM 88001
575-528-5001

Community Health Councils

New Mexico has 38 community health councils (33 county and 5 tribal) that work locally to assess health status and implement health improvement activities. For more details and information on how to join your local community health council, please contact your regional health office.

DOH Online Resources

Tobacco quit line and web resources.
Call 1-800-QUIT NOW or visit
<http://www.quitnownm.com/>

ACT-New Mexico: Services for adults with intellectual and developmental disabilities.
<http://actnewmexico.org>

Indicator-based Information System (NM-IBIS). For data and information on New Mexico's priority public health issues.
<http://ibis.health.state.nm.us>

Environmental Public Health Tracking System (NM-Tracking). For data and information on New Mexico's environment and related health outcomes.
<https://nmtracking.org>

New Mexico Statewide Immunization Information System (NMSIIS). New Mexico immunization registry for children and adults.
<https://nmsiis.health.state.nm.us>

Frequently-Requested Phone Numbers

Immunization

Information on schedules and locations.
866-681-5872 (Toll Free)

Birth and Death Certificate Requests

Request a birth or death certificate.
866-534-0051 (Toll Free)

Epidemiology

Available 24/7 to report notifiable conditions, public health concerns or incidents.
505-827-0006 (Local)

Nurse Advice

Access to a RN 24 hours a day, 365 days a year.
877-725-2552 (Toll Free)

Poison Control

Call 24/7 for poison emergencies and questions.
800-222-1222 (Toll Free)

Mental Health

Call about a crisis, stress, anger, loneliness, etc.
866-HELP-1-NM (Toll Free)

Children, Youth and Families

Child abuse/neglect, child care, domestic violence.
800-797-3260 (Toll Free)
505-841-6100 (Local)

Community Partners

The New Mexico Dept of Health wishes to thank our community partners who have attended statewide and regional planning sessions throughout New Mexico and contributed to our state health assessment and improvement plan.

Statewide Stakeholder Planning Meeting, December 9, 2011

Community Partners

Mary Altenberg, Oral Health Advisory Council, Albuquerque
 Daniel Armistead, La Clinica de Familia, Las Cruces
 Charles Baumgart, Presbyterian Health Plan, Albuquerque
 Karen Cheman, HSD, Behavioral Health Supports Division, Santa Fe
 Sheila Conneen, NM Review Assn (NMMRA), Albuquerque
 Sally M. Davis, UNM, Prevention Research Center, Albuquerque
 Kathy Davis, Presbyterian Medical Services, Albuquerque
 Gerri K. Dupree, Children, Youth and Families Department, Santa Fe
 Anne Foster, HSD, Behavioral Health Supports Division, Santa Fe
 Shelly Fritz, NM Dental Association, Albuquerque
 Jesus Galvan, Delta Dental New Mexico, Albuquerque
 Trish Garduño, NM Hospital Association, Albuquerque
 Joie Glenn, NM Association for Home and Hospice Care, Albuquerque
 Eileen Goode, NM Primary Care Association, Albuquerque
 Vanessa Gutierrez, Rescue Social Change Group, Albuquerque
 Steve C. Hansen, Presbyterian Medical Services, Santa Fe
 Emily Kaltenbach, NM Drug Policy Alliance, Santa Fe
 Barbara Kastner, National Dance Institute, New Mexico, Santa Fe
 Sonja Koukel, NMSU Extension Service, ACES College, Las Cruces
 Richard Kozoll, MD, MPH, Family Practice, Cuba
 Charm Lindblad, NM Health Care Takes On Diabetes, Albuquerque
 Liza Luboff, Dept of Finance and Administration, Santa Fe
 Shelley Mann-Lev, Underage Drinking Prevention Alliance, Santa Fe
 Tony Martinez, Molina Healthcare of NM, Albuquerque
 Daniel Mirabal, Mira Consulting, Inc., Albuquerque
 Patricia Montoya, Aligning Forces for Quality, NMMRA, Albuquerque
 Mark Moores, NM Dental Association, Albuquerque
 Michael Moxey, NM Dental Association, Albuquerque
 Patsy Nelson, Alliance for School Based Healthcare, Albuquerque
 Forrest Olson, Hidalgo Medical Services, Lordsburg
 Lore Pease, El Centro Family Health, Española
 Anna Pentler, NM Immunization Coalition, UNM-HSC, Albuquerque
 Carol Pierce, Public Health Consultants, Albuquerque
 Edna Reyes-Wilson, Children, Youth and Families Dept, Santa Fe
 Sylvia Ruiz, Teen Pregnancy Coalition, Albuquerque
 Carolyn Salazar, Envision New Mexico, Albuquerque
 Jessica Tafoya, Teen Pregnancy Coalition, Albuquerque
 Cesar Uriarte, Children, Youth and Families Department, Santa Fe
 Retta Ward, Aging and Long-Term Services Department, Santa Fe
 Glenn Wieringa, TSB/DOT, Santa Fe
 Bill Wiese, RWJF Center for Health Policy, UNM, Albuquerque
 Michael Young, NMSU, Las Cruces

