Community Health Needs Assessment

Socorro County, New Mexico 2011-2012

Client

Presbyterian Socorro General Hospital

Community Needs Assessment Committee

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Executive Summary

Introduction and Purpose

Presbyterian Socorro General Hospital is the sole hospital providing service to a poor, rural, diverse region of New Mexico facing significant health disparities. With a long-term goal of improving this region's health, PSGH requested this needs assessment to better understand their community members' health priorities, challenges community members face in seeking healthcare and community willingness to participate in community-based health programs.

Methodology

This community needs assessment (CNA) was conducted using a three-part process:[i] a pre-assessment to identify health priorities; an assessment examining community needs related to these priorities and healthcare in general; and, a post-assessment to identify potential remedies to the community's needs.

The pre-assessment included key informant interviews, visual assessment of the county on drive-by visits, and evaluation of existing health indicator data. Access to care, diabetes, tobacco, maternal/child health and mental health were identified as CNA priorities based on being significant issues facing the region and due to the fact potential public health interventions exist to address these priorities.

The CNA collected both quantitative and qualitative information related to these priorities. The quantitative findings are based on a survey administered by trained volunteers throughout the county in in English and Spanish and, in a few instances, verbally translated to Navajo. To encourage a high response rate, several weeks of systematic community outreach were conducted. Participants were entered into a raffle for gifts that had been donated by local businesses. Key informant interviews were conducted to provide qualitative information on priority health issues to help tell the story behind the quantitative numbers. One focus group was conducted related to diabetes. Sample size goals were exceeded during survey collection; however, questions had varying response rates.

Data Analyses and Findings

Surveys were collected throughout the county, emphasizing the traditionally under-evaluated areas: Veguita, Alamo and rural portions of Socorro County. In order to ensure data better reflected the demographics of the county, a post-stratification weighting was used to adjust the data to remove bias from the oversampled areas. Data analyses were conducting with SUDAAN-10 in SAS 9.3.

Priority Access to Care

Poverty

- Poverty impacts Socorro County disproportionately
  - >50% household income < $30,000 (135% federal poverty level)
  - Over 70% of families in Alamo live in poverty
  - Lower income associated with lower literacy levels

- Poverty is an obstacle to healthcare
  - 1 in 10 persons in poverty have not seen a doctor in 5 years
  - 10% fewer respondents in poverty had a regular doctor
  - Over 40% identify cost as a barrier to accessing care
  - Over 10% do not have a phone to call for doctor appointment
  - Almost 30% responded lack of insurance is barrier to care
  - Many would use community-based programs (CBPs) if funded

- Respondents living in poverty had worse self-reported health. Compared to those with household incomes >$30,000:
  - Almost 50% fewer assess health as "excellent"
  - Fewer healthy days in the past 30 days
  - More days with mental health symptoms during the past 30 days
  - More days unable to do work or activities due to health

Time and Distance

- People travel up to 3 hours to reach PSGH
- 1 in 4 rate distance a barrier to care; more so among the poor
- Almost 1 in 5 rate lack of transportation a barrier
- 1 in 4 (more for rural) cannot get time off work to seek care
- Over 35% have trouble getting an appointment
- Many need an after-hours or weekend hours clinic & CBPs

Culture and Language

- 1 in 10 and almost 1 in 5 (among the poor) note language as a barrier
- Over 9% rank citizenship concerns as barrier to care
- 1 in 4 in Veguita; 1 in 10 in Alamo would use CBPs more if the provider spoke their language
- Confidentiality is a key factor for at least 1 in 4 countywide

Diabetes

- 1 in 4 cite this as the top preventable issue for Socorro County
- Identified as the #1 issue for self or family
- Less than 50% have had doctor discuss risks of diabetes
- Majority support use of CBP for diabetes care & health improvement
- Close to 1% report self or relative using a CBP for diabetes
- Need for diabetes education & local dialysis mentioned by respondents

Tobacco & Secondhand Smoke (SHS)

- 23% smoke currently countywide; 27% in the city of Socorro
- 6 in 10 smokers had a doctor discuss quitting this past year
- Smokeless tobacco use is extremely high—almost 10% countywide
- In Alamo, more use smokeless than smoke tobacco
- Over 7% of nonsmokers are being exposed to SHS at home
- Over 8% of nonsmokers are being exposed to SHS in the car
- Despite indoor air regulations prohibiting indoor smoking in almost all venues, 5% of nonsmokers are exposed to SHS at work
- Countywide, respondents think healthcare providers are…
    - Very good at educating about health problems with SHS
    - Good (overall lower ratings) at getting people to quit smoking

Mental Health

- Over 50% state rank drug & alcohol abuse as priority for county
- Over 15% rank domestic violence as a county priority
- More days of mental health symptoms than the rest of US
- Top ranked mental health concerns:
    - Alcohol Abuse
    - Illegal Drug Abuse
    - Prescription Drug Abuse (major priority)
    - Domestic Violence
    - Child Abuse
- All mental health topics supermajority ranked as at least important
- Access to local inpatient care lacking
- Prescription drug abuse growing concern
- 70%: “very important” to seek health professional for mental health
- 10% do not know where to go for help on mental health issues
- 40% never asked by a doctor about mental health issues
- Countywide perception common that violence and substance abuse are law enforcement more than mental health issues

Maternal Child Health

- Close to 20% cite teen pregnancy as top issue countywide
- 5-7% cite vaccines & childhood issues as county and family priority
- 8 in 10 would recommend programs to help build healthy families
- 8 in 10 state prenatal care important to very important
- 8 in 10 support professional health with childhood development

Disclaimer

Analyses in this CNA do not reflect Presbyterian Hospital System, PSGH board or staff. The CNA coordinator did not have any financial benefit or future benefits from the findings in this report. Financial support for costs associated with the assessment included a grant from the Rollins School for Public Health Global Experience Fund (2011) and assistance from the PSGH Board.

The CNA is considered public health practice, not research and is not intended to be generalizable beyond Socorro County; it was not eligible for Institutional Review Board review. Any generalizable research based on data from this project in the future will need to go through IRB approval. If you are interested in data from this project for research, please contact the SPGH CBP office and recognize you will need to use SUDAAN for any analysis due to post-stratification weighting.

Acknowledgements

In addition to PSGH Board and staff, this Community Needs Assessment could not have been successful without the strong support of residents in Socorro County and nearby parts of Catron, Valencia and Torrance Counties. The Alamo Chapter, City of Socorro, Socorro County and Village of Magdalena were instrumental to project success.

Administering over 850 surveys in less than 8 weeks was only possible due to 23 volunteers who spent over 300 hours in summer heat administering surveys (see photo): Naomi Bancroft-Cline, Kristen Beers, Richard Chavez, Betty Cline, Laura Fazio, Roene Fuller, Elizabeth Hayward, Liz Claybaugh, Kent Howell, Kristen Kern, Kimberly Kotowski, Michelle Lee, Christine Lucero, Ruby Mendez-Harris, Veronica Pound, Jennifer Reid, Bryan Romkey and Lee Swiderick.

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Pre-Assessment

PSGH initiated this CNA with knowledge health disparities existed at an alarming rate in this community. The very aspects making this region an appealing place to call home—expansive landscapes, cultural diversity—make providing care a challenge. Poverty leads to complications beyond a lack of insurance or trouble paying health care bills. A family living below poverty may not have a car to get to the clinic, a phone to call and try for an appointment, quality childcare or a job allowing paid time off for doctor visits.

To tackle the health disparities and underlying determinants of these disparities, a systematic approach was needed to identify priorities. From January 2011 to May 2011, the CNA pre-assessment was conducted to identify priority topics by systematically synthesizing stakeholder input, existing health indicators, and regional geography and demographic information. After identification of priorities, further research was conducted to better understand the current state of knowledge these topics.

Pre-Assessment Methodology

The pre-assessment identified community-based priorities. First, meetings were held with the SGH community based programs director and hospital administrator to learn background about the hospital and its community services, and current health concerns from the hospital's perspective. CBP staff also helped identify sources of the most current health indicator data. Using existing state and federal health databases, indicators were assessed to better understand reported morbidity and mortality rates for Socorro County. U.S. Census and local health council information provided additional background into demographics, health disparities and population dynamics of the community.

Existing health indicator data may not be timely, may only represent community members who saw providers within the county, and whose providers reported their conditions. In order to develop a more holistic appreciation of health issues facing Socorro, the pre-assessment incorporated community stakeholders input as well as existing indicator data. Through SGH CBP, local community leaders involved in health-related activities throughout the county were identified. Via email, stakeholders addressed the following questions:

- ✧ In which region(s) of the county do you work? On which issues
- ✧ Is there a certain demographic (gender, age, ethnicity, socio-economic status) with which you work the most?
- ✧ What do you see as the strengths of the current health care system and community health programs?
- ✧ What are the gaps or challenges in the community receiving or seeking health care?
- ✧ Do you have ideas on improving the system or help the community members better utilize existing programs?

- ✧ In approaching people in the community/areas where you work- what is the best method you recommend- in person, phone, email?
- ✧ How open would your community be to participating in community needs project?
- ✧ What is the best time of day to reach people in your community?
- ✧ Are there any types of information (that we would ask in a needs assessment) that would help you with your current work and projects? Either information about a certain health problem, access to healthcare issues, specific communities you'd like to learn about, etc.
- ✧ Any other suggestions?

The pre-assessment stakeholder input was entered into a spreadsheet to determine if certain topics were more prevalent among responses. Using the combination of the stakeholder (including SGH) input, and the pre-existing health indicator data, specific priority topics were identified. In discussion with PSGH CBP staff, out of those topics, "winnable battles" were chosen. Winnable battles included health-related priorities in the community for which it would be possible to obtain a measurable increase and outcome and for which it would be reasonable to assume sufficient resources exist or could be obtained.

Study Sites

This study included data collected by PSGH from participants within the region of southeast central New Mexico served by Presbyterian Socorro General Hospital. PSGH provides care throughout the vast 6700 square miles of Socorro County as well as adjacent portions of Catron County. PSGH is a 25-bed hospital with emergency facility which sits on top of a hill on the west side of the city of Socorro; 75 miles from the nearest trauma center and most specialty services in Albuquerque. Part of Socorro County is so remote; it is still considered officially "frontier." (Appendix 1, Map 1: County Location)

Photo 1. Socorro County's Rural Landscape

Geography

Distances across this mostly desert region of New Mexico can make reaching an emergency room or a general doctor office visit an entire day's activity impacting work hours, childcare needs and income (Table 1). Using Interstate 25, the north and south edges of Socorro County are about an hour from PSGH. From tiny Claunch in the eastern extreme of Socorro County, PSGH is two hours away by two-lane road. From Pie Town in Catron County, patients travel 90 minutes west along a two-lane highway to the hospital.

Photo 2. Ranch in East Socorro County

The county is divided East to West by Interstate 25, the most direct route to the cities of Albuquerque and Las Cruces.

Photo 3. Dirt Road from Alamo north to dialysis and specialty care

East of I25, the county's desertscape fades into lush, green farmlands, small communities and large wetlands preserve along the Rio Grande. Further east, the land rises back up in elevation away from the Rio Grande, quickly returning to arid, ranch terrain. To the south and west of the city of Socorro, there are no towns- just rural residents on large stretches of open land in mostly mountainous terrain. Much of the southeastern corner of the county consists of White Sands National Monument and Missile Range.

Directly west of the city of Socorro, traveling along Highway 60 from Socorro to Pie Town, elevation rises from 4500 feet above sea level in the desert and to over 8000 feet among the piñons at the Continental Divide. The first village on Highway 60 is Magdalena, a historic ranching town with its own senior center, school, and outpatient health clinic. In decades past, persons from the Alamo Band of Navajo Indians about 30 minutes north of Magdalena came to a boarding school in Magdalena. Magdalena hosts the annual rodeo event which, for this study, provided unique data from ranchers and members of the Alamo Band of Navajos. Beyond Magdalena, Highway 60 winds further up

into the mountains—primarily ranch country. Along this route is the world's largest array of satellite dishes -- an unexpected find among the cattle and desert brush.

The Alamo Band of Navajo Indians, north of Magdalena, are the most remote group of Navajos--250 miles from the tribe's primary facilities in Window Rock, Arizona. Alamo has an outpatient health clinic, several ambulances, schools, an early childhood center, a new gymnasium, and a small market with a gas station. In order to seek care at night or on weekends, Alamo residents travel to PSGH – a 1-2 h our drive depending on one's location on the reservation. For dialysis or health care with specialists not available in Socorro, many travel along a poorly maintained dirt road to Belen and Albuquerque which can take a couple of hours in the best of weather conditions (photo 3).

Photo 4. Irrigated farmland near Veguita Along Rio Grande, Socorro County

Northeast of the city of Socorro along the river are dry-lot dairies and family farms in the community of Veguita. A stark visual contrast exists in this area between the green, irrigated crops (photo 4) and two story homes on river-side of the two-lane road through Veguita and the dusty miles of trailers of the dairyworkers on the other side (photo 5). While closer to the city of Belen to the north about 15 minutes, many families still seek care in Socorro 45 minutes away. For medical emergencies, Veguita is now solely provided EMS services by the city of Socorro despite closer proximity to Valencia County EMS. South of Veguita along the Rio Grande lie several other small villages: Las Nutrias, La Joya, San Acacia, and, just to the south of the city of Socorro on the river, San Antonio. Throughout the county, main travel routes include Highway 60 and I25; however, driving to reach the highway, a person may travel for a long time over a short distance due to dirt roads with varying degrees of maintenance.

Photo 5. Trailers in Veguita housing many migrant dairy-worker families

The City of Socorro is the commercial hub of the county and is conveniently located at the intersection of the Highway 60 and I25. Socorro, the second oldest community within New Mexico, is a city of contrasts. Dilapidated multifamily trailers on dusty lots are found across from manicured green lawns of agricultural business leaders. African and Asian international students at New Mexico Institute of Mining and Technology live next door to fourth generation New Mexican families. Low literacy is common countywide; yet, with the

New Mexico Tech, the city is home to a higher percentage of doctoral degrees than the rest of the state.[ii] Though still primarily dependent on agriculture-related income, ever since local 1945 atomic tests, Socorro has become a critical center of Homeland Security with its counter-explosive technology expertise and training.

To best represent both the geographic and demographic dynamics of the PSGH served region, data from this study were collected to represent specific geographic areas served by PSGH: Veguita, Alamo, Magdalena, Socorro City, and general rural regions including adjacent counties. (See Table 1 below for times and distances to the PSGH hospital).

Table 1. Distances (approx.) from Study Locations to PSGH & Albuquerque

Location	Miles to PSGH	Time to PSGH	Miles to ABQ	Time to ABQ
Socorro (city)	0-10	0-15 min	75	1-1.5 hrs
Magdalena	25	30 min	100	1.8-2 hrs
Alamo	58	1.2-3hrs	88.1 (dirt)	2-3 hrs
Veguita	36	45 min	44	1 hr
Rural	Varies	0-3 hrs	Varies	0.75-3.5hrs

Demographics

For the purposes of this analysis, the following demographic parameters from data collected in the 2011 CNA: town of residence, rural/nonrural, income level, language of the survey (primary language), ethnicity, age, gender and number of children per household. Accessing appropriate baseline demographics for this region of New Mexico is difficult. While the U.S. Census Bureau data provides the latest census counts, the true census may vary from these numbers due to the difficulties in accessing remote, rural homes many of which have gates and guard dogs; others of which are truly "off the grid."

For the migrant communities along the Rio Grande, immigration concerns may also have led to undercounting. At the time of this analysis, data from the 2010 census had recently been published showing a more than 50% reduction in persons counted in the census in the Veguita migrant community. Instead of reflecting a mass exodus, this study interprets preliminary 2010 numbers as undercounting. The 2010 census details at the county level demonstrate that the demographics of the county are very similar to 2000.

Table 2. Ethnicity, Percent Living in Poverty & Population Density for Socorro County
Values based on preliminary results of 2010 U.S. Census[iii]

Location	American Indian/ Alaska Native	Hispanic	Non-Hispanic White	Below Federal Poverty Level (%) 2006-2010*	Children in Poverty 2009**	Population Density (Persons/ square mile)*
Socorro County	**11.7%**	**48.5%**	**37.6%**	**26.8**	**38.9%**	**2.7**
New Mexico	9.4	46.3	40.5	18.4%	28.8	17.0
U.S.	0.9	16.3	63.7	13.8	20	87.4

According to the 2010 census, 17,866 persons reside in Socorro County with an average population density of 2.7 people per square mile (Table 2). Catron County (to the west) adds an additional 3725 persons to the service area of PSGH—though the western half of the county is served by a hospital in Springerville, Arizona. Catron County is sparsely populated with an average of 0.5 people per square mile. In order to appropriately weight data, this report only reflects Socorro County resident responses. Due to the fact complete demographics were only available for 2000 when the CNA was designed, these were the numbers upon which probability of selection were determined.

Most federal definitions of "rural" would encompass all areas other than the city of Socorro; some classifications may describe the entire county as "rural."[iv] For the purposes of data collected in the CNA, "rural" residents were defined as persons living within the service area of PSGH but not in the villages of Magdalena, Alamo, Veguita or in the City of Socorro.

Poverty is not a stranger to many in Socorro County (Table 2). The Socorro mean income annually per household (2010) is $23,439, less than half of the national level. In the U.S. an estimated 13.2% of persons and 11.5% of families live in poverty; in Socorro, 31.7% and 24.1%.[v] New Mexico, while having high poverty level at 20%, is still lower than this county.[vi] Data on which this study is based included respondents' estimates of annual household income in deciles.

Baseline comparison data for number of children per household were not available for this region; however, Socorro County, the City of Socorro and Village of Magdalena have between 3-3.2 persons per family; Alamo has 4.87.[vii] Number of children per household was asked on the CNA as an open answer question.

Recently released 2010 census shows median age within Socorro County of 32.4, Socorro City 31.1, Magdalena 41.4 and Alamo 21.8 years old. Magdalena had the highest proportion of residents over 65 years old at 16.0%, followed by Socorro City at 11.6%, the county at 10.9% and Alamo only 4.6%.[viii] While it is possible the younger demographics in Alamo

may reflect low participation among Navajo elders who do not speak English, a local health provider stated this low percent of persons over 65 years old is likely accurate for Alamo.

Socorro is known as a tri-cultural county (Table 3). On the survey, ethnicity data were collected through a check-box system. Table 2 represents the three largest ethnic groups within the county. Within New Mexico, Hispanic/Latino is inclusive of multi-generational New Mexicans in addition to persons with heritage from Latin American countries. Data collected did not differentiate New Mexicans from other Latinos. In addition to checking individual boxes next to a list of the most common ethnicities, an "Other" write-in response was also provided.

Health Indicators

Health indicators are simply data reported to local, state or federal agencies related to health issues in a community. Mortality rates are collected through databases from vital records, medical and law enforcement data. Illness or morbidity data is often reported by health providers or laboratories—such as numbers of cases of HIV in an area. Behavioral data – such as who smokes or when someone last saw their doctors—are often collected through national surveys such as the CDC Behavioral Risk Factor Surveillance System (BRFSS)[ix], Pregnancy Risk Assessment Monitoring System (PRAMS)[x], National Health Information Center[xi], and the Substance Abuse and Mental Health Services Administration[xii].

While health indicators provide the faint outline of what problems may be inherent to a community, they do not tell the whole story. If anything, they underestimate burden of disease due to underreporting and/or because people are diagnosed outside the county line. For example, for an sexually transmitted diseases (STDs) to be reported for a county—the person must go to a doctor and be diagnosed, the doctor must be in the same county the person lives in (except for HIV which reports by hometown not doctor location), and the busy doctor must actually report it. For small close-knit communities, persons would foreseeably be less likely to go to a doctor in their home county to address a stigmatized health problem like STDs, pregnancies, substance abuse, mental illness or domestic violence. For the above concerns, this CNA asks the community directly about health concerns using a survey.

Table 3. Socorro Health Indicators Compared to State of New Mexico and U.S.[xiii]

Health Indicator (# per 100,000 unless indicated)	Socorro County	New Mexico	US 90th percentile
Low Birth-weight newborns 2008-2010	9.1	8.5	8.2
Heart –related Deaths 2007-2009	247.1	203.8	190.9
Unintentional Injury 2003-2007 (for U.S. 2003)	79.6	62.3	37.3
Alcohol Related Deaths 2007-2009 (for U.S. 2005-2007)	64.6	52.9	28.1
Diabetes-related Deaths 2008-2010	54.2	32.5	20.9
Teen Birth Rate 2007-2009 (per 1000 girls aged 15-17 years)	41.1	31.6	20.1

Socorro health indicators demonstrate startling disparities (Table 3). In fact, the teen pregnancy rate is likely higher in Socorro County since these rates do not include the younger girls 13-15yrs old who are becoming pregnant. According to the Socorro County Health Profile 2009, Socorro has a higher age-adjusted mortality rate than the state average.[xiv] [xv] The 2005 Bureau of Vital Statistics shows top causes of death for Socorro County and state of New Mexico to be cancers, heart diseases and injury.[xvi] [xvii] Lung and bronchial cancer are the most common cancers among Hispanic men and non-Hispanic men and women; among Hispanic women, breast cancer.[xviii] Diabetes death rate in the county is 54.2/10,000—higher than the state, 32.5/10,000; and, much higher than the national rate, 20.9/10,000.[xix] Overall, life expectancy after age 65 in Socorro County is 17.4 years; New Mexico, 18.7; U.S., 17.7 years.[xx]

Among infectious diseases, foodborne disease and Hepatitis A were noted to disproportionately impact Socorro County. STD rates are historically low; however, may be misclassified due to testing of Socorro residents in other counties. Pertussis is less common than expected for based on state levels.[xxi] Only 3 cases of plague have been diagnosed in the county since 1949;[xxii] no hantavirus has been diagnosed since 1975.[xxiii] More people in Socorro die from influenza and pneumonia (2006-2009) than statewide or nationally.[xxiv] Approximately 65% of county adults are current on the influenza vaccine.[xxv]

From 1999-2003, smoking-related illness has been attributed to 128.7/10,000 deaths per year; comparatively, 119.2/10,000 deaths[xxvi] are due to smoking statewide. Smoking has been shown to cause lung cancer and heart disease. In a 2005 youth survey in Socorro, 68.6% of high school students report having tried smoking; 15.2% had used chewing tobacco in the 30 days prior. From 2006-2008, adult smoking prevalence for Socorro County was estimated to be 21.5%; New Mexico, 20.1%, and the U.S. 19.8%.[xxvii]

Injuries are classified as unintentional, such those caused by a motor vehicle crash, and intentional, such as those caused by violence. The County Health Profile notes that the majority of county residents in a 2007 survey reported feeling safe in their neighborhood. The report also notes the City of Socorro and Magdalena are the only areas with sidewalks and that most residents do not think there are enough bike paths and lanes. Drive-by pre-assessment showed a lack of walking and running routes that were not at risk from traffic. New Mexico Tech Campus provided an exceptionally safe, walking and biking-friendly environment within the City of Socorro. Minimal bike lanes are present countywide; though bicyclists are frequently seen using Highway 60 outside of Socorro. During walks and runs in the city and region, loose dogs present a dog bite risk.