DOH Staff

Shannon Barnes, PHD, Family Health Bureau, Santa Fe
 Vonnel Bettencourt, PHD, Chronic Disease Bureau, Santa Fe
 Rudy Blea, PHD, Health Systems Bureau, Oral Health, Santa Fe
 Frieda Gonzales, ERD, Injury and Behavioral Epi Bureau, Santa Fe
 Dom Cappello, ERD, Injury and Behavioral Epi Bureau, Santa Fe

Christina Carillo y Padilla, PHD, Health Systems Bureau, Albuquerque
 Yolanda Cordova, PHD, School/Adolescent Health, Albuquerque
 Jane Cotner, PHD, Infectious Disease Bureau, Santa Fe
 Connie Dixon, Region 1/PHD, Albuquerque
 Maggi Gallaher, PHD, Director's Office, Santa Fe
 Lois Haggard, ERD, Community Health Assessment, Santa Fe
 Corazon Halasan, PHD, Chronic Disease Bureau, Santa Fe
 Vicky Howell, DOH, Ofc of Policy and Accountability, Santa Fe
 Michael Landen, ERD, Deputy Division Director, Santa Fe
 Beth Leopold, PHD, Office of Policy and Performance, Santa Fe
 Susan Lovett, PHD, Family Health Bureau, Santa Fe
 Emelda Martinez, PHD, Family Health Bureau, Albuquerque
 Jerry Montoya, Region, PHD, Northwest Region Santa Fe
 Patty Morris, PHD, Office of Nutrition and Physical Activity, Santa Fe
 Rachel O'Connor, ERD, Injury and Behavioral Epi Bureau, Santa Fe
 Jane Peacock, PHD Director's Ofc, Santa Fe
 James Padilla, PHD, Chronic Disease Bureau, Albuquerque
 LeeAnn Roberts, PHD, Health Systems Bureau, Santa Fe
 Jim Roeber, ERD, Injury and Behavioral Epi Bureau, Santa Fe
 Toby Rosenblatt, ERD, Injury and Behavioral Epi Bureau, Santa Fe
 Catherine D. Torres, DOH Health Secretary, Santa Fe
 David Vigil, PHD, Chronic Disease Bureau, Albuquerque
 Tres Schnell, DOH, Office of Policy and Accountability, Santa Fe
 Mack Sewell, ERD, Division Director, Santa Fe
 Wally Vette, DOH, Deputy Director, Santa Fe
 Amy Wilson, PHD, Chronic Disease Bureau, Santa Fe
 Cathy Stevenson, DDS Director, Santa Fe

Southeast Region Turn the Curve on Health, New Mexico, April 24, 2012

Community Partners

Beverly Allen-Ananins, Senator Tom Udall's Office, Carlsbad
 Jane Batson, Eastern NM University (ENMU), Region, Roswell
 Paula Camp, Healthy Kids Chaves County, Roswell
 Patty Collins, Van Hecke Consulting, Hobbs
 Tamara Fresquez, Healthy Kids Chaves County, Roswell
 Carl Guillermo, Carlsbad Coalition, Carlsbad
 Giselle Keyes, ENMU, Region, Roswell
 McKensie Montgomery, ENM Medical Center, Roswell
 Kerry Moore, Roswell Independent School District, Roswell
 Judy Stubbs, Community, Roswell
 Diane Ventura, Senator Jeff Bingaman's Office, Roswell
 Kim Wheeler, United Way of Lea County, Hobbs

Regional DOH Staff

Margie Blatnik, DOH, Southeast Region WIC, Clovis
 Amy Castro, DOH-CMS R4 (Local), Carlsbad
 Kate Daniel, DOH, Northeast Region (local), Santa Fe
 Dyan Ellington, DOH, Southeast Region, Roswell
 Susan Gonzales, DOH, Northeast Region, Santa Fe
 Gayla Jaquess, DOH, Southeast Region, Clovis
 Shanna Lara, DOH, Southeast Region WIC, Roswell
 Jeff Lara, DOH, Southeast Region Director, Roswell
 Andrea Carol Larez, DOH, Southeast Region, Roswell
 Tracey Luna, DOH, Southeast Region, Roswell
 Kevin McCormack, DOH-CMS R4, Roswell
 Delia Mendoza, DOH, Southeast Region OSAH, Roswell
 Carol L. Morgan, DOH-Southeast Region, Portales

Julie Morrow, DOH, Southeast Region, Roswell
Sharon Priller, DOH, Southeast Region, Hobbs
Rebecca Trujillo, DOH, Southeast Region, Roswell
Debbie Vail, DOH, Southeast Region, Roswell

Northwest Region Turn the Curve on Health, New Mexico, May 9, 2012

Community Partners

Sandra Adondakis, Cancer Action Network, Albuquerque
Barbara J. Alvarez, NM Indian Affairs Dept, Santa Fe
Elena Bowers, McKinley Cnty CES, Gallup
Bill Bright, Health Alliance, Gallup
Richard Champany, Indian Health Service, Shiprock
Renee Cleveland, Coalition for Healthy and Resilient Youth, Gallup
Jim Dumont, Ofc of US Senator Jeff Bingaman, Farmington
Sabrina Ezzell, Nurse Contractor, Gallup
Jesse James, Future Foundations Family Center, Grants
Laura Jaramillo, Future Foundations Family Center, Grants
Marlene Jasperse, PhD, GIMC Health Promotion Department, Gallup
Corrine Jymm, NNSDP, Crownpoint
Joseph Lacayo, Gallup McKinley County Schools, Gallup
Karl Lohmann, Boys and Girls Club of Gallup, Gallup
Erin Marshall, Healthier Weight Council, Belen
Jill McQueary, Rotary-Don't Meth With Us, Farmington
DeAnne Pete, Gallup Indian Med Center, IHS Health Promotion, Gallup
Ophelia Reeder, McKinley Community Health Alliance, Gallup
Kimberly Ross-Toledo, Coalition for Healthy & Resilient Youth, Gallup
Kevin Sweeney, Gallup Indian Medical Center, Gallup
Bruce Tempest, School Board, Gallup
Evan Williams, NW NM Council of Governments, Gallup
Clothilda Nez, NNDBHS-Gallup etc, Gallup
Jolene C. Luna, Pine Hill Health Center, Pine Hill

Regional DOH Staff

Ann Anthony, DOH, PHD, Northwest Region, Farmington
Melissa Charlie, DOH, PHD, Northwest Region, Farmington
Connie Dixon, DOH, Northwest Region Director, Grants
Janie Lee Hall, DOH, Northwest Region, OSAH, Gallup
Jerry Montoya, DOH, PHD Northwest Region, Albuquerque
Lucille Ross, DOH, PHD, Northwest Region, Gallup