Motor vehicle crashes (MVC) send over two million people to emergency rooms annually and are the leading cause of death among persons 5-34 years old.[xxviii] MVC are not "accidents" and can be prevented by actions like staying off icy roads. MVC inclement weather was been associated with 7000 deaths, 800, 000 injuries annually in the U.S.[xxix] [xxx] [xxxi] Rural road are often more at risk for injuries and deaths from motor vehicle crashes.[xxxii]

In terms of intentional injury, data has shown more than 1 in 3 high school students had carried a weapon and over 70% had access to a gun at home.[xxxiii]

New Mexico exceeds national alcohol-related death rates by over 20%; unfortunately, Socorro County has an alcohol-related death rate that is 10% higher than the state.[xxxiv] Alcohol has contributed to injury rates in Socorro. In 2004, about one third of fatal motor vehicle crashes in the county involved alcohol; about 11% of injury crashes involved alcohol.[xxxv] Out of persons in the county arrested for DUI, 75% are assessed as needing an alcohol or drug treatment program.[xxxvi] The closest inpatient program run by the state is 75+ miles away.

In 2007, New Mexico's death rate related to drug use was almost twice the national rate. Socorro's death rate was estimated to be even higher than this state level.[xxxvii] Drugs and alcohol may lead to more deaths in the under 65 years old age range; unlike smoking, which usually increases mortality rates in the older ages. Nationally, prescription drug abuse has now surpassed motor vehicle crashes as a leading cause of death.[xxxviii] New Mexico, as of 2007, had an incredibly high rate of 20.1/10,000 deaths caused by prescription drug abuse—second only to West Virginia.[xxxix] Data deaths from prescription drug abuse were not available at the county level at the time of this report.

Medical Facilities (Appendix 1, Figure 2)

PSGH, located on the western side of the city of Socorro, provides emergency care, air flight to the level 1 trauma and specialty hospitals in Albuquerque, has capacity for basic surgeries and labor & delivery, and has 25 beds for inpatients. In 2010, the hospital admitted 662 patients, provided care for 27,485 outpatient and emergency visits, delivered 168 babies, and treated 11, 052 in the Emergency Department. The services associated with PSGH include a family medicine clinic, internal medicine, podiatry, audiology, pediatrics, and women's health. The hospital runs the Community Based Programs that includes a variety of community outreach, promotora-based health programs, hospice and homecare, early childhood intervention and First Born, a program for first-time parents, and Heritage Program for Senior Adults. The hospital provides over 200 jobs locally, is involved with the community through local fundraisers, festivals and has an active locally-based board. A mill levy fund provides critical support to the hospital. Hospital auxiliary members volunteered over 10,000 hours in 2010 to support the hospital in many different capacities. The hospital is one of only 2 in the state to have been recognized by the New Mexico Review Association Brilliant Torch Award for consistently exceeding Medicare core targets. PSGH has exceeded national levels in terms of appropriate discharge instructions given to heart patients and exceeded the 90th percentile for similar sized hospitals with regards to minimizing mortality rates.

Socorro General Medical Group provides outpatient care at a family medicine clinic within the city of Socorro and is associated with PSGH. Presbyterian Medical Services (www.pms-inc.org) maintains one outpatient clinic in the city of Socorro, the Socorro Community Health Center, with doctors, nurses and provides care on a sliding scale. PMS also runs the Magdalena Area Health Center, which—during the assessment—was in between full-time providers and staffed with locum tenens providers. Both clinics provide routine care, mammography, substance abuse services and behavioral health through collaboration with Socorro Mental Health. Dr. Ravi Bhasker operates a private, outpatient facility within the city of Socorro. Veguita does not currently have a clinic; though, the potential need for a clinic has been in discussion among community leaders and policymakers.

Alamo maintains its own clinic that is open on weekdays. The clinic is contracted through the Indian Health Service and provides wellness care as well as routine visits by ophthalmologist, podiatrist, psychiatrist and other specialists. The clinic provides assistance with transportation both to the clinic itself and in arranging Medicaid/Medicare transport for Alamo residents. This transportation may require patients to travel to Albuquerque or Los Lunas with other patients and without family members. During stakeholder interviews, this was mentioned as deterrence for use of funded transport as

having family present during medical care was culturally and personally important to many patients. Alamo traditional healers had—at one time—worked in conjunction with the clinic on cases. However, at present, this was no longer occurring though traditional healers still provided care locally apart from the hospital.

In some areas in the reservation, it is not uncommon for one community to share a phone among several to many households. The clinic is able to use these community phones to alert patients to appointments or make contact with findings after an appointment. Alamo patients do not have access or easy access to the Internet and computers. So, if visiting hospitals or clinics that communicate via email or computer-based servers with patients (as is becoming common nationally), an Alamo resident may not be able to be easily reached or may never see lab results or other records. This is likely not unique to Alamo and an issue in other rural areas in the region that struggle to have dial-up phone and certainly would have challenges getting on-line.

No "after-hours" or weekend care is available within the county other than through the emergency department. The closest outpatient urgent care is in Belen, 30-45 minutes north of the city of Socorro, on the edge of Valencia County.

New Mexico Tech nursing staff provide care including basic care and counseling services including routine examinations, cultures and lab work, consultations and treatments for sexually-transmitted diseases, TB testing, referrals to specialists, prescriptions, and family planning. (www.nmt-edu/healthcenter) Socorro Consolidated Schools have school nurses who are active in nutrition and health education for the youth. A summer program, through the City of Socorro, provides youth an active opportunity to engage in healthy living through exercise programs, nutrition courses. The summer course also provides meals to many children who otherwise may not have access to sufficient nutrition during these months out-of-the school lunch program.

Chiropractic services are available at one clinic within the city of Socorro. At the time of the assessment, there was not an operating acupuncture/oriental medicine clinic.

Emergency Medical Services (Appendix 1: Maps)

The city of Socorro provides professional EMS services throughout the entire county. The city, at the time of the survey, had three ambulances and had recently upgraded two with GPS equipment due to challenges locating persons in rural areas. The city EMS is conducted through the fire department and consists of basic and intermediate EMTs certified responders. The city does not have a paramedic. The city ambulance may take patients to PSGH or to Albuquerque depending on level of care needed. Decisions are made in coordination with emergency department at PSGH.

The city will coordinate with Magdalena's volunteer EMS service that includes one intermediate and a few basic EMTs. The ambulance from Magdalena may assist in transporting persons from Catron County on the western edge of Socorro County to a location where either Socorro EMS or air medics can meet them. The Magdalena volunteer EMS is coordinated through PSGH.

Valencia County, at one time, had an agreement with Socorro County allowing for Valencia ambulance service to provide response within north Socorro County. This part of the county, including Veguita, is significantly closer to Valencia EMS. However, at the time of this needs assessment, this agreement was no longer in effect.

Alamo provides professional EMS with two ambulances and EMTs based out of their clinic. Alamo EMS provides for response throughout the reservation.

As part of emergency response policy in recent years, residents are required to have street addresses (i.e. no longer mile markers on county roads). However, drive-by assessment showed house numbers are not present in many areas- notably in rural areas and in Veguita. One stakeholder noted concerns about citizenship and address identification deter some in Veguita from keeping up street signs and/or house numbers. Additional GPS equipment on EMS vehicles may reduce response times and eliminate challenges from lack of street numbers in Veguita and other villages or rural areas.

Mental health

Socorro Mental Health is located across the parking lot from the hospital and within several blocks of the SGMG and PMS clinics. SMH takes referrals from the hospital, local clinics, Alamo Clinic and from law enforcement for therapy and psychiatric services. SMH has a 24-hour hotline locally for mental health crisis situations. The SMH Casa de Esperanza is a psychosocial day program (outpatient) for adults with mental illness to gain daily living skills in a structured environment. The Comprehensive Community Support Services address community-level barriers to independent living for their clients. This program also assists families and clients through support during crises. SMH provides substance abuse programs on an outpatient basis—including for persons returning from inpatient care out of town—through individual and group programs. SMH works with the Child, Youth and Family Dept. on in-home and family support services. In coordination with Adult and Juvenile Probation, SMH focuses on mental health, life skills, psychiatric services, monitoring and substance abuse for persons in the probation system. At the time of the assessment, SMH also provided fatherhood programs and tobacco cessation programs.

Socorro does not have any in-county inpatient psychiatric or substance abuse treatment. In fact, the closest state-run programs are over an hour and up to 4 hours away. According to

the state health department. New Mexico has 6 facilities providing long-term care of health and mental health issues. The 250-bed facility in Bayard, NM (150 miles from Socorro) provides long term nursing care, in and outpatient chemical dependency. In Las Vegas NM (200 miles from Socorro), the state psychiatric hospital provides inpatient care for adults, adolescent sex offender treatment, has a dementia program and provides community support through telemedicine. In Roswell, (160 miles away), a facility provides some chemical dependency and psychology services as well as other physical and occupational rehabilitation. The Sequoyah, in Albuquerque (75 miles away) has 36 beds for inpatient treatment of adolescents with history of violence and mental disorders. The Turquoise Lodge in Albuquerque provides 34-bed for medically-managed inpatient chemical dependency detoxification and rehab treatment.

Mental health patients are transported to these facilities by law enforcement—usually not receiving medical treatment prior to transit. Transportation back to Socorro, based on stakeholder input, is not provided by the state hospital but must be determined by the patient. Having a local program for alcohol and drug rehab, based on stakeholder input, is important to decreasing recidivism. Socorro Mental Health provides outpatient programs related to substance abuse. Alamo Clinic has a behavior health specialist and has local programs. SMH's 24-hr call line for mental health emergencies received 400 emergency calls in 2003.

Several of the Socorro local providers have been trained in using suboxone for use in treating opiate-dependence and refer patients for counseling. However, it is not clear the degree to coordination between the counseling and suboxone services as they are not necessarily provided through the same entity—making follow-up a challenge. In a local talk during the summer of 2011, several providers expressed anecdotal support for the suboxone services in addressing the local epidemic of opiate dependence. Providers administering suboxone have undergone specific training in order to provide this option. As opiates have been given often as part of a clinic regimen, the degree to which they are treated clinically as a substance abuse issue and not simply a medical issue seems to depend on provider and treatment program.

The Heritage Program for Senior Adults provides outpatient, daily care and group sessions for persons with geriatric issues such as loneliness, sleep issues, loss of motivation, anxiety, depression and loss of a spouse. The program is administered at the PSGH facility and care is coordinated with a psychiatrist through telemedicine. The program includes transportation to services for those without.

Select Additional Community Based Programs

Socorro County has a variety of community-based services—not all of which are included in this account.

PSGH's CBPs include Healthy Family Initiative & First Born-Socorro, Early Intervention/Casa Alegre, HomeCare & Hospice, Heritage Program for Senior Adults and a community-based Diabetes Prevention Program. PSGH staff has a combined 87 years of experience in community health. For successful community work in a tri-cultural setting, all PSGH CBP staff have demonstrated cultural competency in job performance and are required to complete a cultural competency evaluation annually. The programs have a bilingual staff, including 3 Certified Medical Interpreters, enhances trust among clients. PSGH-CBP has collaborated with Navajo partners to develop a *Navajo specific* adolescent health, risk-avoidance curriculum called "Walk in Beauty", and works with local translators as needed. CBP staff assists "non-bilingual" community providers to gain insight on how to best serve clients.

Healthy Family Initiative focuses on family well-being through many programs. HFI works on adolescent risk avoidance, collaborating with local law enforcement on drug abuse issues and parenting classes. PSGH HFI staff are involved with a task force is conducting a needs assessment specific to juvenile justice and child abuse issues within Socorro County.

One of the highlight successes of PSGH CBPs is the First Born Program, providing services to first-time parents on healthy children and healthy families. In 2011 SGH had 151 deliveries and 20 maternal transfers. Over 43% of 2011 Socorro births were documented as "High Risk" due to chronic/acute health issues, drug/alcohol use, and teen aged mothers. Of the 231 mothers delivering babies from Socorro County, 80 (many high risk) delivered in Albuquerque hospitals. Over the past three years, First Born Socorro home visitation program provided culturally appropriate services to approximately 50 first time families/year—despite having funding for only 30 per year. FBS helps families from across the county from pregnancy through the child's 3rd birthday. Promotoras, community health workers, visit with families at the home or as well as in the CBP office—reducing the barriers of transportation and distance that may make regular health visits difficult for many persons in the county. FBS promotoras provide parent education using both an individual and group approach.

SGH-CBP has experience in addressing child abuse and neglect issues. Over the past 2 years, 10% of First Born Socorro clients have had a CYFD referral for Child Abuse and Neglect and 18.3% of Casa Alegre Early Intervention clients having had referrals. In additional to training specific to their programs, FBS and the Early Intervention program staff have attended child abuse prevention trainings and three staff members are currently

working toward infant mental health endorsement from the NM Infant Mental Health Association (NMIMHA) to further expand their skills.

Positive Outcomes (positiveoutcomestherapy.com) provides community-based services of occupational and physical therapy, personal care, and childhood development. PO works across the county and receives referrals through the Socorro Consolidated, Cottonwood Valley, Reserve, Santa Fe public schools and through Socorro and Torrance Counties, Developmental Disabilities Waiver, Medically Fragile Waiver and Disabled and Elderly Waiver.

According to an online non-profit database,[xl] El Puente was founded in 1987 and has 501 (c) (3) nonprofit status with an annual budget of $500,000-$749,000 with a mission to provide shelter and services for victims of domestic violence. El Puente also provides legal services, orders of protection, counseling and 24 hour crisis intervention and assistance, along with food, clothing, supplies and transportation to participants. El Puente maintains a domestic violence shelter for 18 persons,[xli] receives state and local funding, serves both Catron and Socorro Counties, and provides empowerment programs for victims and batterer's intervention for perpetrators involved in domestic violence cases. Cases for El Puente are referred from law enforcement and services for both victims and perpetrators are located within one facility in the central area of town. Male victims of domestic violence are not seen as often as women and are placed in the batterer's program. The victim program includes group empowerment courses with discussions – including movies that involve domestic violence. Programs have been designed uniquely for El Puente by staff.

Current Knowledge on Priority Topics

Access to care

The United States has arguably one of the technologically advanced, clinically specialized care programs in the world. Access to this care is limited for those who lack insurance, who live in poverty or in rural areas without public transport to hospitals, or who do not speak the same language as their providers. The rural Southwest faces particular challenges in addressing health disparities due to the diversity of cultures, language limitations and large distances between locations.

In addition, rural New Mexicans may face challenges accessing care due to issues associated with lack of insurance, poverty, provider shortages, cultural barriers and lack of transportation. In New Mexico 32/33 counties are designated federally as health professions shortage areas, underserved areas or populations.[xlii] A 2010 report indicates a statewide deficit of 400-600 primary care providers and 1000 nurses. Provider shortages are considered a grave underestimate due to the fact a third of providers licensed in NM

practice out of state and 17% of licenses are inactive.[xliii] With the 2014 statewide implementation of the U.S. Affordable Care Act, the state is projected to be short 2800 nurses by 2015 with an estimated 350,000 more residents accessing care. [xliv] New Mexico is 49th out of all the states in percentage of persons without insurance currently.[xlv]

In Socorro County, 27.3% live in poverty and similar levels lack health insurance—10 % more than state levels.[xlvi] Most recent reports from the Centers for Disease Control and Prevention find that while 40% of adults nationally have at least 1 chronic disease, on average 25% have not had health insurance for the past year. Forty percent of the uninsured suffering from chronic conditions such as diabetes skipped care due to cost.[xlvii] In Socorro County for 2010, 27.4% on average are enrolled in Medicaid; in New Mexico, 23.4%.[xlviii] For Socorro, 27.3% report not having insurance in a national survey in 2009; higher than the state, 22.9%, and country, 18.8%.[xlix]

Within Socorro County in the town of Veguita, 89.2% of children live in poverty; in the Navajo community of Alamo, 72.5%.[l] In this Hispanic (47.8%)[li] county, forty percent of homes do not predominantly speak English. Almost half of the residents live outside the main town, sparsely spread out dotted in small towns and ranches throughout the expansive landscape.[lii] Transportation, education, economic and cultural disparities will presumably make it difficult for many to access health services.[1] In fact, the Socorro County Commissions Resolution 2005-52, "Code of the West" for new residents advises that emergency response times for healthcare in such a rural region cannot be guaranteed and may be slow and expensive.[liii]

Health disparities in accessing care

Disparities among ethnicities in access to care have been documented. A 1998 study of Latino inner city parents cited cultural differences, poverty, lack of health insurance, transportation difficulties and long waiting times as the major barriers preventing their children from accessing appropriate healthcare.[liv] A 2008 study found 21% of Latino children, 15.5% of Native American children in a nationwide survey were uninsured compared to 5.7% of white children.[lv] A 2003-04 national survey showed 45.1% of Native American families listed transportation as a limitation to accessing care; compared to 3.9% of whites and Latinos.[lvi].[lvii] Stakeholders during the pre-assessment described access to care issues as including poverty, lack of transportation, low level of understanding/education of health issues and not knowing the programs exist. The assessment specifically asked how people learn about programs in order to improve future CBP outreach efforts.

In evaluating health outcomes at a national level, researchers identified a difference in perceived health quality between whites—68.7% reported being in good or excellent health compared to 41.8% of Latinos and 55% of Native Americans.[lviii] In the 2003-04 study comparing whites to Native Americans and Latinos, whites were more likely to have a usual source of medical care and a doctor appointment within the past year. [lix] The CNA data from Socorro are designed to determine if a similar trend holds true at a more fine-grained geographic scale in a rural area.

Rural living and accessing health care

Living in a rural area geographically may limit care. An AJPH 2004 editorial cites transportation, low density, fewer public funds, trouble recruiting medical staff and fragmented resources as challenges faced in providing rural healthcare.[lx]

In a survey of rural health leaders nationally, access to quality health services was cited as a priority in a 2010 survey of rural health leaders nationally.[lxi] One study proposes financial limitations to health care among rural families may be due to the fact that rural jobs are less likely to be unionized and have insurance. They indicate note that for rural families, the primary resource is the land.[lxii] A North Carolina study also demonstrated transportation is a major issue for rural families who rely on family or friends for transportation.[lxiii] A study in the Spokane County, Washington also noted cost, transportation, scheduling an appointment, comfort with providers and trouble missing work as barriers to accessing care.[lxiv] This assessment found difficulty accessing care to be significantly related to income level, age, ethnicity and[lxv] education. [lxvi] In evaluating of health disparities among rural Hispanic elders noted Hispanic elders are less likely to use long-term care facilities despite a greater need due to preference in being cared for by family or living along and that they prefer home care to long-term care facilities. The authors recommend that nursing homes provide culturally appropriate care- including language. New Mexico rural elderly living in Grant County noted access to care—including to pharmacies and to long-term care facilities—to be a priority health care issues.[lxvii]

At this point, most existing literature on the subject of rural health focuses on white rural populations.[lxviii] One qualitative study of rural elders in Grant County, New Mexico found rural elders had transportation difficulties in accessing regular care, many were not aware of programs available to help defray healthcare costs and communication issues due to cultural and language differences.[lxix] This CNA included questions about these and other potential barriers to care in the survey tool.

Diabetes

Diabetes is a term describing a condition in which the cells in the body do not get the glucose (or sugar) they need to produce energy either because of low levels of the hormone

("insulin") which brings helps glucose enter cells and/or because the cells "resist" insulin. The result is high blood sugar that impacts the small vessels and organ systems throughout the body. Twice as many people die from diabetes in Socorro County compared to the rest of the country. While 18.8 million people had been diagnosed with diabetes nationally as of 2010, an estimated 25.89 million people are affected indicating many people have it but have not been diagnosed. The sooner diabetes is recognized and treated, the higher the likelihood in reduced associated morbidity and mortality.

Diabetes is both preventable and treatable; however, it is still the 7th leading cause of death in the United States. This disease is a top cause of kidney failure, limb amputations not related to trauma, and adult-onset blindness. It is known to lead to heart disease and stroke. National data indicates certain ethnic groups are more heavily hit by diabetes. The risk of diabetes among Hispanics is 66% higher than among non-Hispanic whites. Indian Health Service data in southern Arizona showed 33.% % adults diagnosed with diabetes; Alaska Native adults; 5.5%.[lxx]

One key to preventing diabetes onset is identifying individuals who are pre-diabetic through simple blood tests of blood sugar or A1c levels. Pre-diabetics already will have an increased risk for not only diabetes but also cardiovascular disease. Exercise and weight loss may prevent pre-diabetics from developing type 2 diabetes. Up to 10% of pregnant women are reported as having gestational diabetes; up to 60% of who may develop diabetes within 10-20 years of pregnancy.[lxxi]

Medical management for diabetes has been shown to improve prognosis including reduced risk of kidney, eye and nerve conditions with drops in A1C blood tests. Foot care prevention for diabetics may reduce amputations 45% to 85%. Laser therapy can reduce vision loss by 50%-60%. The 2007-2009 National Health Interview Survey found that nationally among all diabetics, 12% take insulin only and 14% take insulin and oral medication, 58% only take oral medication; 16% do not take medication. The Centers for Disease Control and Prevention note medical expenses for diabetics average twice that of people without diabetes.[lxxii] Studies indicate that lack of insurance—even during a short time out of work—leads people to skip diabetes medication and treatment.[lxxiii] As one community stakeholder emphasized, transportation and turn-over in doctors make long-term management of diabetes a challenge. Community members may also lack understanding of how diabetes impacts their bodies or how treatments and lifestyle changes may reduce the health risks from diabetes.

In addition to medicines, diet and exercise can reduce risks from diabetes.[lxxiv] The Behavioral Risk Factor Surveillance System in 2008 found 21% (95% C.I. 16.3-26.7%) of Socorro County adults are physically inactive, 25.2% (95%CI. 19.5-31.9%) are obese and 7.5% (95% CI 5.5-9.8%) diagnosed with diabetes. In comparison, Santa Fe County, New

Mexico has 12.2% (10.5-14.2) inactive; 12.9% (95% CI 10.9-15.1%) obese and 3.7% (3.0-4.5%) have diagnosed diabetes.[lxxv] At the surface, this difference indicates the potential for increased exercise and reduction in obesity may likely lower diabetes rates in Socorro County. However, underlying poverty and disparities in accessing care may make it difficult to provide obese adults, prediabetics and undiagnosed diabetics within Socorro County sufficient exercise and dietary interventions. Only 17.5% of adults in the county in a 2003-2009 study reported eating at least five servings of fruits and vegetables daily, lower than state and U.S. reports. However, youth rates were similar to national and state rates of fruits and vegetable consumption.[lxxvi]

A study of rural people with diabetes in the Midwest showed that those who were active reported better health overall. Their odds of being active increased if they had nearby places to walk and regular group activities.[lxxvii] A study of elderly Medicare beneficiaries with diabetes found those rural areas used less healthcare overall and were more likely to use home care than hospitals and clinics compared to their urban counterparts.[lxxviii]

Experts note community-based, culturally relevant health education programs are most effective; a 2003 review points out a need for evaluated or experimentally-designed programs with control groups to better evaluate how successful community programs can be in diabetes prevention.[lxxix] A more recent trial compared diabetics in a peer-led diabetes self-management program with those not in a program. While A1C did not change between the groups, those in the program had less depression, fewer symptoms of hypoglycemia, improved ability to read food levels, and improved eating and communication with physician.[lxxx] A 2012 economic model predicted if the community-based program, "Promoting a Lifestyle of Activity and Nutrition for Working to Alter the Risk of Diabetes" were implemented nationally- could save $5.7 billion in healthcare over 25 years.[lxxxi] "Vamos a Caminar" in the Colonias, Texas found a lower rate of depression, improved physical health after residents participated in a culturally sensitive walking group.[lxxxii]

One purpose of this CNA is to evaluate community participation is, interest in and support of community-based programs to help diabetics. Community-based programs may provide a cost-effective strategy to fill the gap in community education and care related to diabetes for families lacking the money, transportation or time to travel to a clinic in town.

Socorro recognizes this issue and is actively addressing the enormous burden of diabetes in their community. According to the most recent SCOPE Health Improvement Plan, PSGH partners with wellness centers, women's programs, gardening and agricultural groups, community health centers and after school programs to address diabetes prevention. PSGH CBP is currently coordinating a countywide diabetes education program with community outreach, regular lectures and meetings.

Tobacco

From the direct effects of smoking such as cancers, lung and cardiovascular diseases to the indirect damages of secondhand smoke (SHS) such as heart attacks, asthma, and cancers, tobacco-related illness and death have been well documented. The Centers for Disease Control and Prevention estimate 443,000 persons in the U.S. die from secondhand smoke and smoking on an annual basis; with 8.6 million more suffering from associated illnesses.[lxxxiii]The Surgeon General has determined there is no safe level of SHS exposure.[lxxxiv]

While indoor smoking bans have improved protections from SHS, across the country 53% of children and 61% of those living in poverty continue be exposed in their homes, workplaces or vehicles.[lxxxv] While the number of people smoking has decreased since the 1950s, 1 out every 5 persons in this country still smoke. More men (21.5%) than women (17.3%) smoke; those living in poverty (28.9%) smoke at a much higher rate than those living at at or above the poverty line (18.3%). Native Americans/Alaska Islanders (31.4%) smoke more than whites (21%) who smoke more than Hispanics (12.5%) at the national level.[lxxxvi]

Youth Grades 9-12 Smoking 1+ Cigarette/Last Month (2009 YRBS)	
Socorro	31.9% (CI 22.8-42.6)
NM	24.0%
US	19.5%

In New Mexico, smoking has decreased from 23.8% in 2001 to 18.5% nine years later. The Tobacco Use Prevention and Control Program of New Mexico Dept. of Health cites the importance of health provider interventions in contributing to decreasing smoker prevalence. Only about 4 in 10 smokers were advised to quit by their doctor in 2001; by 2009, almost 8 out of 10 were so advised. Like the rest of the country, those without health insurance or trouble paying for healthcare had higher rates of smoking (up to 31%).[lxxxvii]

Smoking during pregnancy is one of the leading causes of infant deaths and morbidity. Up to 8% of premature births, up to 20% of low birth-weight babies and as many as 34% of Sudden Infant Death Syndrome deaths have been attributed to smoking while pregnant. Nationally, 21.1% (CI 16.4–26.7) of Native Americans, 3.9% (CI 3.3–4.7) and 15.9% (CI15.1–16.6) of non-Hispanic white pregnant women in 2008 smoked during the last 3 months of pregnancy. For New Mexico in 2005, 8.6% (CI 7.0-10.5) of women smoked during the last 3 months of pregnancy.[lxxxviii] One out of 7 mothers smoke and one in five infants are exposed to environmental tobacco smoke within this region[lxxxix].

Preventing kids from becoming smokers is arguable more effective and cost effective than treating smoking related illness and cessation. However, in order to address tobacco related illness and death- a combination of prevention and cessation strategies is key. The CDC has compiled a list of effective strategies- including addressing community disparities

in smoking prevalence, communication strategies and cessation programs in the Best Practices for Comprehensive Tobacco Control Programs 2007.[xc] While providing smoking cessation programs to rural communities can be a challenge, Internet and email-based cessation programs have shown promise even within communities who do not routine use computers to learn about healthcare.[xci] [xcii] Yet, in Alamo, many lack phones and internet access; countywide, computer access cannot be assumed.

Containing over 20 carcinogens and being linked to cancers, oral disease and reproductive health problems, smokeless tobacco is not a safe alternative to smoking.

Unfortunately, 4.2% of New Mexican adults use smokeless tobacco-- a full percent higher than the national level.[xciii] Nationally, just like smoking, differences exist in who uses the product. Men (7%) use smokeless tobacco much more often than women (0.3%); 5.7% of Native Americans use smokeless products compared to 4.5% of whites and 1.1% of Hispanics.[xciv] The National Survey on Drug Use and Health found up to 8.4% of rural people nationally use smokeless tobacco.[xcv]

SGH provides courses in tobacco prevention and secondhand smoke as part of the Healthy Family Initiative.[xcvi] The Tobacco Use, Prevention and Control (TUPAC) Program at Socorro Mental Health focuses on tobacco cessation through classes, counseling, and pharmacotherapy, eliminating disparity among the Alamo Navajo Reservation, providing technical assistance for tobacco brief interventions and working to end tobacco disparity among the mentally ill and substance-abusing populations.

Maternal/Child Health

Prenatal Care & PreConception Care

Within this country each year, 12% of babies are born premature, 8% at a low birth weight, 3% have birth defects and 31% of women experience pregnancy complications. In order to address these serious issues, prenatal care standards have been developed related to healthy living (eating, exercise, not smoking or drinking) and routine medical check-ups. For most women, prenatal care begins at 11-12 weeks. For 2007, the U.S, 80%, and in New Mexico, 73% women (72.5-73.5%) of women receive prenatal care

Based on PRAMS data; 2005	Late or No Prenatal Care	Low Birthweight Newborns	Breast Feeding >/=8 wks
HFI Clients	**4%**	**3%**	**100%**
Socorro County	16.1%	12.4%	62.4%
New Mexico	39.2%	8.5%	61.6%

during the first trimester. In Socorro County 2008-09 data shows a lower rate than both state and national of only 50.5% (46.1-54.9%) of women received prenatal care within the first trimester.[xcvii]

In a 2001-02 survey of New Mexico women with no or late prenatal care, 36% did not get care because they did not know they were pregnant, 30% had no money or insurance for care, 26% were unable to get an appointment.[xcviii]

Preconception care is a newer concept related to minimizing risks to the fetus when it is the most vulnerable—during the first 4-10 weeks post conception. Current recommendations are to include preconception care discussions with women of childbearing years during routine medical appointments to discuss if how a pregnancy could be impacted by medications being taken, alcohol misuse, smoking, current medical conditions and genetic predispositions.[xcix]

In terms of preventable morbidity and mortality, Socorro County has several areas in which improvement is direly needed. In terms of maternal/infant health, PSGH CBP Healthy Family Initiative (HFI)'s First Born Socorro (FBS) has become a model program in terms of prenatal care interventions. As shown in the table, this PSGH CBP have successfully intervened with prenatal care, improving birth-weight and breast-feeding.

Teen Pregnancy

Nationally, teen pregnancy rates have fallen from the early 1990s, Almost one quarter of the reduction has been attributed to decreased sexual activity; for over 75%, the primary reason was improved contraception use.[c] The 2009 birthrate was 3.9 babies were born to every 1000 mother of ages 15-19. Teen pregnancies cost society billions each year in foster care, increased health costs, incarceration and lost taxes. Education level affects moms and their kids. Only about 50% of teen moms receive high school diplomas; and, their kids are more likely to drop out and to become the next generation of teen parents. Hispanic, Black and American Indian girls and any girl coming from a low socioeconomic background are more likely to become teen parents.

Intervention strategies have been evaluated to address teen pregnancy. The President's Teen Pregnancy Prevention Initiative and the Office of Adolescent Health are supporting programs to fund innovative, evidence-based programs to reduce teen pregnancy.

The CDC best practices model involves an evidence-based information program on risk factors to pregnancy, linkages to quality health services teens, community stakeholder involvement and sustainability. The model program goal is 10% fewer teen pregnancies, more students abstaining from intercourse and improved understanding of correct contraception usage. Washington State, Colorado, and North Carolina's programs have all been evaluated as scientifically based, successful intervention programs including the

above recommended best practice components.[ci] Due to the importance of family influence on youth decision-making, the CDC and the Academy of Pediatrics have prepared evidence-based programs for parents to help them address teen pregnancy concerns at home.[ciiciii]

New Mexico Department of Health Teen Pregnancy Prevention Program shows the state teen birth rate to be 52.7/1000 women. There has been a 20% decline since 1991, yet the state rate is still higher than expected nationally. The estimate for economic impact to New Mexico taxpayers in 2008 was estimated at $118 million. The NMDOH instituted Cuidate!, a 6 week Hispanic-culturally based sexual risk reduction program for teens, and TOP (Teen Outreach Program) , a 9 month evidenced-based service learning program to address pregnancy prevention.[civ]

Early Childhood Development

During the early years of childhood, a child develops cognitively and behaviorally. In recognition of the importance of a healthy early childhood and the need to identify developmental delays, early childhood intervention programs have been created. Programs include screening of young children to assess for appropriate development as well as home visitation programs for those children in need of services. According to a report of the National Governor's Association, a $5 benefit in terms of long-range health care costs has been calculated for every $1 spent on early childhood home visits.[cv]

The NGA cites research which shows that model early childhood programs have led to reduced cases of child abuse and neglect, improved readiness for school and improved literacy, enhanced prenatal care and immunizations. Support for parents is a key element of the successful model programs.[cvi]

Need for early childhood programs within New Mexico is high. A recent state-wide report noted only 5000, about 17%, of the state's newborns in 2010 received early childhood home visits.[cvii] The state currently has 53 programs for home visitations. Socorro County is one of the counties identified as having high vulnerability in child-raising capacity and seen as a priority area for early childhood programs. The vulnerability is partially based on the higher than state average numbers of children in poverty and children raised in single parent households.[cviii] The report recommends prioritizing low income, teen mothers and first-time mothers due to the fact the visitations have been proven to lead to long-lasting social, behavioral and health impacts.[cix] Within Socorro County, PSGH CBP provides early childhood services through the Casa Alegre Early Childhood Intervention Program. Through CA/EI, trained staff provides visitations for children throughout the county—including in Alamo and Veguita. Since CBP provides a first-time parenting program, First Born, children identified for developmental screening needs can be referred within the CBP programs. In addition to CA/EI, a program called Positive Outcomes also provides home

visitation services for early childhood intervention. In Alamo, an early childhood development center also focuses on children's cognitive and behavioral health needs and provides screenings, sometimes in conjunction with the other programs.

Providing programs which implement best practices which have been researched and thoroughly evaluated is important. Though Socorro is very vulnerable in terms of child-raising capacity, the First Born Program has reached an estimated 18% of families, slightly higher than expected by state levels.[cx] Both reports cited here discuss existing best practices models. The statewide report emphasizes the need for ensuring any early childhood program be accessible to even those most disadvantaged families. With the passage of the Affordable Care Act, additional funding may be available to continue to improve capacity among these existing programs in Socorro County.

Mental Health

Mental health incorporates a broad range of services including mental illness, substance abuse and violence. Intervention can stop a mental illness from ending up as an injury to oneself or others. According to NM DOH, "Globally, mental illness, including suicide, is the second leading cause of disease burden in established market economies." Suicide-related deaths among youth and adults in New Mexico, including Socorro, are well above national averages. Socorro youth report having persistent feelings of sadness or hopeless more often than would be expected by national prevalence rates.[cxi]

Substance abuse issues also impact Socorro disproportionally. Socorro ranks above state averages for cocaine, ecstasy and prescription pain killer use.[cxii] Drug-related deaths are almost twice as prevalent in Socorro County as in the rest of the US.[cxiii]

Drug Related Deaths/100,000 PY (95% CI) 2007-2009	
Socorro	23.9 (13.0-46.0)
NM	22.8 (21.6-24.0)
US	12.7

From 2001-2005, 40-60% of domestic violence cases in Socorro County involved alcohol and drug abuse. During 2008, 148 (2.8% higher than 2007) domestic violence cases were filed. More than one in ten women are abused during pregnancy.[cxiv] In 2010, 23.1 child abuse allegations/1000 children under 18 countywide were reported; this is higher than the state rate that year of 18.5/1000.[cxv] Understandably, stakeholder input was consistent with the SCOPE 2011-2014 Health Improvement Plan in identifying mental health as a critical area of need.

Mental Health in Rural Populations

Fifteen million of the 62 million people in the rural U.S. are estimated to struggle with mental illness. Addressing rural mental health issues is unique to urban setting due to several issues: lack of resources including multidisciplinary medical teams, confidentiality concerns, increased stress among family caregivers and altered boundaries between caregiver-patient and family.[cxvi] One researcher compared rural mental health clinics as "fishbowls" as comings, going and interactions are easily observed- possibly deterring usage. This researcher found that while specialty care may improve mental health outcomes, many prefer to seek care in a primary care setting. [cxvii]

For the past 20 years, rural suicide rates among the elderly have been triple that of urban elderly. New Mexico has the 6th highest suicide rate among adults nationally. Most counties lack alcohol treatment facilities and/or psychiatric beds in hospitals. Less than 10% of New Mexico counties have enough psychiatrists. In one qualitative study, nurses commented on challenges of providing care when psychiatrist only comes through every few months. [cxviii]

Providing culturally sensitive and appropriate mental health interventions are critical to program success. As one study noted, simply increasing providers does not work unless they understand the cultural context in which they work. For example, in a Hispanic community, the author noted not to generalize but to use the strong family-centered culture in creating a plan for patients.[cxix]

Prescription drug abuse is a national epidemic costing insurers up to $72.5 billion. The CDC reports enough painkillers were prescribed in 2010 to medicate every American adult every day for one month. [cxx] Men and middle aged persons abuse these medications most often. Rural persons are twice as likely to overdose as are whites and American Indian/Alaskan Natives. Programs targeting rural prescription drug abuse are currently being piloted in the country. Recommendations include improved prescription monitoring programs, monitor "doctor shopping," encouraging professional boards to take action against inappropriate prescriptions and increasing access to substance abuse treatment.

A novel program in North Carolina, Project Lazarus, successfully led to an almost 70% drop in opiate-overdose deaths from 2009-20111 by developing a multiparty collaborative to lower rates of abuse by focusing on community activation, epidemiologic surveillance, medical education, use of rescue medications and programmatic evaluation.[cxxi]

In Socorro County, there are no inpatient facilities for substance abuse treatment. In New Mexico, the inpatient facilities are in Albuquerque, Santa Fe, Carlsbad, Roswell, and Fort Bayard. According to a national treatment center association, 12% of all inpatient and outpatient facilities in the state are run by tribal governments, 6% by Indian Health Service (IHS), 2% VA, 8% Federal government, 3% state government, 3% local government, 18% private non-profit and 57% private for-profit.[cxxii]

Domestic Violence

Domestic violence, or intimate partner violence, impacts 1 in every 4 women. Approximately 85% of domestic violence victims are women-- with 1.3 million women are victims of physical assault by an intimate partner each year. Most cases are never reported in to the police and fewer than 1 in 5 victims with injuries access medical care.[cxxiii] One to two-thirds of persons who abuse his or her spouse also abuse the children.

New Mexico is one of only 3 states which does not require health care providers to report suspected domestic violence and is one of many which still do not have specific training, health care protocols or screening programs related to domestic violence. New Mexico does have a Domestic Violence Homicide Review Team and protections for victims against insurance discrimination.[cxxiv] A state report showed that law enforcement training had led to improvements in how to identify the primary aggressor. The report cites that significant increase in both identifying a victim and in identifying suspects from 2005 to 2009.[cxxv]

Socorro County's Domestic Violence Task Force meets regularly to discuss domestic violence issues. The task force incorporates both law enforcement and healthcare provider participation. El Puente provides all domestic violence services within the county. Over the past few decades, significant data have been collected to make it possible to evaluate how effective different programs are at reducing batterers from repeating abuse, in preventing cycles of violence and in helping victims of domestic violence. The U.S. Dept of Health and Human Services have identified model programs to address domestic violence and its impacts on families, tribal families, and low income children which all require evidence-based programmatic elements.[cxxvi]

Batterer's programs focus on breaking the cycle of the perpetrator continuing abuse. A 2009 report from the University of Iowa[cxxvii] identified key criteria as part of BEPs to be effective including: screening for psychiatric disorder, gender-based cognitive-behavioral batterer counseling, 3-4x week sessions during the first 1-2 months, swift response to non-compliance, ongoing risk/case management, continued support post any reunification with family members, and fatherhood training. The report lists two websites with model programs for domestic violence victims and their children. The Substance Abuse and Mental Health Administration (www.samsha.org) identifies 5 effective, high rated programs for victims and children of families with domestic violence: Children in the Middle, Cognitive Behavioral Therapy for Child Sexual Abuse (CBT-CSA), Families and Schools Together (FAST), Parenting Wisely, Safe Dates. A California organization has systematically evaluated programs using scientific evidence- their recommendations can be found at http://www.cachildwelfareclearinghouse.org/. An evidence-based approach clearly is possible and can provide a validated approach to addressing the complex issues of domestic violence.

Assessment

While many health issues face Socorro County, the 3 priorities for this needs assessment were chosen as follows:

- ✧ Diabetes, smoking and mental health issues are all impacting the community at levels beyond what is happening around the country. All were mentioned by stakeholders important issues for a needs assessment.
- ✧ They are "winnable battles," health problems that can be far less severe if caught early and for which interventions exist
    - Early diabetes detection and continued counseling on diet and exercise can minimize hospitalizations, eye problems, amputations and death related to the disease
    - Interventions of smoking cessation or in-home/car smoke policies can reduce health impacts from secondhand smoke and tobacco-related illnesses and deaths
    - Sustainable mental health counseling and interventions can help communities address substance abuse, violence and suicides

Assessment Methodology

Outreach

Obtaining sufficient sample sizes from a community as sparsely populated as Socorro can be a challenge. In order to maximize response rates and participation, an outreach strategy was implemented from May-June 2011. A fact sheet was developed to explain project to partners across the county (Appendix 3).

Photo 6. Alamo Chapter

To both create public awareness and to gain further community input on the project, the project was presented at the Socorro City Council Meeting on 5/23/2011 and at the Council for the Village of Magdalena meeting on 6/6/2011. The mayor of Socorro met with the CNA coordinator to discuss priority issues and to provide

input into the survey design and administration. The City of Socorro sent fliers in the monthly water bill (Appendix 4) in June to encourage participation from Socorro residents.

The Alamo Band of Navajo Chapter held a planning meeting (photo 6) in May at which they approved a presentation about the CNA for the June Chapter meeting. Per their request, a Navajo translator was brought to the Chapter meeting where the conduction of the CNA was authorized by a majority vote from the Chapter. The Chapter also provided suggestions for administration of the survey within the main area of the reservation (fitness center, mini mart, health facility, senior center) instead of attempting a door-to-door survey.