Metro Region Turn the Curve on Health, New Mexico, May 15, 2012

Community Partners

Natasha Abruzzo, Brookline College, Albuquerque
Ginny Adame, Los Lunas/Valencia County DWI Pgm, Los Lunas
Barbara J. Alvarez, NM Indian Affairs Department, Santa Fe
Loren Anthony, Brookline College, Albuquerque
Enrique Cardiel, International District Healthy Communities Coalition, Albuquerque
Leigh Caswell, UNM-Health Sciences Center, Albuquerque
Jacob P. Chacko, Brookline College, Albuquerque
Billie Clark, Partnership for a Healthy Torrance Co, Moriarty
Theresa Cruz, UNM/Prevention Research Center, Albuquerque
Amalia Danclar, Brookline College, Albuquerque
Khara Davis, HealthInsight New Mexico, Albuquerque
Denise Dion, UNM Center for Telehealth, Albuquerque
Jane Dehner, LLCPC Dental Clinic, Albuquerque

Michael Disco, UNM College of Pharmacy, Albuquerque
Claire Dudley, Presbyterian Health Care Services, Albuquerque
Peggy Folk Cote, Sandoval County Community Services, Bernalillo
Jeannette Forrester, Albuquerque Public Schools, Albuquerque
Angelo Gonzales, UNM Center for Educ Policy Research, Albuquerque
Peggy Gutjahr, Community Wellness Council-Valencia, Belen
David Guthrie, Centers for Disease Control and Prevention, Atlanta
Jerry Harrison, NM Health Resources, Albuquerque
Lucha Herrera, Family Health Partnership Program-UNM, Rio Rancho
Evita Hernandez, Family Health Partnership Program-UNM, Rio Rancho
Christine Hollis, NM Voices for Children, Albuquerque
Sally Ironside, Presbyterian Health Care Services, Albuquerque
Patricia Keane, UNM-PRC, Albuquerque
Joe Keefe, Partnership for a Healthy Torrance Co, Corona
Loren Kelly, UNM College of Nursing, Albuquerque
Richard Kimball, UNM College of Nursing, Albuquerque
Richard Kozoll, Nacimiento Community Foundation President, Cuba
Frank Lawrence, ICF International—CDC Contractor, Atlanta
Charm Lindblad, NM Health Care Takes on Diabetes, Albuquerque
Ray Lyons, LLCPC Special Care Dentistry, Albuquerque
Hilary Maez, Community Wellness Council, Peralta
Jan Martin, UNM-Health Sciences Center, Albuquerque
Anne Sonya Martinez, Partners in Wellness, Los Lunas
Richard Mason, Sandoval County Health Services, Rio Rancho
Tracy McDaniel, BCCHC—Bernalillo Cnty, Albuquerque
Marsha McMurray-Avila, BCCHC—Bernalillo Cnty, Albuquerque
Margaret Migliorati, UNM Center for Telehealth, Albuquerque
Shiraz Mishra, UNM-PRC, Albuquerque
Antonia Montoya, Change Is Yours, Albuquerque
Michael Moxey, NM Dental Association, Albuquerque
Cathie Moya, Community Dental Services, Albuquerque
Aamna Nayyar, DDS, Santa Fe Community College, Santa Fe
Patsy Nelson, Alliance for School Based Health Cntrs, Albuquerque
Bill Niendorff, MIRA Consulting, Albuquerque
Barbara Overman, Family Health Partnerships/CON, Bernalillo
Sheryl Padilla, UNM Dental Residency Pgm, Albuquerque
Galina Priloutska, HealthInsight New Mexico, Albuquerque
Danielle Reed, Bernalillo County Office of Environmental Health, Albuquerque
Michael Robertson, City of Albuquerque, Albuquerque
Giovanna Rossi, Collective Action Strategies, Albuquerque
Harris Silver, UNM, Albuquerque
Sherry Spitzer, NM Asian Family Center, Albuquerque
Jeannette Stahn, UNM HSC Office of Diversity, Albuquerque
Cynde Tagg, UNMH, Bosque Farms
Pauline Tither, Brookline College, Albuquerque
Monique Vallabhan, UNM, Albuquerque
Betsy VanLeit, UNM, Albuquerque
Margaret West, Centers for Disease Control, Atlanta
Margy Wienbar, HealthInsight New Mexico, Albuquerque
Rachael Wilenta, Brookline College of Nursing, Albuquerque
Zekaris Woldegiorgis, Brookline College, Albuquerque