Photo 7. Schools assisted in outreach efforts for CNA

Socorro Consolidated School District also provided important outreach support to increase responses from families in the city of Socorro and surrounding rural areas. Two schools placed notices on their marquis that were easily visible from both the school parking lot, carpool line and nearby streets (Photo 7). One school sent home fliers with children on the last day of school. The First Baptist Church inserted the notice of the CNA in a May church bulletin. CNA volunteer staff posted fliers throughout the city of Socorro as well as in Magdalena and Alamo.

Media coverage also provided increased awareness about the CNA. The local Comcast station provided a public service announcement in both English and Spanish encouraging CNA participation beginning on 5/27/2011. On the same day, the *Magdalena Mountain Times* online published a story about the assessment. *El Defensor Chieftain* newspaper covered the story of the upcoming assessment on 5/28/2011. In Alamo, an hour-long radio show on KBAR discussing health priorities and the CNA was conducted in both Navajo (translated by DJ) and English on 6/22/2011 and replayed on 6/26/2011.

During the majority of the weeks of survey administration, the First State Bank electronic sign on the main thoroughfare through Socorro exhibited a multi-screen message encouraging residents to fill out the CNA survey. After the survey was complete, the bank sign changed to a thank you message to the community.

Community feedback during the CNA reflected that the outreach efforts had raised awareness about the project. Many residents during the convenience sampling said they had either read about the project or seen a sign “somewhere.”

Due to the fact the survey took time to administer, a token raffle ticket was offered. One of the CNA volunteers from Socorro approached local businesses and collected over 20 items

for a voluntary raffle which was conducted at the end of the survey. Many of the outreach materials noted the raffle as an incentive for completing the survey.

One of the strongest reasons for the success in survey administration for the project came from the existing relationships between the healthcare workers from PSGH CBP and the communities in which they work. Specifically, in Alamo, clinic staff who had worked with PSGH CBP came and spoke in support of the project at the Alamo Chapter meeting. In Veguita, promotoras from PSGH CBP created enough awareness through word-of-mouth that the systematic sampling was possible and successful. Overall, having PSGH support for the CNA provided legitimacy to the project and appears to have increased participation.

Survey Development

After identifying the priority targets for the needs assessment, a survey was created to address those target issues. The demographic questions were based on input from PSGH CBP and from existing questions from BRFSS, PRAMS and other surveys. It is important to note that statistical comparisons cannot be done between this survey and national surveys asking the same questions (due to differences in order and context of questions); however, descriptive comparisons are possible.

The literacy question is based on a screening tool identified by an expert at RSPH as the best tool related to health-care associated literacy.[cxxviii] The list of priority preventable health issues was compiled based on the indicator data identified and stakeholder input during the pre-assessment. The list of health facilities was created with consultation of health stakeholders, PSGH staff as well as the mayor in Socorro.

The questions related to current health status were adapted from current BRFSS questionnaires.[cxxix] Healthcare barriers reflect those cited as important in the literature and from pre-assessment community stakeholders. All questions related to CBP knowledge were developed in consult with PSGH CBP staff. Staff developed questions related to diabetes, maternal/child health, mental health, and early childhood intervention using background from existing state and federal surveys. Most of the tobacco questions were based on the CDC Adult Tobacco Survey tool for Hispanic Communities.[cxxx] The mental health priority issues were developed based on existing health indicator, and input from stakeholders and PSGH staff. The domestic violence question was developed based on concerns identified during the pre-assessment.

Income levels and ages were asked by category because local stakeholders stated people would be more likely to answer categorical questions than write in a number.

The survey was translated into Spanish by PSGH CBP staff with assistance from a volunteer living locally to ensure language was in appropriate, colloquial terms.

The survey was initially screened by PSGH CBP staff members who frequently work in the community and understand the literacy levels throughout the county. Words were modified as needed to improve readability. It was then piloted in English (n=5) and in Spanish (n=5) using trained volunteers (see below) to determine both whether questions made sense and how long it took to take. The survey was administered in the CBP office and at the John Brooks grocery store. Average time was 15-25 minutes to complete the survey. Feedback led to clarifying confusing words, adding "do not know" responses as options to certain questions, inclusion of additional clinic and hospital locations, inclusion of additional community based program names, and input that the survey took a long time to complete. The time issue was not addressed but identified as a component that may impact the survey completion.

In order to ensure anonymity, a coding system for the surveys was developed using initials from the location of surveys (to help determine if demographic differences existed between survey locations) and a three-digit number. Names and identities were never tied to the coded number. Raffle tickets were given to interested respondents and were always kept separate in a different envelope from surveys to ensure participant identities remained anonymous. A file system for survey collection was developed, including having one CNA committee member double-checking as they were returned to the office.

Survey Volunteer Training

All but one of the 24 persons trained in survey administration collected surveys in the field. Each survey administrator undertook a standardized training including a Powerpoint and handout which were developed for this project to minimize any sampling bias. The training discussed methods of survey collection, provided a survey script, explained how to do door-to-door sampling (including never going to house not "listed" during a systematic sample), and described how to handle non-respondents and questions about survey questions. Due to the many different survey administrators, the volunteers were instructed to not explain any question and to let the respondent know it is okay to say "don't know" or to skip a question. Volunteers were to practice reading aloud before administering any aloud. Only volunteers fluent in Spanish were authorized to conduct surveys in Spanish. Surveys were read aloud upon request. If a volunteer saw a respondent check that they had serious literacy difficulties on question 7, volunteers were allowed to ask if the person would rather they read aloud.

To go into the field, volunteers were provided clipboards, pens, an envelope for raffle tickets, a set of anonymously coded surveys and a separate envelope for completed surveys and—if appropriate—a list of houses for sampling.

Data from surveys were entered in Excel 2003. Four volunteers also completed a standardized training on data entry and coding. To practice, each person completed survey

entry and then checked another volunteers' entry. Through pilot data entry, several coding issues were identified and addressed prior to survey entry. Any comments were entered verbatim, without spelling corrections. Recoding of data for purposes of cleaning and analyses in SUDAAN and SAS software occurred after data was entered and reviewed.

Sampling Methodology

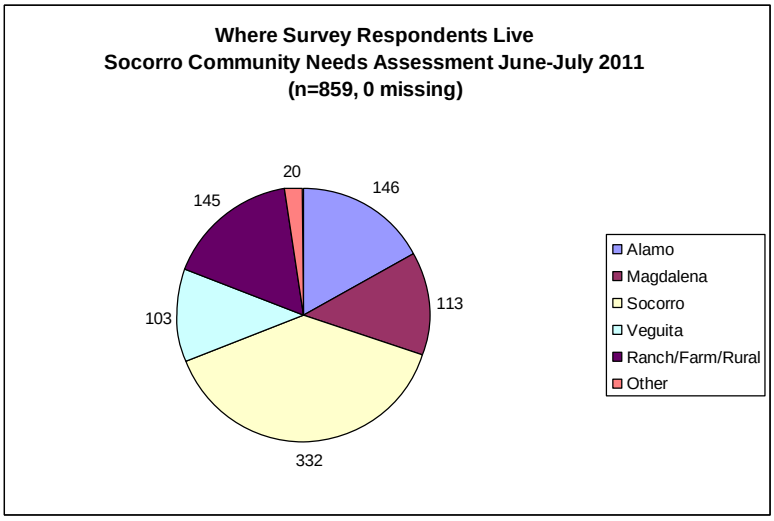
Survey Administration

The CNA target population included all persons over 18 years old who lived within the service area of PSGH and were willing to participate in the survey.

Stakeholder input prior to the CNA indicated data were needed to improve service to certain potentially underserved subpopulations in Veguita, Alamo and rural areas; however, stakeholders also emphasized that collecting data from these populations would be very challenging. In order to appropriately represent these populations, a stratified sampling protocol was designed using the above-mentioned strata: City of Socorro, Magdalena, Veguita, Alamo and Rural. Persons were identified as being from these locations based on self-assessment. Target sample sizes of 89-100 were calculated for each strata to detect a 10% difference between two groups with 80% power at 95% significance level. Sample size goals for each location were exceeded.

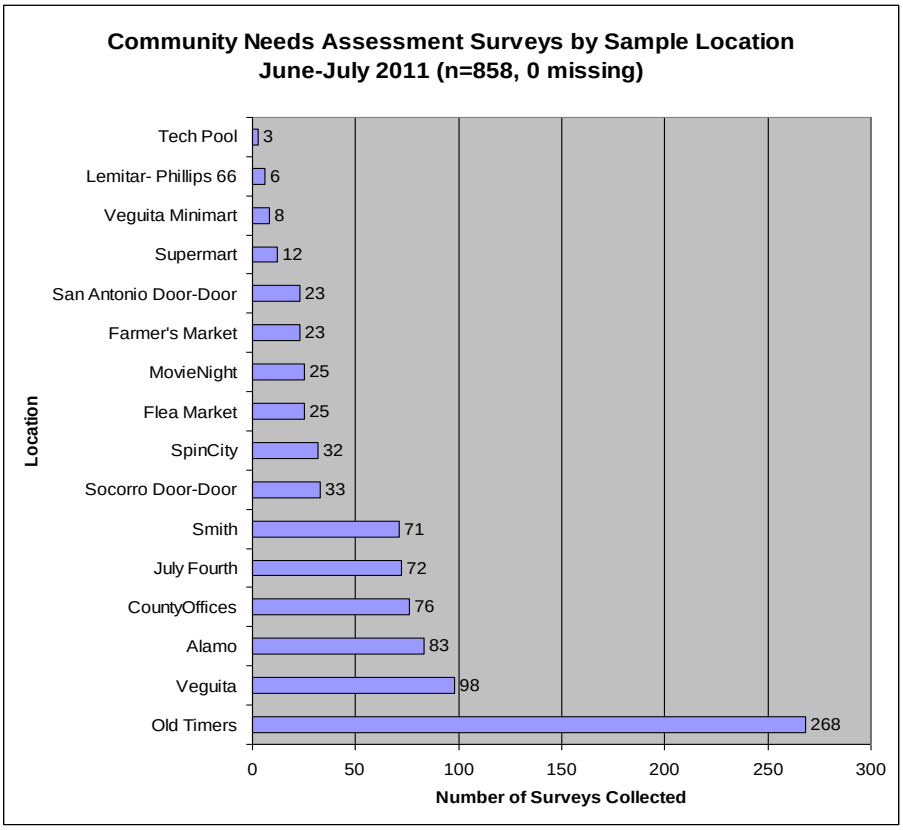
Originally, the CNA aimed to solely conduct a systematic sampling of households along; however, due to the sparse housing and physical barriers to accessing many rural households, convenience sampling was predominantly used. For Veguita, a dice was rolled to select the first house on the eastern side of town and then households were enumerated using a sampling fraction of 4 (every 4th house) to pre-list the households to be sampled. At these households, the first person over the age of 18 available was asked to respond to the survey. In Veguita, the majority of families work on ranching, farming or on shifts with the dairies and are often found home though frequent uses of gates, electrical fencing and guard dogs prevented many houses enumerated from being sampled. A total of 57.5% response rate was obtained (based on 103 of the surveys from 179 households). Due to the current drop in census participation, this response rate was considered successful for this community. Non-respondents were primarily due to inaccessibility to the home or persons not being home. Out of the 103 surveys collected in the systematic sample in Veguita- 47.6% were administered in Spanish.

Figure 1. Sample Sizes Collected by Respondent Residence



For Socorro and Magdalena, systematic sampling was started but not implemented due to inefficiencies in collecting representatives samples. In Alamo, the Chapter and local promotoras advised the survey coordinator that the door-to-door survey administration would not be possible or effective. For rural areas, the city of Socorro and village of Magdalena, civic leaders and local healthcare workers advised door-to-door surveys may not be fruitful due to concerns about crime, gates and guard-dogs blocking entry to properties and community reluctance to allow persons not invited in to complete a survey. Vast distances between ranches decreased the likelihood sample sizes could be met using door-to-door sampling methods within the two-month timeframe.

In order to collect data reflective of the community perceptions, the CNA conducted convenience location survey collections with trained survey administrators at targeted locations. Persons from throughout the county come to the city of Socorro for groceries and other errands. Due to lack of laundry facilities in Alamo, many Alamo residents visit Socorro laundromats. Socorro and Catron residents attend New Mexico Tech's Fourth of July celebration and Magdalena's Old Timer's Rodeo event. Rural residents frequent both the local farmer's markets (selling goods). Convenience samples were collected at the Farmer's Market, Smith's and John Brooks Supermarkets, Senior Center, at all county offices including the courthouse, Spin City Laundromat, NM Tech 4th of July Celebration in the city of Socorro, at Old Timer's in Magdalena, and at the local minimart, gymnasium and Senior Center in Alamo. In total, 859 surveys were collected.



Surveys were administered within eyesight of the volunteer so that, if questions arose, they could be addressed. Volunteers were instructed to only survey persons over the age of 18 who lived or worked within Socorro County or nearby areas that also use the hospital (such as Catron County). Each surveyor was directed to place their initials and date on the top of each survey they administered prior to survey administration. Surveyors checked a box to indicate if it a survey were read aloud to the respondent. For sampling in Veguita, maps and addresses of target houses were placed in a separate location as well.

Surveys were collected in June and July 2011, predominantly in writing (95%) unless persons requested to have the survey read aloud. Each survey was conducted individually though other persons may have been present—such as other family members in a home or, at the Senior Center in Alamo, the surveys were translated to the group of seniors at one time due to the fact a translator was assisting two Navajo elders with the survey. The Navajo translator had not undergone the full survey administration training but was instructed to directly translate each question as written and not to explain, describe or embellish upon the written questions.

Survey Data Management

Two of the four trained persons entered all collected survey data into Microsoft Excel (2003) after passing the standardized data entry training. One of these people is bilingual and entered over 80% of the surveys, including all of the surveys in Spanish. Data entry for each survey was double-checked by this author and fewer than 5% of the surveys had an incorrect entry.

Data cleaning included ensuring correct coding for use in SUDAAN, illegible answers were coded as missing data. Certain questions required additional data management. Data cleaning, for example, included when persons wrote in a number larger than the potential denominator- the maximum number was used. When two answers were checked, in terms of likert scales, the value closest to the middle range was chosen. Write in answers, as possible, were translated into numeric values. For the barriers to care—which were provided in a chart format (Appendix 2), some persons only checked boxes for "yes" but skipped others. For these persons, all values not checked were assumed to be "no." For persons who checked some "yes" and some "no," any additional skips on this question were not included.

The following data were analyzed separately: anyone who lived outside of Socorro. Data which were excluded were residents beyond the service area of the hospital (i.e. Albuquerque), persons under 18 (2 persons filled out the survey who were underage), surveys which were taken by more than one person, one survey which was partially complete but the administrator noted the respondent was too intoxicated to complete accurately, and two surveys for which respondents quit after just a few of the demographic questions.

Due to the fact data collection intentionally over-represented specific underrepresented locations, data were adjusted prior to analysis using a post-stratification weighting (weights=proportion of persons in a given location within the county based on the census/proportion of persons in the sample in the given location). The latest finalized census data (2000) was used to develop weighting proportions.

While women were also overrepresented (61% of the sample), post-stratification was not conducted on gender due to the fact women are more frequent users of healthcare systems and, in fact, are 60% of PSGH clientele. Weights (Table 4)were calculated after all exclusions applied (n=835). Data from Catron, Torrance and Valencia Counties were evaluated separately.

Table 4. Post-stratification weights for data adjustment

Strata	Weights
Socorro City	1.220
Magdalena	0.372
Alamo	0.372
Veguita	0.866
Rural *	1.633

*Rural values estimated based on countywide demographics and included persons not living in the above listed localities.

Survey Data Analyses

Descriptive analyses were conducted using SAS 9.0 and SUDAAN. Descriptive univariate analyses for continuous data were conducted by county, gender, location, age and poverty level. For the purposes of these analyses, the cutoff was set at 135% of the federal poverty level (or $30,000) for average household income. NM Human Services Department states an income of 120%-135% of the federal poverty level qualifies individuals under Medicaid.

Qualitative Data

Due to the nature of qualitative information collected from stakeholders, the information will be included in the results section under the topic mentioned within the stakeholder meeting. All meetings were conducted as open interviews though needs, priorities and innovative approaches to addressing any under met needs were discussed. The stakeholder meetings also provided the CNA team with further information about services available.

A focus group of 5 diabetes patients was conducted to discuss their perceptions of diabetes in their community, concerns and strategies related to diabetes interventions. Responses were left anonymous and will be discussed in aggregate in this report. The participants signed consent waivers prior to participating in the focus group. Due to the small sample, findings will be discussed during the diabetes section of the results but were not quantifiable for further evaluation.

Results

All results are based on post-stratification analyses in SUDAAN after exclusion criteria were applied. Due to difference in response rates for different questions, number of respondents will be noted for each question as (n=). For frequency information, percentages will be provided with standard error (SE). For continuous variables (like minutes to town), an average or mean value will be used with a 95% confidence interval (CI) as well as the median (or 50% mark) also with a 95% CI. Final sample included 145 surveys are included from Alamo; 112, Magdalena; 145, Rural; 332, Socorro City; 101, Veguita; 305, women.

Demographics of Survey Respondents

(See Tables 5-9)

Understanding the dynamics of health issues and health access in a community requires thorough knowledge of community demographics. While U.S. Census data was used for adjusting data, it may likely have undercounted many persons within this community due to difficult access to rural homes, lack of participation and concerns of citizenship.

For this analysis, the 135% of federal poverty level[cxxxi] for a family of four was the income cut-off used- $30,000 annual household income. The high prevalence of respondents living poverty were consistent with past census findings: 33.1% (2.0) live below $20,000/year; 52.4% overall live below the $30,000 cut-off. Living wage for Socorro County is estimated at $47,346/year for a family of four.[cxxxii] Alamo and Socorro had more respondents stating household income under $10,000 Magdalena and rural were $20-29,000; Veguita responses were most often $10-19,000. It is important to note up to 25% of responses related to income are missing, unknown or not willing to respond for the different groups.

Overall, 60.2% of respondents were female. Slightly more men responded in the >65 age range (20.5% SE 2.6) compared to women (13.1% SE 1.7). Twenty percent more women than men reported household incomes below $30,000/year. Women report driving a few minutes more to the hospital on average- compared to men. Overall, persons reported having an average of 2 children per household. Those making under $30,000 per household overall were Hispanic as were those making over $30,000 (though whites were a close second for the higher incomes).

For the entire survey, 4.5% (SE 0.7) were read aloud by survey administrator. Women and men had similar literacy levels based on a question screening for ability to read materials from doctor or pharmacy. There was a 15% difference between those in the higher and lower income levels for the literacy-screening question. Corresponding to this, a much higher percent of persons living under the poverty level required the survey to be read aloud 5.2% (SE 1.2) compared to 2.6% (SE 1.0) for those with higher household incomes.

Respondents work throughout the county and a few work out of the county. Almost one out of every three people responding to the survey said they are not working (some of these wrote in next to the response “retired”).

Alamo respondents were predominantly female, American Indian, young and had on average one more kid per household compared to the other areas in the study. With 3 out of every 4 persons reporting below poverty household incomes, Alamo had the most severe poverty prevalence in this project. Some Alamo respondents reported driving up to 3 hours to reach PSGH; the average was almost 69 minutes. Alamo respondents had the highest

percent of surveys read aloud (9.7% SE 2.5). Alamo had more people reporting difficulties in reading material from their doctor or pharmacy.

Magdalena had the highest percentage of women; the same number of kids/household as the county overall; and, the highest proportion of respondents over 65 years old. Magdalena respondents were mostly white and were less likely to live in poverty than other areas of the project. They drive about half an hour to reach PSGH. Only 2.7% (SE 1.5) of surveys were read aloud; most respondents never had issues reading write materials from doctor or pharmacy.

Rural residents were mostly 45-64 years old, white and had a lower rate of persons living in poverty compared to other areas in the study. Average driving distance to PSGH from rural households was about 25 minutes. Fewer rural residents needed the survey read to them compared to other locations (2.1% SE 1.2) and most had no trouble reading written material from doctor or pharmacy.

Socorro respondents were well distributed by age, mostly female, the lowest average number of children, and half of respondents reporting household income below $30,000. Residents were predominantly Hispanic/Latino. They drive on average 9 minutes to reach PSGH. Almost 5% of respondents had the survey read aloud; about 68% of respondents never had trouble reading written material from doctor or pharmacy.

Veguita demographics reflected that it is predominantly Hispanic, has more respondents in the 25-44 year age range and over two-thirds living in poverty. Average driving time to PSGH from Veguita was reported to be 41 minutes. Like Alamo, Veguita had a high rate of surveys read aloud at 6.9% (SE 2.5), and literacy more of an issue in this community.

Table 5 Respondent Demographics by Location of Residence, Age, Gender, Income, Number of Kids
[% (Standard Error)]

	18-24 yrs % (SE)	25-44 yrs % (SE)	45-64 yrs % (SE)	>65 yrs % (SE)	Women % (SE)	< $30,000 Household/yr % (SE)	Average # kids<18 * (95% C.I.)
Alamo	17.4% (3.2)	43.1% (4.1)	35.4% (4.0)	4.2% (1.7)	61.7% (4.2)	75.5% (4.2)	2.9 (2.6-3.3)
Magdalena	5.3 (2.1)	27.7% (4.3)	35.7 (4.6)	31.3 (4.4)	68.3 (4.6)	46.2 (5.3)	2.2 (1.9-2.5)
Rural	7.6 (2.2)	21.5 (3.4)	48.6 (4.2)	22.2 (3.5)	57.1 (4.2)	47.5 (4.6)	2.2 (1.8-2.6)
Socorro	11.9 (1.8)	40.4 (2.7)	35.3 (2.6)	12.5 (1.8)	60.6 (2.7)	50.4 (3.1)	2.0 (1.8-2.2)
Veguita	8.9 (2.9)	44.5 (5.0)	32.7 (4.7)	13.9 (3.5)	61.4 (5.0)	66.7 (5.5)	2.2 (1.9-2.4)
Women	11.8 (1.6)	37.1 (2.4)	37.9 (2.5)	13.2 (1.7)	----	55.2 (2.8)	2.2 (2.0-2.3)
< $30,000 Household/yr	13.3 (1.9)	40.0 (2.9)	29.1 (2.7)	17.6 (2.3)	64.3 (2.9)	----	2.2 (2.0-2.3)
County	**10.4** (1.2)	**35.0** (1.8)	**38.9** (1.9)	**15.8** (1.4)	**60.2** (1.9)	**52.4** (2.2)	**2.2** (2.0-2.3)

*Only for persons reporting having children under 18 years old in household n=(Alamo: 98; Magdalena: 40; Rural: 50; Socorro : 139; Veguita=58; women:244; <30,000/yr):188 total: 385)Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 6. Reported Annual Household Income

[% (Standard Error)]

Mean Household Income (x$1000)	<10	10-19	20-29	30-39	40-49	50-59	60-69	70+	DNK/ Missed/ no answer
Alamo	**30.0%** (3.8)	15.2% (3.0)	11.0% (2.6)	11.0% (2.6)	2.1% (1.2)	2.1% (1.2)	2.1 % (1.2)	0.7 % (0.7)	26.9 % (3.7)
Magdalena	11.6 (3.0)	8.9 (2.7)	**17.0** (3.6)	9.8 (2.8)	9.8 (2.8)	8.0 (2.6)	2.7 (1.5)	13.4 (3.2)	18.8 (3.7)
Rural	9.0 (2.4)	12.5 (2.8)	**18.1** (3.2)	7.6 (2.2)	9.0 (2.4)	4.2 (1.7)	9.0 (2.4)	13.2 (2.8)	17.4 (3.2)
Socorro	**14.5** (1.9)	12.1 (1.8)	13.3 (1.9)	8.2 (1.5)	8.5 (1.5)	6.3 (1.3)	4.5 (1.1)	11.8 (1.7)	20.9 (2.2)
Veguita	13.9 (3.5)	**15.8** (3.7)	19.8 (4.0)	5.9 (2.4)	4.0 (2.0)	5.0 (2.2)	3.0 (1.7)	6.9 (2.5)	25.7 (4.4)
Males	7.8 (1.6)	14.5 (2.2)	**14.5** (2.3)	9.1 (1.8)	9.0 (1.9)	6.5 (1.5)	8.3 (1.8)	9.2 (1.8)	21.1 (2.6)
Females	**17.5** (1.9)	10.5 (1.6)	15.8 (1.8)	7.6 (1.3)	7.5 (1.4)	4.8 (1.1)	3.9 (1.1)	11.7 (1.7)	20.7 (2.0)
County	**13.6% (1.3)**	**12.7% (1.3)**	**15.4% (1.4)**	**8.1% (1.0)**	**7.8 % (1.1%)**	**5.4% (0.9)**	**5.4% (0.9)**	**11.0% (1.2)**	**20.7 (1.5%)**

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 7. Respondent Demographics by Ethnicity

[% (Standard Error)]

	American Indian/ Alaska Native	Asian/ Pacific Islander	Black/ African American	Hispanic/ Latino	White	>1 Ethnicity	Other	Declined/Not Sure
Alamo	**93.1%** (2.1)	1.4% (1.0)	0%	0.7% (0.7)	0.7% (0.7)	2.8% (1.4)	0%	1.4% (1.0)
Magdalena	8.0 (2.6)	0	0	26.8 (4.2)	**54.5** (4.7)	3.6 (1.6)	2.7 (1.3)	4.5 (2.0)
Rural	6.9 (2.1)	0.7 (0.7)	0	32.4 (3.9)	**51.0** (4.2)	3.5 (1.5)	1.4 (1.0)	4.1 (1.7)
Socorro	3.9 (1.1)	1.2 (0.6)	2.1 (0.8)	**57.8** (2.7)	27.7 (2.5)	3.3 (1.0)	1.5 (0.7)	2.4 (0.8)
Veguita	0	0	0	**75.3** (4.3)	18.8 (3.9)	3,0 (1.7)	1.0 (1.0)	2.0 (1.4)
Wome	10.9 (1.2)	0.7 (0.4)	0.8 (0.5)	**49.6** (2.4)	31.8 (2.4)	2.4 (0.7)	1.2 (0.6)	2.7 (0.9)
Men	8.7 (1.4)	0.9 (0.6)	1.6 (0.8)	**44.4** (3.1)	36.2 (3.0)	3.8 (1.2)	1.3 (0.7)	3.1 (1.1)
<30,000/yr	15.4 (1.7)	1.3 (0.7)	0.7 (0.5)	**48.8** (2.8)	**26.8** (2.6)	1.3 (0.7)	0	3.1 (1.0)
>30,000/yr	5.3 (1.1)	0.9 (0.6)	1.2 (0.7)	**45.0** (3.1)	**41.3** (3.1)	1.1 (0.6)	0	1.1 (0.6)
County	**10.4 % (0.8)**	**0.9% (0.4)**	**1.0% (0.4)**	**47.1% (1.8)**	**33.1% (1.8)**	**3.3% (0.7)**	**1.4% (0.5)**	**2.9% (0.7)**

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 8. Work Locations as Reported by Respondents and Described by Location of Residence [% (Standard Error)]

Location of Residence	Work in Alamo	Work in Magdalena	Work in Ranch/rural	Work in San Antonio	Work in Socorro	Work in Veguita	Not working*	Work >1 places	Abq/ Out of area
Alamo 3.5%missing	**46.4%** (4.2)	2.1% (1.2)	0.7% (0.7)	0	10.0% (2.5)	0	37.1% (4.1)	3.6% (1.6)	0
Magdalena 3.6%missing	2.8 (1.6)	36.1 (4.6)	1.9 (1.3)	0.9 (0.9)	11.1 (3.0)	0	**40.7** (4.8)	6.5 (2.4)	0
Rural 2.1%missing	3.5 (1.6)	1.4 (1.0)	9.2 (2.4)	3.5 (1.6)	**38.0** (4.1)	0.7 (0.7)	31.0 (3.9)	10.6 (2.6)	2.1 (1.2)
Socorro 1.5%missing	0	0.3 (0.3)	0.6 (0.4)	0.6 (0.4)	**64.5** (2.7)	0	29.4 (2.5)	4.6 (1.6)	0
Veguita 5.9% missing	0	0	2.1 (1.5)	0	5.3 (2.3)	31.6 (4.8)	**44.2** (5.1)	4.2 (2.1)	12.6 (3.4)
County 3.0% missing	**4.2%** (0.4)	**2.5%** (0.4)	**3.3%** (0.8)	**1.7%** (0.5)	**44.7%** (1.8)	**3.4%** (0.5)	**32.4%** (1.8)	**6.3%** (0.9)	**1.9%** (0.5)

*Includes write-in answers for "retired"

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 9. Reported Difficulties in Reading Medical Written Materials [% (Standard Error)]

	Never need help reading	Rarely need help reading	Sometimes need help reading	Often Need Help Reading	Always need help reading
Alamo	**32.9%**	26.6 %	26.6%	7.0%	7.0%
1.4% missing	(SE 3.9)	(SE 3.7)	(SE 3.7)	(SE 2.1)	(SE 2.1)
Magdalena	**71.2**	17.1	8.1	1.3	1.3
0.1% missing	(4.3)	(4.3)	(2.6)	(0.5)	(0.5)
Rural	**72.0**	16.8	9.8	0.7	0.7
1.4% missing	(3.8)	(3.1)	(2.5)	(0.7)	(0.7)
Socorro	**62.8**	18.9	11.6	3.1	3.7
1.2% missing	(2.7)	(3.3)	(1.77)	(1.0)	(1.0)
Veguita	**36.4**	25.3	27.3	4.0	7.1
2.0% missing	(4.9)	(4.4)	(4.5)	(2.0)	(2.6)
Men	**61.9**	20.2	10.3	2.8	3.8
1.6% missing	(3.0)	(2.5)	(1.8)	(1.1)	(1.2)
Women	**61.0**	17.9	16.3	1.8	2.9
0.1% missing	(2.4)	(1.9)	(1.8)	(0.6)	(0.8)
<$30,000	**54.4**	20.7	17.3	3.2	2.7
1.4% missing	(2.9)	(2.4)	(2.1)	(0.9)	(0.6)
>$30,000	**72.0**	17.8	7.8	1.6	0.9
3.0% missing	(2.8)	(2.4)	(1.7)	(0.8)	(0.5)
County	**61.1%**	**19.4%**	**13.3%**	**2.7%**	**3.3%**
1.3% missing	(1.8)	(1.5)	(1.3)	(0.6)	(0.6)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Most Important Preventable Health Issues for County
(Table 10)

Respondents were asked about which preventable health issues were most important to Socorro County. While the question stated to only check one box; respondents often checked more than one box or wrote in "all of the above." Survey administrators noted many respondents told them that there were too many pressing issues that it was simply not possible to check just one box. Listed topics included cancer, diabetes, drug and alcohol abuse, heart and lung disease, injury & accidents, mental health, obesity, teen pregnancy, vaccines & childhood and do not know. In addition to listed categories, the following responses were written in: "need a bigger hospital," "poor diet," "geriatric," "pills," "hunger," "LGBT youth," "AIDS," "kidney failure," "psychologist," tick-borne & lyme diseases. Due to multiple responses, each illness/disease category was evaluated independently. The top items chosen for each group of respondents are the three categories with the highest percentage of "yes" responses.

Here are the top 3 preventable health issues for the county by group of respondents (#1, #2, #3):

- ✧ Alamo: Diabetes, Drug & Alcohol Abuse, Teen Pregnancy
- ✧ Magdalena: Drug & Alcohol Abuse, Diabetes, Teen Pregnancy & Obesity
- ✧ Rural: Drug & Alcohol Abuse, Diabetes, Obesity
- ✧ Socorro: Drug & Alcohol Abuse, Diabetes, Teen Pregnancy & DV
- ✧ Veguita: Drug & Alcohol Abuse, Cancer, Obesity
- ✧ Men: Drug & Alcohol Abuse, Diabetes, Obesity
- ✧ Women: Drug & Alcohol Abuse, Diabetes, Teen Pregnancy
- ✧ <$30,000/yr: Drug & Alcohol Abuse, Diabetes, Teen Pregnancy
- ✧ >$30,000/yr: Drug & Alcohol Abuse, Diabetes, Obesity
- ✧ 18-24 years old: Drug & Alcohol Abuse, Teen Pregnancy, Cancer
- ✧ 25-44 years old: Drug & Alcohol Abuse, Diabetes, Teen Pregnancy & Obesity
- ✧ 45-65 years old: Drug & Alcohol Abuse, Diabetes, DV, Teen Pregnancy
- ✧ > 65 years old: Drug & Alcohol Abuse, Diabetes, Teen Pregnancy, Cancer
- ✧ County: Drug & Alcohol Abuse, Diabetes, Teen Pregnancy

Table 10. Most Important Preventable Issues for the County [% (Standard Error)]

Location	Cancer	Diabetes	Drug Alcohol Abuse	Domestic Violence	Heart & Lung	Injury	Mental Health	Obesity	Teen Pregnancy	Vaccine/ childhood	Do not know
Alamo 1.4% missing	14.7% (3.0)	**50.4%** (4.2)	**35.0%** (4.0)	16.8% (3.1)	5.6% (1.9)	12.6% (2.8)	10.5% (2.6)	19.6% (3.3)	**23.8%** (3.6)	7.0% (2.1)	21.0% (3.4)
Magdalena 0.9% missing	7.2 (2.5)	**25.2** (4.1)	**46.9** (4.76)	11.7 (3.1)	6.3 (2.3)	8.1 (2.6)	6.3 (2.3)	**18.9** (3.7)	**18.9** (3.7)	4.5 (2.0)	6.3 (2.3)
Rural 4.1% missing	13.0 (2.9)	**25.9** (3.7)	**48.9** (4.3)	13.0 (2.9)	5.0 (1.9)	2.2 (1.2)	5.0 (1.9)	**20.1** (3.4)	12.2 (2.8)	4.32 (1.7)	9.4 (2.5)
Socorro 2.4% missing	16.7 (2.1)	**26.5** (2.5)	**49.4** (2.8)	**18.8** (2.2)	8.6 (1.6)	6.5 (1.4)	11.4 (1.8)	16.7 (2.1)	**21.3** (2.3)	4.3 (1.1)	9.3 (1.6)
Veguita 3.9% missing	**27.8** (4.6)	**19.6** (4.1)	**34.0** (4.8)	**17.5** (3.9)	5.2 (2.3)	13.4 (3.5)	12.4 (3.4)	**16.5** (3.8)	**18.6** (4.0)	8.3 (2.8)	14.4 (3.6)
Male 1.3% missing	14.5 (2.1)	**25.0** (2.7)	**43.5** (3.1)	**15.3** (2.2)	4.1 (1.1)	7.5 (1.5)	7.1 (1.5)	**18.8** (2.5)	12.8 (2.1)	2.5 (0.9)	12.0 (2.0)
Female 2.9% missing	17.4 (1.9)	**27.4** (2.3)	**49.6** (2.5)	17.6 (2.0)	7.7 (1.4)	5.5 (1.1)	10.3 (1.6)	16.6 (1.9)	**21.6** (2.1)	6.2 (1.2)	9.4 (1.4)
<$30,000 2.2%missing	**19.4** (2.4)	**29.4** (2.7)	**44.4** (3.0)	18.1 (2.3)	9.8 (1.8)	8.6 (1.5)	9.5 (1.7)	15.2 (2.1)	**20.7** (2.4)	6.2 (1.4)	11.9 (2.0)
>$30,000 0.7% missing	12.2 (2.1)	**27.5** (2.8)	**52.2** (3.2)	13.9 (2.2)	4.6 (1.2)	3.3 (1.0)	7.6 (1.6)	**21.4** (2.6)	15.6 (2.2)	3.9 (1.2)	4.7 (1.3)
18-24yrs	**18.2** (4.6)	15.4 (4,0)	**37.8** (5.7)	12.0 (3.7)	1.4 (1.4)	7.6 (3.1)	8.6 (3.4)	8.1 (3.2)	**29.5** (5.3)	2.3 (1.6)	17.1 (4.2)
25-44yrs	14.1 (2.2)	**21.7** (2.6)	**46.0** (3.2)	14.8 (2.3)	3.2 (1.1)	4.7 (1.2)	6.1 (1.4)	**18.7** (2.5)	**18.4** (2.4)	4.2 (1.3)	11.1 (2.0)
45-64 yrs	15.9 (2.2)	**32.7** (3.0)	**49.3** (3.2)	**20.4** (2.6)	9.2 (1.8)	7.3 (1.5)	12.5 (2.0)	16.2 (2.3)	**17.8** (2.4)	5.4 (1.4)	8.4 (1.7)
65 yrs+	**21.0** (4.0)	**34.3** (4.8)	**46.0** (5.1)	13.4 (3.3)	14.0 (3.5)	8.1 (2.7)	10.0 (3.0)	**27.2** (4.6)	12.6 (3.3)	7.4 (2.6)	8.5 (2.8)
County 2.5% missing	**16.3%** (1.4)	**27.2%** (1.7)	**46.6%** (1.9)	**16.5%** (1.4)	6.9% (1.0)	6.5% (0.9)	9.4% (1.1)	**17.9%** (1.5)	**18.5%** (1.5)	4.9% (0.8)	10.5% (1.2)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment. 3.1% missing for age.

Most Important Preventable Health Issues for Self & Family

(See Table 11)

Respondents were next asked about which preventable health issues were most important to themselves and family members. Just like in the county-based question and contrary to instruction, respondents often checked more than one box or wrote in "all of the above." Survey administrators again noted many respondents told them that there were too many important issues that it was simply not possible to check just one box. Listed topics included cancer, diabetes, drug and alcohol abuse, heart and lung disease, injury & accidents, mental health, obesity, teen pregnancy, vaccines & childhood and do not know. The following issues were written in the "other" category: "bigger hospital," "nothing in particular," "general physical well-being," "arthritis," "lyme and tickborne," "insurance," "need doctor in Magdalena," "age" and "geriatric care," "health providers," "acne," "depression," "dental," "fitness," "high blood pressure," "medicaid," "son with ADHD," and "cholesterol."

Due to multiple responses, each illness/disease category was evaluated independently. The top items chosen for each group of respondents are the three categories with the highest percentage of "yes" responses.

<u>Here are the top 3 health issues for self & family by group of respondents (#1, #2, #3):</u>

- ✧ Alamo: Diabetes, (Do Not Know), Obesity, Drug & Alcohol Abuse
- ✧ Magdalena: Heart & Lung and Diabetes, Injury & Accidents, Cancer
- ✧ Rural: Diabetes, Heart & Lung, Injury & Accidents
- ✧ Socorro: Diabetes, Cancer, Heart & Lung
- ✧ Veguita: Diabetes, Cancer, Drug & Alcohol Abuse
- ✧ Men: Diabetes, Injury & Accidents, (Do Not Know), Heart & Lung
- ✧ Women: Diabetes, Cancer, Heart & Lung
- ✧ <$30,000/yr: Diabetes, Cancer, Injury & Accidents
- ✧ >$30,000/yr: Diabetes, Cancer, Injury & Accidents
- ✧ 18-24 years old: Diabetes, Heart & Lung, Cancer, Teen Pregnancy
- ✧ 25-44 years old: Diabetes, Cancer, Injury
- ✧ 45-64 years old: Drug & Alcohol Abuse, Diabetes, Teen Pregnancy
- ✧ >65 years old: Diabetes, Heart & Lung, Injury, Cancer
- ✧ County: Diabetes, Cancer, (Do Not Know), Injury & Accidents

Table 11. Most Important Preventable Issues for the Self and Family [% (Standard Error)]

Location	Cancer	Diabetes	Drug Alcohol Abuse	Domestic Violence	Heart & Lung	Injury	Mental Health	Obesity	Teen Pregnancy	Vaccine/ childhood	Do not know
Alamo 3.4% missing	10.7% (2.6)	**52.1%** (4.2)	**17.1%** (3.2)	10.7% (2.6)	7.1% (2.2)	5.7% (2.0)	7.9% (2.3)	**18.6%** (3.3)	11.4% (2.7)	5.7% (2.0)	**26.4%** (3.7)
Magdalena 4.5% missing	**13.1** (3.27)	**20.6** (3.9)	6.5 (2.4)	2.8 (1.6)	**20.6** (3.9)	**15.9** (3.6)	4.7 (2.1)	4.7 (2.1)	0	5.6 (2.2)	7.5 (2.6)
Rural 4.8% missing	12.3 (2.8)	**26.8** (3.8)	8.7 (2.4)	2.9 (1.43)	**23.0** (16.7)	**18.8** (3.3)	7.3 (2.2)	10.1 (2.6)	2.9 (1.43)	7.3 (2.2)	14.5 (3.0)
Socorro 3.9% missing	**16.9** (2.1)	**31.0** (2.6)	10.3 (1.7)	2.2 (0.8)	**13.5** (1.9)	12.9 (1.9)	4.7 (1.2)	13.2 (1.9)	2.4 (0.9)	4.1 (1.1)	13.2 (1.9)
Veguita 2.0% missing	**23.2** (4.3)	**27.3** (4.5)	**14.1** (3.5)	11.1 (3.2)	12.1 (3.3)	13.1 (3.4)	7.1 (2.6)	9.1 (2.9)	7.1 (2.6)	9.1 (2.9)	20.2 (4.1)
Male 2.6% missing	12.2 (2.0)	**25.4** (2.7)	10.3 (1.9)	3.5 (1.0)	**13.3** (2.2)	**17.5** (2.5)	4.4 (1.3)	9.3 (1.8)	2.9 (1.0)	3.3 (1.1)	15.7 (2.3)
Female 4.6% missing	**17.9** (2.0)	**32.7** (2.4)	10.4 (1.6)	4.0 (0.9)	**14.9** (1.9)	11.0 (1.7)	6.4 (1.3)	13.6 (1.7)	3.5 (0.9)	7.8 (1.4)	14.8 (1.8)
<$30,000 3.0% missing	**15.3** (2.2)	**32.6** (2.8)	9.6 (1.7)	5.3 (1.2)	13.8 (2.1)	**14.5** (2.1)	7.6 (1.6)	11.0 (1.8)	3.2 (1.0)	6.5 (1.5)	14.4 (2.1)
>$30,000 3.8% missing	**16.8** (2.4)	**30.5** (3.0)	12.0 (2.1)	2.2 (0.7)	14.2 (2.2)	**14.9** (24)	3.3 (1.1)	13.3 (2.1)	2.7 (1.0)	4.7 (1.3)	11.1 (2.0)
18-24yrs	**11.2** (3.8)	**26.1** (5.1)	9.1 (3.4)	1.9 (1.5)	**11.6** (4.1)	8.1 (3.3)	0.9 (0.6)	**10.0** (3.6)	7.1 (2.9)	3.9 (2.2)	25.4 (5.1)
25-44yrs	**15.5** (2.4)	**28.1** (2.9)	11.0 (2.0)	4.6 (1.2)	7.5 (1.7)	**15.1** (2.3)	6.5 (1.6)	11.3 (2.1)	3.4 (1.1)	9.0 (1.9)	16.3 (2.3)
45-64 yrs	**16.8** (2.3)	**31.9** (3.0)	11.3 (2.0)	4.2 (1.2)	**17.7** (2.5)	**17.0** (2.5)	7.0 (1.7)	14.2 (2.2)	2.9 (1.2)	4.5 (1.3)	11.3 (2.0)
65 yrs+	15.1 (3.5)	34.3 (4.8)	8.1 (2.8)	3.4 (1.6)	21.9 (4.1)	10.4 (3.2)	4.1 (1.9)	8.4 (2.8)	3.5 (1.8)	2.8 (1.7)	13.7 (3.5)
County 3.8% missing	**15.7%** (1.4)	**30.3%** (1.8)	10.5% (1.2)	4.0% (0.7)	14.2% (1.4)	**14.3%** (1.4)	5.9% (0.9)	11.8% (1.3)	3.6% (0.7)	5.7% (0.9)	14.9% (1.4)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment . Age- 3.1% missing overall

Use of Medical Services

(See Tables 12-15)

Medical services provide regular check-ups, treat chronic disease conditions, address emergencies and provide a critical means for persons to learn how to improve their health, well-being and to make healthy choices. Prevention is a key means to reducing burden of a disease on a community.