Regional DOH Staff

Kate Daniel, DOH, PHD, Northeast Region, Santa Fe
Jerry Montoya, DOH, PHD Northwest Region, Albuquerque
Michelle Skrupskis, DOH, PHD Northwest Region, Albuquerque

Southwest Region Turn the Curve on Health, New Mexico, May 22, 2012

Community Partners

Freida Adams, First Step Center, Las Cruces
 Rachel Anaya, Dona Ana County HHS, Las Cruces
 Pamela Angell, St. Lukes, Las Cruces
 Margaret Ann Bock, NMSU, Las Cruces
 Eric Bransford, Doña Ana County, Las Cruces
 Dean Brock, Agape Chiropractic, Truth or Consequences
 Luan Wagner Burn, The Community Foundation of SNM, Las Cruces
 Diana Bustamente, Colonias Development Council, Las Cruces
 Angela Chavez, Doña Ana County HHS, Las Cruces
 Joy V. Chavez, Concilio CDS Inc, Las Cruces
 Cynthia Connolly, Mountain Spring Education, LLC, Socorro
 June Donohue, Southern NM Diabetes Outreach, Las Cruces
 Penny Downs, CHINS, Alamogordo
 MJ Dyke, AppleTree Educational Center, Truth or Consequences
 Sharon Finarelli, Sierra Vista Hospital, Truth or Consequences
 Sherry Fletcher, Non-profit sector, Truth or Consequences
 Javier Garcia, Doña Ana Cnty HHS, Las Cruces
 Chelo Gonzales, Doña Ana Cnty HHS, Las Cruces
 Connie Grove, Deming Public Schools, Deming
 Reilly Hamil, Sierra Health Council, Truth or Consequences
 Tammy Hopkins, Hidalgo Medical Services, Animas
 Tiffany Knauf, Grant County Community Health Council, Silver City
 Sonja Koukel, NMSU Extension, Las Cruces
 Rachel Kutcher, Hidalgo Medical Services, Silver City
 Donna Lee, Ben Archer Health Center, Las Cruces
 Lee Ann Loney, Otero Cnty Community Health Council, Alamogordo
 John Manzi, Dona Ana County HHS, Las Cruces
 Armida Martinez, The Volunteer Center of, Silver City
 Tony Martinez, Molina Healthcare of NM, Las Cruces
 Josefina Mata, Concilio CDS Inc, Las Cruces
 Gwenda McClure, Mimbres Memorial Hospital, Deming
 Alma Mendoza, Concilio CDS Inc, Las Cruces
 Timothy Miller, Optum Health, Las Cruces
 Lydia Montoya, Healing House—Domestic Violence Services, Deming
 James Nelson, LCPS Head Start, Las Cruces
 Darrick Nelson, MD, Hidalgo Medical Services, Silver City
 Ernest Pargas, Jr, SCOPE, Socorro
 Lisa Patch, Alamogordo Public Schools, Alamogordo
 Valois Pearce, Stakeholder, Las Cruces
 Kay Redd, Healthy Kids Las Cruces, Las Cruces
 Kathryn Ritterbusch, Presbyterian Medical Services, Deming
 Veronica Salcido-Harding, Center School of Med, Albuquerque
 Anabel Sanchez, Doña Ana County, Las Cruces
 A. J. Sandoval, Healthy Kids Healthy Communities, Silver City
 Sylvia J. Sapien, La Clínica de Familia, Las Cruces
 Kathleen Schuster, Catron County Health Council, Glenwood
 Xochitl Torres Small, Tom Udall's Office, Las Cruces
 Linda Summers, NMSU, Las Cruces
 Jenny Torres, Doña Ana Cnty HHS, Las Cruces
 Susie Trujillo, Gila Regional Medical, Silver City
 Tresa VanWinkle, CAPPED, Inc, Alamogordo
 Kathy Villalon, Doña Ana Cnty, Las Cruces