People need to use health services in order for the health provider community to influence preventable illnesses. For example, without a regular doctor, a diabetic may not be diagnosed, will likely not be given medication or advice on nutrition and exercise. To help that patient, the whole picture must be addressed. For the county overall, about 6 out of 10 respondents had seen a doctor within the past year; 8 of 10, within the past 2 years; and 9 of 10, within the past 5 years.

Overall, 8-10% of county residents had not seen a doctor in the past 5 years or ever. Veguita had the most people not seeing a doctor in the past 5 year (12.9% SE 3.4), followed by rural residents. Persons within the poverty bracket (<$30,000 for this study) had a much higher percent of persons not seeing a doctor ever or in the past compared to those in higher income levels. The percentage of persons in poverty with at least one regular doctor was about 10% less than those with higher incomes. Men and women had similar responses in terms of when they last saw a doctor. More women than men reported having at least one regular doctor.

Fewer respondents from Alamo reported having at least one regular doctor compared to other parts of the county. Alamo had one of the lowest percentages of persons responding they had seen a doctor within the past year (just about half of the respondents); 17.2% (SE 31.5) said they did not know and 5% had not seen a doctor in over 5 year, about 2% had never seen a doctor. In Magdalena, more than 7/10 people had seen a doctor within the past 2 years. The city of Socorro had the highest percentage of residents responding that they had at least one or more regular doctors.

For non-emergencies, countywide respondents report going most often to Socorro General Medical Group, Bhasker Clinic, PSGH and Socorro Presbyterian Medical Services much more often than to any other provider location. The lower income persons would go to Socorro PMS, SGMG and PSGH whereas those with higher income prefer Bhasker Clinic, SGMG and Socorro PMS. Men and women had the same preferences overall. In Alamo, persons most often use Indian Health Service (IHS) or Alamo Clinic, then PSGH and Socorro PMS. Almost 60% in Magdalena use the local Magdalena PMS; 8-12% report going to Albuquerque, Bhasker Clinic, Socorro PMS and PSGH. Most rural residents use SGMG, Bhasker Clinic and Socorro PMS though a few wrote in that they go to Reserve, Quemado,

Los Lunas, Dr. Goforth, use nurse hotlines, Dr. Reid or use New Mexico tech nursing staff. Socorro residents use these same local services of SGMG, Bhasker Clinic and Socorro PMS and also utilize care from chiropractors and New Mexico Tech nurses. Veguita- on the north side of the county- had the largest percentage of respondents using Albuquerque and Belen for non-ER care and had a few persons writing in they go to Los Lunas or to Dr. Sanchez. Veguitans also use the hospital (PSGH) for non-emergency care; one person wrote in they have nowhere to go.

In emergency situations, the majority of respondents go to PSGH. About 40% of Veguita respondents would go to Albuquerque as would about 20% of those in Magdalena. Alamo residents also use IHS and Alamo clinic about 22%; PSGH, 75%. No differences were noted between the genders. A slightly larger proportion of respondents with higher incomes go to Albuquerque compared to the lower income.

During the needs assessment surveys and during stakeholder interviews, limitations of EMS countywide was an issue for many residents. Many north county respondents explained they had waited over 30-45 minutes for an ambulance—including, in one case, for a person with acute paralysis. The area had previously been served by Valencia County EMS under an agreement, which was no longer operational. Rural persons expressed concern that EMS may have difficulty locating homes. Socorro Fire has instituted GPS into 2 of the 3 ambulances to improve rural response. Additionally, for Veguita, the assessment team noted a lack of street signs and streets numbers. One stakeholder explained citizenship concerns may make residents wary of posting addresses. Socorro County does provide street numbers. Unfortunately, the unintended consequence of a lack of house numbers may be slower emergency response. The Magdalena volunteer service relies on trained volunteers and provides service to many areas west of Magdalena, including to Datil on the edge of Catron County. A junior fire-fighting program may help to recruit future EMTs if the youth stay in the Magdalena area. Ensuring volunteer EMTs are covered for liability was expressed as an issue for recruiting volunteers.

Socorro no longer uses a paramedic for EMS and relies on EMT 1 and 2s working in consortium with the hospital due to the limited number of calls requiring higher-level treatment. The majority of Socorro calls are within the city; however, capacity can be challenged when an ambulance is required to transport to Albuquerque. Due to prolonged rural response times, several rural residents interviewed during the Old Timers Event in Magdalena expressed interest in local first aid and CPR. Overall, the survey indicated need for additional EMT capacity, improved ability to locate rural residences. Studies have demonstrated a future for using telemedicine in rural areas within ambulances so that patient status is better monitored prior to arriving at the emergency room and so that EMTs will have improved advanced medical supervision in incidents of cases requiring critical care.[cxxxiii]

Table 12. Time Since Last Routine Visit with Health Care Provider [% (Standard Error)]

	<1 Year	1-2 Years	2-5 Years	>5 Years	NEVER	Do not know/ skipped
Alamo	53.1% (4.2)	14.5% (2.9)	7.6% (2.1)	5.5% (1.9)	2.1 % (1.2)	17.2% (3.2)
Magdalena	64.3 (4.6)	15.2 (3.4)	8.0 (2.6)	6.3 (2.3)	1.8 (1.3)	4.5 (2.0)
Rural	61.4 (4.1)	11.0 (2.6)	11.7 (2.7)	**9.0 (2.4)**	1.4 (1.0)	5.5 (1.9)
Socorro	61.8 (2.7)	15.4 (2.0)	9.3 (1.6)	8.1 (1.5)	1.8 (0.7)	3.1 (1.0)
Veguita	57.4 (4.9)	10.9 (3.12)	10.9 (3.1)	**12.9 (3.4)**	3.0 (1.7)	5.0 (2.2)
Men	59.4 (3.1)	14.3 (2.2)	10.2 (1.9)	**8.9 (1.8)**	2.5 (1.0)	4.8 (1.3)
Women	61.6 (2.5)	13.6 (1.7)	9.6 (1.5)	8.5 (1.4)	1.4 (0.6)	5.3 (1.1)
<$30 ,000	60.0 (2.9)	11.2 (1.8)	11.1 (1.9)	**11.5 (1.9)**	2.0 (0.8)	4.3 (1.1)
>$30,000	62.9 (3.1)	17.3 (2.4)	10.3 (2.0)	6.5 (1.5)	1.0 (0.7)	2.1 (0.8)
County	60.8% (1.9)	13.6% (1.3)	10.0% (1.2)	**8.6%** (1.1)	1.82% (0.5)	5.24% (0.81)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment . 0% Missing

Table 13. Frequency of Respondents Having a Regular/Primary Doctor [% (Standard Error)]

	1 or more regular doctors	No regular doctor / Not sure
Alamo 2.8% missing	58.9% (SE 4.2)	41.1% (SE 4.2)
Magdalena 1.8% missing	66.4 (4.5)	33.6 (4.5)
Rural 4.1% missing	74.8 (3.7)	25.2 (3.7)
Socorro 1.2% missing	77.4 (2.3)	25.2 (2.3)
Veguita 4.0% missing	48.5 (5.1)	51.6 (5.1)
Men 1.6% missing	68.3 (2.9)	31.7 (2.9)
Women 2.3% missing	74.2 (2.1)	25.8 (2.1)
<$30,000 2.2% missing	68.1 (2.7)	31.9 (2.7)
>$30,000 0.3% missing	78.1 (2.6)	21.9 (2.6)
County 2.4% missing	**71.9% (1.7)**	**28.1% (1.7)**

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 14. Facilities Respondents Will Use for Non-Emergency Medical Care [% (Standard Error)]

	Acu	ABQ	Bhasker	Public Healh	Belen	IHS/ Alamo	Mag PMS	Socorro PMS	PSGH	SGMG	Trad Healer	Not Seek Care	Don't know
Alamo 4.1% missing	2.6% (0.6)	7.9% (2.3)	5.0% (1.9)	1.4% (1.0)	0	**55.4% (4.2)**	2.9 % (1.4)	**9.4% (2.5)**	**34.5% (4.0)**	2.2% (1.2)	6.5% (2.1)	1.4% (1.0)	4.3% (1.7)
Magdalena 0% missing	0	8.0 (2.56	8.0 (2.6)	0.9 (0.9)	1.8 (1.3)	3.6 (1.8)	**58.0 (4.7)**	**8.9 (2.7)**	**12.5 (3.1)**	6.3 (2.3)	0	1.8 (1.3)	0
Rural 2.1%missing	0.9 (0.9)	9.2 (2.4)	**22.5 (3.5)**	0	3.5 (1.6)	1.4 (1.0)	5.6 (1.9)	**16.2 (3.1)**	11.3 (2.7)	**23.2 (3.6)**	0	0.7 (0.7)	0
Socorro 1.5% missing	2.8 (1.4)	6.1 (1.3)	**21.1 (2.3)**	1.2 (0.6)	0.6 (0.4)	0.6 (0.4)	0.9 (0.5)	19.6 (2.2)	**19.9 (2.2)**	**27.2 (2.5)**	0.3 (0.3)	2.1 (0.8)	2.1 (1.2)
Veguita 2.9% missing	2.0 (1.4)	**22.2 (4.2)**	4.1 (2.0)	4.1 (2.0)	**32.7 (4.8)**	1.0 (1.0)	0	20.4 (4.1)	**21.4 (4.2)**	6.1 (2.4)	0	1.0 (1.0)	1.0 (1.0)
Men 3.0% missing	0.9 (0.6)	9.6 (1.9)	**18.8 (2.6)**	1.5 (0.7)	5.0 (1.3)	5.45 (1.08)	3.3 (1.0)	**15.6 (2.4)**	22.4 (2.6)	**16.6 (2.4)**	1.1 (0.5)	1.3 (0.7)	4.2 (1.3)
Women 1.2% missing	3.4 (1.0)	8.7 (1.4)	**16.9 (2.0)**	0.8 (0.4)	4.4 (0.9)	4.01 (0.54)	6.5 (1.0)	**19.9 (2.0)**	15.3 (1.8)	**23.9 (2.2)**	0.2 (0.1)	1.8 (0.7)	0.9 (0.5)
<$30,000 1.1% missing	2.4 (1.0)	8.3 (1.7)	15.2 (2.2)	2.2 (0.8)	4.7 (1.0)	6.49 (0.97)	3.8 (0.9)	**19.9 (2.3)**	**19.0 (2.2)**	**21.3 (2.5)**	0.8 (0.3)	1.8 (0.7)	2.9 (1.1)
>$30,000 0.3% missing	2.6 (1.0)	9.3 (1.7)	**22.1 (2.7)**	0.4 (0.4)	4.4 (1.3)	2.43 (0.61)	7.2 (1.4)	**15.9 (2.4)**	14.8 (2.2)	**22.5 (2.7)**	0.5 (0.4)	1.6 (0.8)	0.8 (0.5)
County 2.0% missing	2.6% (0.6)	8.9% (1.1)	**18.1% (1.5)**	1.2% (0.4)	4.8 (0.7)	4.54% (0.47)	5.2% (0.7)	**17.5% (1.5)**	**18.1% (1.4)**	**21.2% (1.6)**	0.6% (0.2)	1.6% (0.5)	2.2% (0.6)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 15. Facilities Respondents Will Use in Case of Health Emergency [% (Standard Error)]

	ABQ	IHS/Alamo	PSGH	Traditional Healer	Not seek Care	T or C
Alamo	11.8% (2.7)	**22.9% (3.5)**	**75.0% (3.6)**	2.8% (1.4)	0.7% (0.7)	0
Magdalena	**20.9 (3.9)**	1.8 (1.30	**78.2 (4.0)**	0	0	0
Rural	13.0 (2.9)	1.5 (1.0)	**84.1 (3.1)**	0.7 (0.7)	0.7 (0.7)	0.7 (0.7)
Socorro	12.7 (1.9)	0	**90.7 (1.6)**	0	0	0
Veguita	**40.8 (5.0)**	1.0 (1.0)	**59.6 (5.0)**	0	1.0 (1.0)	0
Men	16.4 (2.2)	2.5 (0.5)	**82.1 (2.3)**	0.8 (0.6)	0.4 (0.3)	0
Women	15.6 (1.8)	2.0 (0.6)	**85.2 (1.8)**	0.2 (0.1)	0.4 (0.4)	0.4 (0.4)
<$30,000	14.3 (2.0)	3.4 (0.9)	**84.3 (2.0)**	0.8 (0.5)	0.5 (0.5)	0
>$30,000	**17.4 (2.4)**	1.0 (0.3)	**83.8 (2.4)**	0.1 (0.1)	0	0.5 (0.5)
County	16.1 (1.4)	2.1 (0.4)	**83.8 (1.4)**	0.4 (0.2)	0.3 (0.2)	0.2 (0.2)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment . 2.5% missing.

Perception of current state of health

(See Tables 16-17)

While this survey did not intend to diagnose health issues, a few questions were included to better understand how persons describe their current state of health. These questions looked current state of health, number of days full of energy and good health, number of days where respondent had sadness/anxiety/depression and the number of days that activity or work was impacted by physical or mental health.

Overall, most people in the county, both genders and all locations described their health in the middle category: "good." Alamo had the fewest persons responding that current health was excellent. Magdalena had the largest percentage reporting "poor" health but had more "very good"s as well. The percentage of persons reporting excellent health among those not in poverty was twice that of those in poverty.

Countywide, people averaged around 22 healthy days a month; 7 days with mental health symptoms and 3-4 days of limited activity due to health. Women had about 2 more days/month with mental health symptoms, 1 fewer healthy day, and about 1 more day of limited activity per month compared to men. Persons with higher incomes had about 3 more healthy days, 3 fewer mental health and 2 fewer days of limited activity compared with those below the poverty level of $30,000/household. Comparing locations- Alamo had the fewest healthy days, Socorro had the most. Alamo and Veguita both had about 8 days a month- higher than everywhere else- of mental health symptoms. Rural respondents had the fewest mental health days (about 5 days). Alamo had the most days limited by health issues; rural had the fewest.

Age also impacted how healthy people felt. The younger age brackets were more likely to self-report an excellent or very good state of health and more days (about 1 more day) of feeling very healthy and energetic. Younger persons were more likely than those over 65 years old to report days with mental health symptoms. Those over 65 years old reported about 1 day of limited activity each month from health compared to younger ages. However, this may be due to the fact they have less activities—either job or family related—and may not reflect overall health.

Table 16. Self-Described Current State of Health of Respondents [% (Standard Error)]

	Excellent	Very Good	Good	Fair	Poor
Alamo 0.7%missing	5.6% (1.9)	22.2% (3.5)	40.3% (4.1)	28.5% (3.8)	3.5% (1.5)
Magdalena 1.8%missing	16.4 (3.5)	38.2 (4.7)	25.5 (4.2)	13.6 (3.3)	6.4 (2.3)
Rural 3.4%missing	15.7 (3.1)	32.1 (4.0)	40.0 (4.2)	10.0 (2.5)	2.1 (1.2)
Socorro 1.5%missing	16.5 (2.1)	30.0 (2.5)	34.3 (2.6)	17.1 (2.2)	2.14 (0.8)
Veguita 1.0%missing	13.0 (3.4)	25.0 (4.4)	31.0 (4.7)	27 (4.5)	4.0 (2.0)
Men 2.0%missing	15.9 (2.3)	30.6 (2.9)	38.9 (3.1)	12.4 (2.0)	2.1 (0.9)
Women 1.4%missing	15.4 (1.9)	29.4 (2.3)	32.7 (2.4)	19.6 (1.9)	2.9 (0.8)
<$30,000 0.6%missing	**11.6 (1.9)**	27.0 (2.6)	34.9 (2.8)	22.7 (2.4)	3.8 (1.1)
>$30,000 0.7% missing	**22.4 (2.7)**	33.9 (3.0)	33.4 (3.0)	9.1 (1.8)	1.3 (0.7)
18-24yrs	24.5 (5.1)	34.8 (5.6)	32.8 (5.4)	7.9 (2.9)	0 (0)
25-44yrs	14.8 (2.3)	31.2 (3.0)	36.5 (3.1)	16.0 (2.3)	1.5 (0.6)
45-64 yrS	14.4 (2.3)	29.4 (2.9)	34.0 (3.0)	19.4 (2.4)	2.9 (1.0)
65 yrs+	12.3 (3.4)	25.8 (4.3)	39.2 (5.0)	16.4 (3.5)	6.3 (2.4)
County	15.2% (1.4)	30.0% (1.8)	**35.5% (1.9)**	16.7 % (1.4)	2.6% (0.6)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment
Countywide 1.7% missing, Age data 3.1% missing.

Table 17. Number of Healthy and Unhealthy Days Out of the Past 30 days (n=# respondents) [% (Standard Error)]

	Average Number of Days Healthy & Full of energy (95% CI)	Average Number of Days Depressed, Anxious (95% CI)	Average Number of Days Activity Limited by Physical and Mental Health (95% CI)
Males	**23.4** (22.2-24.6)	**5.5** (4.5-6.55)	**2.8** (2.0-3.7)
Females	**22.3** (21.3-23.2)	**7.9** (6.9-8.9)	**3.6** (2.8-4.4)
<$30,000	**21.3** (20.1-22.5)	**8.2** (7.0-9.3)	**4.5** (3.5-5.5)
>$30,000	**24.2** (23.2-25.3)	**5.3** (4.2-6.3)	**2.1** (1.4-2.7)
Alamo	**18.5** (16.5-20.4)	**8.3** (6.6-10.0)	**5.6** (4.1-7.1)
Magdalena	**21.1** (19.1-23.2)	**6.7** (4.9-8.4)	**4.2** (2.6-6.0)
Rural	**22.3** (20.6-24.0)	**5.0** (3.6-6.4)	**2.5** (1.4-3.5)
Socorro	**23.7** (22.7-24.6)	**7.7** (6.6-8.8)	**3.4** (2.6-4.3)
Veguita	**22.2** (20.1-24.3)	**8.0** (6.0-10.0)	**4.5** (2.6-6.4)
18-24yrs	**23.6** (21.7-25.5)	**8.8** (6.4-11.1)	**4.1** (2.2-5.9)
25-44yrs	**22.6** (21.4-23.8)	**6.8** (5.7-7.9)	**2.8** (2.0-3.6)
45-64 yrs	**22.7** (21.5-24.0)	**7.7** (6.4-8.9)	**3.9** (2.9-4.9)
65 yrs+	**22.3** (20.2-24.5)	**4.1** (2.6-5.6)	**3.0** (1.5-4.4)
County	**22.7** (21.9-23.4)	**7.0** (6.2-7.7)	**3.4** (2.9-4.00

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment . *Alamo 10.3% missing, Veguita 12.9% missing; ** Alamo 11.7% missing, Rural 8.3% missing, Women 7.5% women,; ***Alamo 11.0% missing, Veguita 13.9% missing. Countywide: question about healthy days 8.5% missing, mental health days: 7.1% missing and activity limited days: 8.7% missing

Barriers to accessing healthcare

(See Tables 18-19)

As determined during the pre-assessment, barriers to accessing care range well beyond who has and does not have insurance. From needing a phone to trying to get on a busy doctor's schedule to trying to take time from work and get a ride to paying the bill, the obstacles are numerous.

Several time and distance issues emerged as barriers. Alamo and Veguita had the highest percent of persons reporting distance and transportation as barriers to accessing care. From all locations, over 1 in 5 persons noted difficulties taking time from work to seek care. The majority in Alamo and over one third countywide stated the lack of a clinic with night and weekend hours as a barrier. Distance barriers were reported 2 to 3 times more often by those with household incomes <$30,000.

Persons in Alamo, Veguita and those in lower income levels were most likely to report difficulty seeking care due to childcare responsibilities. One of the stakeholders recommended setting up a community "daycare" for sick children to be paid for on a daily basis may help parents keep working when children have minor illnesses and will also keep sick children from attending school. The stakeholder mentioned a room could be set up at this facility for children of persons with medical appointments to help remove this barrier and noted success of a similar partnership between a rural hospital and school system in setting up this system in another state. Almost 1 in 4 persons countywide noted scheduling appointments as a barrier to accessing healthcare. In stakeholder meetings, lack of sufficient and consistent providers was addressed as a major limiting factor for wellness care visits. Frequent turnover of providers also was anecdotally noted as a deterrent to persons opting to seek routine wellness care.

Economic barriers were reported as a key factors limiting access to care countywide. Alamo and Veguita in particular expressed concern about insurance; over 1 in 4 noted cost as an issue throughout the region. Two to three out of 10 in Alamo and Veguita cited lack of a phone as a barrier. No public payphones were noted in the drive by assessment. Clearly, persons in lower income brackets more often report cost-related barriers.

Citizenship was more of a concern in Veguita and among those with lower incomes. Language differences were barriers for about 12% countywide; but three times this level in Veguita and Alamo and slightly higher among women.

Table 18. Reported Barriers to Accessing Care by Location of Residence [% (Standard Error)]

Location of Residence	Lack of Transportation (8.02% missing)	Distance to clinic (6.23% missing)	Scheduling an Appointment (6.95% missing)	Language differences (7.31% %missing)	Lack of Insurance (6.11% missing)	Cost of Care (6.95% missing)	Time from Work (6.83% missing)	Citizenship (7.90 % missing)	No phone (7.19% missing)	Lack Quality Childcare (7.43 % missing)	No nights or weekend hours (8.02% missing)
Alamo	37.0% (SE 4.3)	59.7% (SE 4.2)	62.8% (SE 4.3)	34.9% (SE 4.2)	45.0% (SE 4.4)	55.4% (SE 4.4)	46.3% (SE 4.3)	20.5% (SE 3.6)	33.3% (SE 4.1)	24.0% (SE 3.8)	60.8% (SE 4.3)
Magdalena	10.6 (3.0)	26.7 (4.3)	35.2 (4.7)	7.8 (2.7)	26.7 (4.3)	47.1 (4.9)	22.1 (4.1)	7.7 (2.6)	11.4 (3.1)	7.8 (2.7)	35.9 (4.8)
Rural	9.9 (2.6)	18.8 (3.4)	34.1 (4.1)	6.0 (2.1)	22.7 (3.7)	38.9 (4.3)	23.5 (3.7)	5.3 (2.0)	5.3 (2.0)	8.3 (2.4)	28.6 (3.9)
Socorro	16.8 (2.1)	14.1 (2.0)	33.3 (2.7)	8.7 (1.6)	28.8 (2.6)	41.5 (2.8)	26.6 (2.5)	5.5 (1.3)	8.3 (1.6)	10.0 (1.7)	33.8 (2.7)
Veguita	24.7 (4.4)	52.5 (5.0)	47.5 (5.0)	32.3 (4.7)	35.0 (4.8)	56.3 (5.1)	29.2 (4.7)	32.3 (4.8)	22.9 (4.3)	23.5 (4.3)	43.6 (5.1)
County	16.7 (1.4)	23.3 (1.5)	37.1 (1.9)	12.2 (1.2)	28.7 (1.8)	43.5 (2.0)	27.1 (1.7)	9.4 (1.0)	10.8 (1.1)	11.8 (1.2)	35.2 (1.9)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 19. Reported Barriers to Accessing Healthcare by Gender, by Income & for Persons > 65 Years Old [% (Standard Error)]

	Lack of Transportation (8.02% missing)	Distance to clinic (6.23% missing)	Scheduling an Appointment (6.95% missing)	Language differences (7.31% %missing)	Lack of Insurance (6.11% missing)	Cost of Care (6.95% missing)	Time from Work (6.83% missing)	Citizenship (7.90 % missing)	No phone (7.19% missing)	Lack Quality Childcare (7.43% missing)	No nights or weekend hours (8.02% missing)
Male	13.1% (SE 2.1)	21.0 % (SE 2.5)	36.0% (SE 3.1)	10.4 % (SE 1.8)	29.4% (SE 2.9)	42.3% (SE 3.2)	27.4% (SE 2.9)	8.3% (SE 1.7)	11.1% (SE 1.9)	10.3% (SE 1.9)	29.5% (SE 2.9)
Female	18.7 (2.0)	23.7 (2.0)	37.0 (2.5)	13.4 (1.6)	28.0 (2.3)	44.2 (2.6)	26.1 (2.3)	9.5 (1.4)	10.2 (1.4)	12.6 (1.7)	37.2 (2.0)
>65 Years Old	15.2 (3.6)	20.8 (4.1)	27.2 (4.6)	7.8 (2.5)	20.7 (4.1)	33.7 (4.9)	9.2 (2.9)	6.9 (2.4)	11.2 (3.1)	4.5 (1.9)	23.3 (4.3)
<$30,000	23.5 (2.5)	31.1 (2.6)	36.9 (2.8)	17.0 (2.1)	39.3 (2.9)	53.5 (3.0)	31.4 (2.8)	14.7 (1.9)	13.8 (1.9)	15.0 (2.0)	38.5 (2.9)
>$30,000	7.1 (1.7)	14.1 (2.2)	37.2 (3.1)	5.8 (1.5)	14.6 (2.2)	32.7 (3.0)	25.1 (2.7)	3.7 (1.1)	5.4 (1.4)	8.6 (1.8)	32.0 (3.0)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Use and Knowledge of Community-based Programs (CBP)

(See Tables 20-23)

CBPs may be a means for improving access to care in a rural region with residents who may not be able to come into a clinic. CBPs assist in areas of doctor shortages by providing preventive services that can be provided through community health workers.

The survey included several questions to find out if persons knew about community-based programs. To learn best ways for community outreach about programs- questions were included to learn where people had heard about CBPs and what sources they would trust for health-related program information.

As a follow-up to looking at the barriers to care, the CBP section asked which changes to programs could be made to improve use and usability.

Out of 808 of total respondents, 38.5% (SE1.9) had heard about PSGH CBPs. More men (40.0% SE 3.1) than women (37.7% SE 2.5) knew the programs; persons in higher income brackets (41.9% SE 3.2) were more likely to have heard than those below the poverty level (36.9% SE 2.9). By location, half of person in Magdalena, almost a third in Veguita, almost 40% in Socorro and 44% in rural areas knew the programs. Alamo had the least amount of respondents knowing the PSGH CBPs (20.3% SE 3.4).

Out of the 294 who knew the programs, women, persons from Alamo, and persons with income under $30,000/yr were most likely to have heard about the programs from medical professionals. Men and respondents from Magdalena and rural areas primarily heard through family. Persons living in Socorro and Veguita and those with incomes over $30,000 heard mostly through friends. Almost no one had heard about CBP using the Internet. Women were much more likely to have learned about programs through schools than men. Written comments noted that people had learned of CBPs by driving by the office and either because they or their family member worked at PSGH. One person had heard from being on the board of an organization.

In order to learn how best to reach the community about health-related programs, a question asked respondents to rank the top 3 trusted sources. Across the board, medical professionals, family and friends were the most trusted. The newspaper was also ranked by almost one in 5, except for in Veguita where only 5% considered this a trusted source. In Alamo, many also considered radio a trusted source. Those with incomes over $30,000 as well as those living in Socorro were more likely to use the Internet as a trusted source. Women ranked the phonebook and the newspaper more often than men in their top 3 trustworthy sources.

To better understand who is using CBPs now, a question asked persons to mark any of the following CBPs used within the past year by self or family: Casa Alegre/Early Intervention, DWI program, First Born Socorro, Healthy Family Initiative, Homecare/Hospice, Heritage Program for Seniors, Positive Outcomes, Socorro Community Diabetic Program, Socorro Mental Health, TUPAC, and WIC. Respondents could also write in other programs or state if they had not used programs, were not interested or were not sure if they had used a CBP this past year.

For the county overall, while almost half had not used programs, the top 5 most common programs used were WIC, Socorro Mental Health, Homecare/Hospice and Positive Outcomes. For those in the lower poverty levels, SMH, WIC and Positive Outcomes were most common; for those making over $30,000/yr, WIC, First Born Socorro, Homecare Hospice and Positive Outcomes were most common. Men used WIC, HCH and SMH. Women also used SMH, WIC and Positive Outcomes.

In Alamo, almost one-quarter responded they were not sure if they had used a CBP; about 30% said they did not use any programs. An Alamo resident stated that they "need more of our resources in Alamo." One also uses a community clinic in Socorro. WIC and Positive Outcomes were the most common programs used in Alamo. Very few had used Heritage and none had used TUPAC.

In Magdalena, HCH and PO were most often used; no one reported using Casa Alegre, Heritage or TUPAC. One Magdalena respondent wrote that they had used the Gambling Program at SMH specifically; another wrote "doctor office." Rural respondents predominantly used WIC, SMH and HCH; none used the diabetic program and very few used Casa Alegre, DWI or FBS. Rural residents wrote in they also used services in Reserve, Puerto Seguro, Medicare and the Hospital.

Those living in the city of Socorro noted using SMG, WIC, PO and HCH more than the others; few used Heritage, TUPAC or the diabetic program. Socorro write-ins included County Public Health, Free Birth Control and the hospital. Those in Veguita reported using WIC, HFI and CA/EI more than others and did not use DWI, Heritage, PO programs. La Vida was written in by one Veguita and one Socorro resident.

For the county, having a CBP close to home, covered by insurance, recommended by medical professional and available nights and weekends were the key factors to making a person more likely to use a CBP. For those making >$30,000 having a medical recommendation was more often noted as a key factor as was confidentiality. Women seemed more interested in men in having a nights & weekends CBP- though both ranked this in over 20% of responses.

Having a CBP close to home was important to all groups—particularly in Alamo and Veguita. Confidentiality was most important to Alamo, Socorro, women and those making >$30,000. Having insurance coverage for the CBP was important everywhere- but less so for Alamo and Veguita. Magdalena was the least interested in having a medical professional recommend a program. Everyone was more likely to use a CBP that was free of charge. Almost one in four responses among people in Veguita noted it would be important to have CBP be in their language (Spanish); in Alamo, 12% (Navajo). Alamo residents were most interested in programs open Monday-Friday 8am-5pm. More respondents marked interest in after-hours programs. Over 1/5 of Alamo respondents would use a CBP if transportation was available; this was also important to those making <$30,000, Socorro residents and women. Many marked that they were not sure what factors would encourage their use of a CBP.

Overall themes in the comments focused on a need for CBPs with known quality, more outreach and clearer/lay language information available. Several write-in comments were shared by respondents including: “all good,” “alternative healthcare,” “quality of care,” “would have to know more about diabetes than we do,” “Need it,” “all of the above,” “none of the above,” “work time,” “being able to talk to Dr or nurse instead of hotline,” “no medical terms,” “make themselves (CBPs) better established and known,” “better reputation on providing care,” “specific disease there are services for,“ and “information readily available.”

Table 20. Sources from which Respondents Had Learned of PSGH Community Based Programs [% (Standard Error)]

	Ad / Phone-book	Doctor / Healthcare worker	Family	Friend	Internet	Newspaper	Radio	School	Brochure	Not heard	Not Sure
Alamo	3.5% (3.4)	**31.0%** (8.6)	17.2%(7.0)	27.9% (8.3)	3.5% (3.4)	0%	6.9%(4.7)	0%	6.9%(4.7)	0%	17.2%(3.5)
Magdalena	1.8 (1.8)	20.0 (5.4)	**27.3** (6.0)	25.5 (5.9)	0	10.9(4.2)	0	0	5.5 (3.1)	1.8 (1.8)	7.3 (3.5)
Rural	5.1 (2.9)	18.6 (5.1)	**30.5** (6.0)	15.3 (4.7)	1.7 (1.7)	11.9 (4.2)	0	5.1 (2.9)	3.4 (2.4)	0	8.5 (3.6)
Socorro	2.5 (1.4)	28.1 (4.1)	16.5 (3.4)	**24.8** (3.9)	0	9.9 (2.7)	0.8 (0.8)	4.1 (1.8)	4.96 (2.0)	3.3 (1.6)	4.1 (1.8)
Veguita	3.3 (3.3)	26.7 (8.1)	10.0 (5.5)	**36.7** (8.8)	0	0	0	10 (5.5)	0	0	3.3 (3.3)
<$30,000	4.6(2.2)	**28.0** (4.5)	22.1 (4.3)	20.3 (4.0)	0	6.6 (2.5)	0.3 (0.3)	3.7 (1.8)	4.9 (2.2)	2 (1.4)	6.3 (2.3)
>$30,000	3.4(1.8)	23.6 (4.2)	23.1 (4.2)	**25.5** (4.2)	1.6 (1.3)	11.0 (3.2)	0	5.4 (2.4)	3.1 (1.7)	1.2 (1.0)	2.8 (1.8)
Men	2.4 (1.5)	23.5 (4.3)	**27.7** (4.7)	21.2 (4.2)	0	5.8 (2.4)	1.0 (1.0)	1.0 (1.0)	5.1 (2.2)	2.4(1.5)	7.2 (2.7)
Women	3.4 (1.7)	**24.6** (3.7)	17.4 (3.2)	23.8 (3.5)	1.2 (1.0)	12.7 (3.0)	0.4 (0.3)	7.4 (2.3)	3.8 (1.6)	1.5 (1.0)	5.7 (2.0)
County	3.3(1.2)	**24.5** (2.7)	21.2 (2.7)	22.9 (2.6)	0.7 (0.6)	9.4 (1.9)	0.7 (0.4)	4.5 (1.4)	4.1 (1.3)	1.7 (0.8)	6.1(1.5)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment . Includes only those persons who responded on a prior question that they did know about CBPs at PSGH.

Table 21. Most Trusted Sources for Learning About Community-Based Programs (top 3 in bold) [% (Standard Error)]

	Ad / Phonebook*	Doctor / Healthcare Worker	Family	Friend	Internet	Newspaper	Radio	Social network/ Facebook	School	Brochure	Not sure**
Alamo 2.8% missing	10.6% (2.6)	**50.4%** (4.2)	**39.0%** (4.1)	**31.9%** (3.9)	10.6% (2.6)	17.0% (3.2)	17.0% (3.2)	5.0% (1.8)	10.6% (2.6)	16.31% (3.12)	11.4% (2.7)
Magdalena 2.7% missing	11.9 (3.2)	**50.5** (4.8)	**44.0** (4.8)	**48.6** (4.8)	17.4 (3.7)	18.4 (3.7)	10.1 (2.9)	1.8 (1.3)	7.3 (2.5)	19.3 (3.8)	7.3 (2.5)
Rural 6.9% missing	9.6 (2.6)	**61.5** (4.2)	**39.3** (4.2)	**32.6** (4.1)	20.0 (3.5)	21.5 (3.6)	5.9 (2.0)	5.2 (1.9)	7.4 (2.3)	14.8 (3.1)	5.9 (2.0)
Socorro 3.9% missing	9.4 (1.6)	**54.9** (2.8)	**40.4** (2.8)	**38.6** (2.7)	24.1 (2.4)	20.4 (2.3)	4.1 (1.1)	5.6 (1.3)	8.5 (1.6)	16.3 (2.1)	8.4 (1.6)
Veguita 4.0% missing	7.2 (2.6)	**60.8** (5.0)	**42.3** (5.0)	**34.0** (4.8)	9.3 (3.0)	5.2 (2.3)	4.1 (2.0)	5.2 (2.3)	14.4 (3.6)	16.5 (3.8)	13.3 (3.4)
<$30,000 1.9%missing	10.1 (1.8)	**54.4** (2.9)	**39.6** (2.9)	**36.2** (2.8)	14.5 (2.1)	17.5 (2.2)	7.7 (1.5)	6.4 (1.5)	9.2 (1.6)	17.5 (2.2)	7.1 (1.5)
>$30,000 1.4% missing	8.6 (1.8)	**64.3** (3.0)	**44.1** (3.2)	**40.0** (3.1)	27.0 (2.9)	23.3 (2.8)	5.1 (1.3)	4.2 (1.3)	7.4 (1.7)	16.1 (2.3)	5.0 (1.4)
County 4.1% missing	9.5 (1.1)	**56.8** (1.9)	**40.4** (1.9)	**36.5** (1.9)	20.2 (1.6)	18.7 (1.5)	5.8 (0.9)	5.2 (0.9)	8.9 (1.1)	16.1 (1.4)	8.0 (1.1)
Men 4.6% missing	6.7 (1.6)	**55.7** (3.2)	**44.3** (3.2)	**40.4** (3.1)	21.2 (2.7)	14.8 (2.3)	7.7 (1.6)	6.5 (1.6)	8.1 (1.7)	14.6 (2.3)	6.7 (1.6)
Women 3.7%missing	11.0 (1.6)	**58.1** (2.5)	**38.5** (2.5)	**34.9** (2.4)	20.8 (2.1)	20.8 (2.1)	4.3 (1.0)	4.6 (1.1)	9.2 (1.5)	17.3 (1.9)	9.0 (1.4)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment . Overall Phone 4.2% missing.* Not sure overall 4.0% missing

Table 22. CBP Program Use By Respondents Within the Past Year [% (Standard Error)]

	CA/EI	DWI	FBS	HFI	HCH	Heritage	Postive Outcomes	SCDP	SMH	Tupac	WIC	Did not use any	No Interest	Not sure
Alamo 2.8%missing	6.4 (2.1)	5.0 (1.9)	5.7 (2.0)	3.6 (1.6)	7.9 (2.3)	1.4 (1.0)	**18.0** (3.3)	2.1 (1.2)	3.6 (1.6)	0	**22.1** (3.5)	**29.3** (3.9)	3.6 (1.6)	23.6 (3.6)
Magdalena 9.8%missing	0	1.0 (1.0)	2.0 1.4)	2.0 (1.4)	**9.9** (3.0)	0	**5.9** (2.3)	3.0 (1.7)	4.0 (2.0)	0	5.0 (2.2)	**61.4**% (4.9)	3.0 (1.7)	9.9 (3.0)
Rural 9.7% missing	0.8 (0.8)	0.8 (0.8)	3.1 (1.5)	1.5 (1.1)	**6.1** (2.1)	2.3 (1.3)	3.8 (1.7)	0	**5.3** (2.0)	1.5 (1.1)	**6.1** (2.1)	**58.8** (4.3)	1.5 (1.7)	5.3 (2.0)
Socorro 8.4% missing	2.6 (0.9)	4.3 (1.2)	4.6 (1.2)	3.6 (1.1)	**6.6** (1.4)	1.0 (0.6)	**7.9** (1.6)	2.0 (0.8)	**13.2** (1.9)	0.3 (0.3)	**13.5** (2.0)	**45.1** (2.9)	3.6 (1.1)	9.9 (1.7)
Veguita 5.9% missing	**6.3** (2.5)	0	4.2 (2.1)	**7.4** (2.7)	3.2 (1.8)	0	0	1.1 (1.1)	3.2 (1.8)	1.1 (1.1)	**22.1** (4.3)	**43.2** (5.1)	5.3 (2.3)	11.6 (3.3)
<$30,00 2.8%missing	4.2 (1.2)	3.7 (1.1)	3.5 (1.1)	3.2 (1.1)	7.4 (1.6)	1.5 (0.8)	**7.9** (1.5)	1.2 (0.6)	**13.8** (2.1)	0.9 (0.6)	**14.6** (2.0)	**41.4** (2.9)	3.6 (1.1)	10.3 (1.7)
>$30,000 7.5% missing	1.28 (0.7)	1.7 (0.8)	**5.0** (1.5)	3.1 (1.1)	**5.6** (1.4)	1.0 (0.7)	**4.9** (1.4)	1.7 (0.8)	4.8 (1.5)	0.9 (0.6)	**9.7** (1.9)	**59.4** (3.2)	2.3 (1.0)	5.3 (1.4)
County 7.7% missing	2.6 (0.6)	2.7 (0.6)	4.1 (0.8)	3.4 (0.7)	**6.3** (1.0)	1.2 (0.5)	**6.5** (0.9)	1.4 (0.4)	**8.8** (1.1)	0.7 (0.4)	**12.5** (1.3)	**48.5** (2.0)	3.2 (0.7)	9.7 (1.1)
Men 8.2% missing	1.9 (0.9)	3.4 (1.1)	5.3 (1.5)	3.5 (1.2)	**7.5** (1.7)	2.0 (0.9)	5.3 (1.2)	1.1 (0.6)	**8.9** (1.9)	1.2 (0.8)	**10.6** (2.0)	**45.2** (3.3)	4.1 (1.3)	11.9 (2.0)
Women 7.0% missing	3.0 (0.8)	2.1 (0.7)	3.5 (0.9)	3.3 (0.9)	5.9 (1.2)	0.8 (0.5)	**6.6** (1.3)	1.7 (0.6)	**8.6** (1.5)	0.5 (0.2)	**13.5** (1.7)	**51.9** (2.6)	2.6 (0.8)	7.7 (1.3)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 23. Factors Most Likely to Increase Use of CBP By Respondents (bolded if >25%) [% (Standard Error)]

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

	Close to home	Confidential	Covered by Insurance	Dr / Nurse Rec'd	Free/ no $	Speak my language	Open M-F 8-5	Open nights & weekend	Transport avail	Not Sure
Alamo 3.4% missing	**46.4%** (4.2)	23.6% (3.6)	17.9% (3.3)	22.9% (3.6)	**27.9%** (3.8)	12.1% (2.8)	17.1% (3.2)	**27.1%** (3.8)	20.7% (3.4)	22.9% (3.6)
Magdalena 3.6% missing	**43.5** (4.8)	17.6 (3.7)	**32.4** (4.5)	4.1 (4.1)	**26.9** (4.3)	0.9 (0.9)	13.0 (3.3)	20.4 (2.9)	2.8 (1.6)	18.5 (3.8)
Rural 9.7% missing	**34.4** (4.2)	16.8 (3.3)	**27.5** (3.9)	**26.7** (3.9)	**25.4** (3.8)	1.5 (1.1)	9.2 (2.5)	19.9 (3.5)	4.6 (1.8)	17.6 (3.3)
Socorro 3.9% missing	**39.8** (2.7)	22.6 (2.3)	**31.7** (2.6)	**32.0** (2.6)	**31.0** (2.6)	7.8 (1.5)	12.2 (1.8)	**27.3** (2.5)	7.2 (1.5)	15.6 (2.0)
Veguita 3.0% missing	**50.0** (5.1)	19.4 (4.0)	19.4 (4.0)	18.4 (3.9)	**30.6** (4.7)	**24.5** (4.4)	8.2 (2.8)	22.5 (4.2)	5.1 (2.2)	18.4 (3.9)
<$30,000 1.9%missing	**42.8** (2.9)	18.5 (2.2)	**26.1** (2.6)	23.5 (2.5)	**30.2** (2.7)	10.0 (1.6)	12.6 (1.9)	**24.7** (2.5)	10.6 (1.7)	14.0 (2.1)
>$30,000 2.4% missing	**40.1** (3.1)	22.9 (2.7)	**36.1** (3.1)	**39.0** (3.1)	**31.0** (3.0)	6.2 (1.5)	9.8 (1.8)	**26.1** (2.8)	3.6 (1.1)	14.1 (2.3)
County 4.7% missing	**40.1** (1.9)	20.5 (1.6)	**28.0** (1.8)	**28.0** (1.8)	**29.0** (1.8)	7.9 (1.0)	11.3 (1.2)	**24.4** (1.7)	6.9 (1.0)	17.0 (1.5)
Men 4.6% missing	**38.2** (3.1)	17.2 (2.4)	**28.4** (2.9)	**28.2** (2.9)	**26.6** (2.8)	5.8 (1.3)	8.5 (1.7)	20.1 (2.5)	4.3 (1.2)	18.8 (2.5)
Women 4.3% missing	**40.4** (2.5)	22.0 (2.1)	**28.12** (2.32)	**28.2** (2.3)	**31.2** (2.4)	9.1 (1.4)	12.6 (1.7)	**27.1** (2.3)	7.7 (1.3)	16.1 1.9

Perceptions of Diabetes & CBPs

(See Tables 24-28)

Health indicator data shows diabetes is devastatingly affecting this community. For a preventable, treatable disease to have such a high mortality rate indicates either need for outreach for detection and more routine medical checks, more prevention outreach focusing on diet & fitness, potential lack of compliance with medical treatments and lifestyle changes or, possibly, concurrent illness.