Regional DOH Staff

Amanda L. Askin, DOH/OSAH, Las Cruces

Mary Ballard, DOH/TUPAC, Las Cruces
 Aimee Bennett, DOH, Ruidoso
 Elizabeth Burr, DOH-Luna PH, Deming
 Angie Corral, Office of Border Health, Las Cruces
 Lizabeth C. Gutierrez, Office of Border Health, Las Cruces
 Debby Hanus, DOH Immunization Program, Las Cruces
 Sharon Hodges, Otero County PHO, Alamogordo
 Judy Lopez, DOH, Las Cruces
 Rosa Lopez, DOH, Las Cruces
 Laura Mandabach, DOH, Las Cruces
 Gil Padilla, DOH Southwest Region, Las Cruces
 Patrick Stafford, DOH, Las Cruces
 Mary Stoecker, DOH Southwest Region, Silver City
 Vanessa Tavarez-Corral, DOH/PHD CMS, Las Cruces
 M.Nadine Ulibarri-Keller, DOH, Polvadera

Northeast Region Turn the Curve on Health, New Mexico, May 31, 2012

Community Partners

JoAnne Allen, NM Dental Association., Albuquerque
 Barbara J. Alvarez, NM Indian Affairs Department, Santa Fe
 Kathy Armijo Etre, CHRISTUS St. Vincent, Santa Fe
 Tana Beverwyk-Abouda, El Centro Family Health, Rio Arriba
 Karen Cheman, Office of Substance Abuse Prevention, HSD, Santa Fe
 Judith Cooper, Union County CHC, Clayton
 Yolanda Cruz, San Miguel County Hlth Cncl, Las Vegas
 Cindy Cullen, La Clínica del Pueblo de Rio Arriba, Tierra Amarilla
 Jolene Cunningham, Health and Wellness, Pueblo of San Felipe
 Maxine F. Daggett, North Central Community Based Services, Chama
 Vivian Heye, Community, Santa Fe
 John Hutchinson, Holy Cross Hospital, Taos
 Barbara Kastner, NDI New Mexico, Santa Fe
 Rebecca Leppala, Department of Finance and Administration, Santa Fe
 Shelley Mann-Lev, Santa Fe Public Schools, Santa Fe
 Julie Martinez, Taos Alive, Taos
 Nichole Summer Martinez, Pueblo de San Ildefonso, Santa Fe
 Fredi Martinez, Small Smiles Dental Center, Albuquerque
 Harry Montoya, Hands Across Cultures, Espanola
 Venus Montoya-Felter, Diabetes Prevention Program, Nambe Pueblo
 Sunshine Muse, UNM, Health Sciences Center, Santa Fe
 Dr. Alfred Otero, Metropolitan Deternion Center, Bernalillo
 Lauren Reichelt, Rio Arriba County, Española
 JoAnne Rivera-Velasquez, Guadalupe County Health Council, Santa Rosa
 Brenda Romero, Presbyterian Española Hospital, Espanola
 Joann V. Salazar, Villa Therese Catholic Clinic, Santa Fe
 Pat Serna, North Central Community Based Services, Chama
 Dr. Arturo Sisneros, El Centro Family Health, Peñasco
 Robert Sturm, NM Community AIDS Partnership, Santa Fe
 Karen Ziegler, CYFD, Head Start Collaboration **Dir**, Santa Fe

Regional DOH Staff

Kate Daniel, DOH, PHD, Northeast Region, Santa Fe
 Susan Gonzales, DOH, PHD, Northeast Region, Santa Fe
 Betsy Martinez, DOH, PHD, Northeast Region, Taos
 Susan Oviedo, DOH, PHD, Northeast Region, Santa Rosa
 Dr. Ron Romero, DOH/OOH, Santa Fe
 Amy Sandoval, DOH, PHD, Northeast Region, Santa Fe
 Ron Ulibarri, DOH, PHD, Northeast Region, Santa Fe

Preface (4–5)

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Population Characteristics (6–9)

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Tobacco Use (20–21)

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