This part of the assessment focused on learning whether people had been asked by a doctor about having diabetes and how well they think a CBP may improve quality of life and health of a person with diabetes. Overall, about 47% of respondents a doctor discuss risks of diabetes; almost 45% had a doctor discuss risks. About 5.5% of women had talked with doctor about risks for diabetes only during pregnancy (note, this is without knowing which women had been pregnant).

Most respondents stated it was either very important or important to see a health professional regularly if one is diabetic. About 5% of men and almost no women said that it is not important. Over 10% of Alamo respondents were not sure and had a lower percentage in the "very important" category compared to residents of other locations. When asked if a community outreach program can help with diabetic care, the majority said yes. However, about 20% of Alamo respondents and 18% of rural residents said they did not think the program would help or were not sure if it could help. There were no differences in response frequencies between men and women or those with incomes above or below the $30,000 household income.

A majority of respondents marked that a CBP can improve the health of a person living with diabetes. More men than women did not think or were not sure the CBP could help; and, more men did not think or were not sure if they would recommend diabetes CBPs. Residents of Alamo and of rural areas had the highest (18-20%) level of doubt that a CBP could help improve a diabetic's health and were also the least likely to recommend a CBP (24-27% said they would not or were not sure). The higher income bracket and those persons in Magdalena had the least (about 8%) negative or not sure responses to this question. Overall, about 80% would recommend a CBP for diabetics.

Focus group members discussed a need for community outreach as changes in diet and lifestyle are most effective with family support. The majority of the five members of the group were not diagnosed by a doctor or health provider—one person used a feline glucometer and another used a relatives' glucometer. Improved diagnoses and outreach—not only among diabetics but to families and friends—were recommended by the group.

Table 24. Frequency of Doctor Discussing Diabetic Risks with Respondents [% (Standard Error)]

	Doctor Has Talked About Diabetes	Doctor Has NOT talked about Diabetes	Doctor Only Talked about Diabetes during Pregnancy	No answer
Alamo 4.8% missing	49.3% (4.3)	35.5% (4.1)	4.4% (1.7)	10.9% (2.7)
Magdalena 5.4%missing	43.4 (4.8)	48.1 (4.9)	0.9 (0.9)	7.6 (2.6)
Rural 6.2%missing	45.6 (4.3)	47.1 (4.3)	3.7 (1.6)	3.7 (1.6)
Socorro 5.1% missing	43.2 (2.8)	48.3 (2.8)	3.5 (1.0)	5.1 (1.2)
Veguita 5.9% missing	47.4 (5.2)	48.4 (5.2)	1.1 (1.1)	3.2 (1.8)
<$30,000 3.9% missing	46.2 (3.0)	47.6 (3.0)	3.1 (1.1)	3.1 (1.0)
>$30,000 2.7% missing	44.4 (3.2)	47.7 (3.2)	3.2 (1.2)	4.6 (1.4)
Men 5.9%missing	45.0 (3.2)	49.7 (3.2)	N/A	5.3 (1.4)
Women 4.8% missing	45.4 (2.6)	44.1 (2.6)	5.5% (1.2)	5.0 (1.1)
County 5.4%missing	**44.7 (2.0)**	**47.1 (2.0)**	**3.2% (0.7)**	**5.0% (0.8)**

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 25. Importance of Seeing Healthcare Professional Regularly if Diabetic

[% (Standard Error)]

	Very Important	Important	Not Important	Not Sure
Alamo 5.5% missing	59.9% (4.2)	24.1% (3.7)	3.7% (1.6)	12.4% (2.8)
Magdalena 8.0% missing	73.8 (4.4)	16.5 (3.7)	2.9 (1.7)	6.8 (2.5)
Rural 6.9% missing	67.4 (4.1)	24.4 (3.7)	1.5 (1.0)	6.7 (2.2)
Socorro 6.9% missing	72.5 (2.5)	20.4 (2.3)	2.6 (0.9)	4.5 (1.2)
Veguita 7.9% missing	75.3 (4.5)	16.1 (3.8)	1.1 (1.1)	7.5 (2.6)
<$30,000 5.8% missing	70.7 (2.8)	20.9 (2.5)	1.5 (0.6)	6.9 (1.6)
>$30,000 3.8% missing	72.9 (2.9)	21.7 (2.7)	2.2 (0.9)	3.2 (1.1)
Men 8.2% missing	67.3 (3.1)	23.3 (2.8)	4.8 (1.4)	4.6 (1.3)
Women 5.8% missing	73.6 (2.3)	19.0 (2.1)	0.7 (0.3)	6.8 (1.3)
County 6.9% missing	**70.6% (1.8)**	**21.2% (1.6)**	**2.2% (0.6)**	**6.1% (0.9)**

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 26. Efficacy of Community Outreach Programs in Helping with Diabetic Care
[% (Standard Error)]

	Helpful	Not helpful or Not Sure if Helpful
Alamo 4.8%missing	78.3% (3.5)	21.7% (3.5)
Magdalena 6.3%missing	91.4 (2.7)	8.6 (2.7)
Rural 8.3%missing	81.2 (3.4)	18.8 (3.4)
Socorro 6.6%missing	86.5 (2.0)	13.6 (2.0)
Veguita 5.0%missing	85.4 (3.6)	14.6 (3.6)
<$30,000 4.7%missing	85.6 (2.1)	14.4 (2.1)
>$30,000 3.1%missing	85.8 (2.3)	14.0 (2.3)
Men 7.2%missing	83.4 (2.4)	16.6 (2.4)
Women 5.4%missing	85.6 (1.9)	14.4 (1.9)
County 6.3%missing	**84.6% (1.4)**	**15.4% (1.4)**

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 27. Percent of Respondents Who Would Recommend or Participate in A Community Based Program for Diabetics [% (Standard Error)]

	Would Recommend or Use Diabetes CBP	Would Not or Not Sure if Would Use or Recommend A Diabetes CBP
Alamo 5.5%missing	73.7% (3.8)	26.3% (3.8)
Magdalena 6.3%missing	82.9 (3.7)	17.1 (3.7)
Rural 9.0%missing	75.8 (3.7)	24.2 (3.8)
Socorro 5.7%missing	81.2 (2.2)	18.9 (2.2)
Veguita 6.9%missing	85.1 (3.7)	14.9 (3.7)
<$30,000 4.2%missing	79.4 (2.5)	20.7 (2.5)
>$30,000 2.7%missing	84.4 (2.4)	15.6 (2.4)
Men 7.9%missing	75.7 (2.8)	24.3(2.8)
Women 5.2%missing	82.1 (2.0)	17.9 (2.0)
County 6.5%missing	**79.7% (1.6)**	**20.4% (1.6)**

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 28. Responses to Whether a CBP Can Lead to Improved Health for Diabetic [% (Standard Error)]

	Yes, Can Help Improve Health	No or Not Sure Can Improve Health
Alamo 4.8%missing	78.3% (3.5)	21.74% (3.52)
Magdalena 6.3%missing	91.4 (2.7)	8.57 (2.74)
Rural 8.3%missing	81.2 (3.4)	18.8 (3.4)
Socorro 6.6%missing	86.5 (2.0)	13.6 (2.0)
Veguita 5.0%missing	85.4 (3.6)	14.6 (3.6)
<$30,000 3.9%missing	87.5 (2.0)	12.5 (2.0)
>$30,000 3.8%missing	91.5 (1.8)	8.5 (1.8)
Men 7.5%missing	85.63 (2.3)	14.4 (2.3)
Women 5.8%missing	88.81 (1.6)	11.2 (1.6)
County 6.8%missing	**87.4 % (1.3)**	**12.6% (1.3)**

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Tobacco Use, SHS Exposure and CBP/Medical Interventions

(See Tables 29-34)

In order to find out how one of the leading preventable causes of death is impacting this community, questions were included on smoking prevalence, smokeless tobacco use, days of SHS exposure and about providers role in helping someone stop smoking and in teaching SHS exposure risks. For these questions, ceremonial tobacco use is explicitly not included.

Overall smoking in Socorro County is about 23%. A lower percentage of rural residents (around 17%) and Veguita (18%) reported smoking compared to the other locations. The City of Socorro residents reported the highest, around 27%. Those making under $30,000 had a prevalence which was 10% higher than those making over this amount. Among smokers who had visited a doctor for routine care within the past year, around 60% (57.3% SE 5.3) had a doctor or healthcare provider discuss quitting. For this particular question, the sample sizes were much smaller for Veguita, Alamo, Magdalena and Rural areas which led to larger standard error. Smokers were less likely than the overall sample to recommend a community based program to help someone quit smoking. Both smokers and the overall sample showed up to 20% of respondents were not sure if they would recommend such a program.

Smokeless tobacco use was close to 10% countywide. Men, those making < $30,000, rural residents and Alamo resident had the highest prevalence. Alamo's smokeless use was higher than their smoking prevalence with about one-quarter of respondents reporting some use of smokeless tobacco not related to ceremonial or traditional use.

In the home, 7.6% (SE 1.2) of 566 non-smokers stated they had been exposed to at least 1 day of SHS during the past 7 days. The 47 non-smokers exposed at home to SHS were exposed on average 4.58 days (3.7-5.4). In the car, 8.8% (SE 1.3) of 567 non-smokers were exposed to SHS at least 1 out of the past 7 days. The 47 non-smokers exposed to SHS in cars were exposed on average 4.2 days (CI 3.4-4.9) days out of the past week. Out of 562 non-smokers, 5.3% (SE 1.1) were exposed to SHS at least 1 in 7 days while at work. Veguita did not have any non-smokers reporting SHS exposure at work. Out of the non-smokers exposed at work (n=29), they were exposed about 4.2 (3.3-5.1) days out of the past 7.Overall for the county, respondents said that healthcare providers can be very good job educating about health problems related to SHS. Men, person in the income bracket >$30,000/yr, persons from Veguita and Magdalena rated them as excellent in educating on SHS. Compared to others, Alamo residents rated them fair to poor in teaching about SHS.

Though overall doctors, nurses and healthcare workers were rated "very good" or "good" at helping people stop smoking; each responder group had higher percentage stating they are "fair" or "poor" at helping someone quit smoking compared to the question asking how well they educate about SHS.

Table 29. Prevalence of Current Smoking and Smokeless Tobacco Use (Socorro County CNA 2011) [% (Standard Error)]

	OVERALL SMOKING PREVALENCE 7.5%missing	Smoke Cigarette Everyday	Smoke Cigarette Somedays	Do Not Smoke	Not Sure if Smoke		OVERALL* SMOKELESS PREVALENCE 8.4%missing	Smokeless Daily Use	Smokeless Sometime Use	Do Not Use Smokeless	Not Sure if Use Smokeless
Alamo	22.9% (3.7)	6.6% (2.1)	15.3% (3.1)	73.7% (2.8)	4.4% (1.8)		25.6% (3.9)	9.6% (2.5)	14.7% (3.1)	70.6% (3.9)	5.2% (1.9)
Magdalena	22.9 (4.12)	15.1 (3.5)	7.6 (2.6)	76.4 (4.1)	0.9 (0.9)		8.7 (2.8)	4.8 (2.1)	3.8 (1.9)	90.5 (2.9)	1.0 (1.0)
Rural	17.4 (3.3)	13.4 (3.0)	3.7 (3.0)	81.3 (3.4)	1.5 (1.1)		13.2 (3.0)	6.8 (2.2)	6.1 (2.1)	84.9 (3.1)	2.3 (1.3)
Socorro	27.4 (2.5)	17.6 (2.2)	9.6 (1.7)	72.7 (2.5)	0.6 (0.5)		7.1 (1.5)	3.2 (1.0)	3.9 (1.1)	92.6 (1.5)	0.3 (0.3)
Veguita	18.1 (4.0)	8.4 (2.9)	9.5 (3.0)	81.1 (4.0)	1.1 (1.1)		5.4 (2.4)	3.2 (1.8)	2.1 (1.5)	92.6 (2.7)	2.1 (1.5)
<$30,000	26.1 (2.6)	17.4 (2.3)	8.4 (1.6)	73.2 (2.7)	1.1 (0.6)		11.1 (1.9)	6.0 (1.4)	5.0 (1.3)	87.6 (2.0)	1.5 (0.7)
>$30,000	16.7 (2.4)	11.0 (2.0)	5.6 (1.5)	82.7 (2.5)	0.7 (0.6)		8.8 (1.9)	4.0 (1.3)	4.8 (1.4)	90.5 (1.9)	0.8 (0.6)
Men	24.3 (2.8)	14.9 (2.3)	9.5 (1.9)	74.8 (2.8)	1.2 (0.7)		16.2 (2.4)	8.5 (1.9)	7.3 (1.7)	82.6 (2.5)	1.8 (0.9)
Women	20.9 (2.1)	13.9 (1.8)	6.9 (1.2)	78.4 (2.1)	0.81 (0.48)		5.8 (1.2)	2.4 (0.8)	3.4 (0.9)	93.3 (1.3)	1.0 (0.5)
County	**23.1% (1.7)**	**14.6% (1.4)**	**8.2% (1.0)**	**76.0% (1.7)**	**1.2% (0.4)**		**9.9% (1.2)**	**4.7% (0.8)**	**5.0% (0.8)**	**88.9% (1.2)**	**1.4% (0.5)**

For both smoking and smokeless –"overall" prevalence includes some and every day; not sure counted as missing. Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 30. Frequency of Smokers With Whom Doctor Discussed Quitting

(Sample: Smokers* Who Report Seeing Doctor Within Past Year)
[% (Standard Error)]

	Dr Talked about Quit smoke	No dr talked about quit smoke	Not sure if dr told quit smoke
Alamo N=15	26.7 (11.5)	66.7 (12.2)	0
Magdalena N=15	46.7 (12.9)	53.3 (12.9)	0
Rural N=15	60.0 (12.7)	33.3 (12.2)	0
Socorro N=50	60.0 (7.0)	38.0 (6.9)	2.0 (2.0)
Veguita N=7	57.1 (18.8)	57.1 (18.8)	0
<$30,000 N=50	66.5 (7.3)	31.0 (7.1)	2.5 (2.5)
>$30,000 N=26	61.5 (10.0)	33.2 (9.5)	0
Men N=39	56.2 (8.5)	36.0 (8.1)	3.0 (2.9)
Women N=53	58.0 (7.4)	42.0 (7.3)	0
County N=102	**57.3% (5.3)**	**39.6% (5.3)**	**1.2% (1.2)**

*Every & someday smokers who also answered on Q11 they had seen doctor within past year for routine care. Note-2 men from this question put "do not smoke"-responses not included in the table above. N=sample size. Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 31. Percentage of All Respondents Who Would Use or Recommend a CBP to Help Someone Quit Smoking [% (Standard Error)]

	Recommend or Use	Would Not Use or Recommend	Not Sure
Alamo 6.9%missing	63.0% (4.2)	14.8% (3.1)	22.2% (3.6)
Magdalena 6.3%missing	70.5 (4.5)	16.2 (3.6)	13.3 (3.3)
Rural 9.7%missing	70.2 (4.0)	15.3 (3.2)	14.5 (3.1)
Socorro 5.7% missing	70.6 (2.6)	11.8 (1.8)	17.6 (2.2)
Veguita 5.9%missing	77.9 (4.3)	10.5 (3.2)	11.6 (3.3)
<$30,000 3.6 %missing	70.4 (2.8)	11.1 (1.9)	18.5 (2.4)
>$30,000 3.4%missing	76.9 (2.7)	13.1 (2.2)	10.0 (1.9)
Men 6.6%missing	71.8 (2.9)	12.8 (2.1)	15.4 (2.4)
Women 6.6%missing	69.4 (2.4)	13.9 (1.9)	16.7 (1.9)
County 6.7%missing	**70.8% (1.8)**	**13.1% (1.34)**	**16.2% (1.45)**

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 32. . Percentage of All Smokers Who Would Use or Recommend a CBP to Help Someone Quit Smoking [% (Standard Error)]

	Recommend or Use	Would Not Use or Recommend	Not Sure
Alamo N=30	50.0% (9.2)	26.7% (8.1)	23.3 (7.8)
Magdalena N=23	60.9 (10.2)	21.7 (8.6)	17.4 (7.94)
Rural N=23	69.6 (9.6)	17.4 (7.4)	13.0 (7.1)
Socorro N=83	61.5 (5.4)	15.7 (4.0)	22.9 (4.6)
Veguita N=17	64.7 (11.7)	17.7 (9.3)	17.7 (9.3)
<$30,000 N=86	66.0 (5.7)	16.0 (4.5)	18.0 (4.6)
>$30,000 N=48	68.1 (7.2)	14.3 (5.2)	17.7 (5.9)
Men N=69	63.7 (6.2)	15.5 (4.4)	20.8 (5.3)
Women N=91	60.1 (5.7)	20.4 (4.7)	19.5 (4.6)
County N=176	**62.7% (4.0)**	**17.2% (3.1)**	**20.1% (3.3)**

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 33. Respondent Ratings of Success of Doctor, Nurse or Healthcare Worker in Educating About Health Effects of Secondhand Smoke Health Problems [% (Standard Error)]

	SHS Excellent	SHS Very Good	SHS Good	SHS Fair	SHS Poor	SHS Not sure
Alamo	17.8 (3.4)	25.6 (3.9)	**26.4** (3.9)	16.3 (3.3)	13.2 (3.0)	0.8 (0.8)
Magdalena	**31.8** (4.5)	**31.8** (4.5)	23.4 (4.1)	8.4 (2.7)	4.7 (2.1)	0
Rural	28.03 (3.9)	**31.8** (4.1)	22.7 (2.7)	10.6 (2.7)	6.1 (2.1)	0.8 (0.8)
Socorro	29.6 (2.6)	**32.2** (2.6)	22.3 (2.4)	8.6 (1.6)	6.3 (1.4)	1.0 (0.6)
Veguita	**40.9** (5.1)	30.1 (4.8)	16.1 (3.8)	7.5 (2.8)	5.4 (2.4)	0
Men	**31.8** (3.1)	28.2 (2.9)	22.9 (2.7)	8.9 (1.9)	8.2 (1.8)	0
Women	27.9 (2.3)	**34.7** (2.5)	22.1 (2.2)	9.5 (1.5)	4.6 (1.1)	1.3 (0.6)
<$30,000	27.6 (2.7)	**34.5** (2.9)	21.4 (2.5)	9.5 (1.7)	5.6 (1.3)	1.4 (0.7)
>$30,000	**35.8** (3.1)	31.1 (3.0)	19.0 (2.6)	8.3 (1.8)	5.8 (1.6)	0
County	**29.7%** (1.8)	**31.4%** (1.9)	**22.1%** (1.6)	**9.5%** (1.2)	**6.5%** (1.0)	**0.7%** (0.4)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment
SHS: County overall 7.2%missing. Stopping 7.5% missing

Table 34. Respondent Ratings of Success of Doctor, Nurse or Healthcare Worker Help People Stop Smoking
[% (Standard Error)]

	Stop Smoke Excellent	Stop Smoke Very Good	Stop Smoke Good	Stop Smoke Fair	Stop Smoke Poor	Stop Smoke Not Sure or Depends
Alamo	19.4% (3.5)	20.9% (3.6)	**32.6%** (4.1)	15.5% (3.2)	10.1% (2.7)	1.6% (1.1)
Magdalena	20.0 (3.9)	**30.5** (4.5)	21.9 (4.1)	17.1 (3.7)	10.5 (3.0)	0
Rural	19.2 (3.5)	23.1 (3.7)	**33.1** (4.1)	15.4 (3.2)	8.5 (2.5)	0.8 (0.8)
Socorro	21.0 (2.3)	**28.7** (2.6)	26.1 (2.5)	15.9 (2.1)	7.6 (1.5)	0.6 (0.5)
Veguita	**38.3** (5.0)	29.8 (4.7)	13.8 (3.6)	10.6 (3.2)	6.4 (2.5)	1.1 (1.1)
Men	19.9 (2.6)	**28.9** (2.9)	26.3 (2.9)	16.3 (2.4)	8.6 (1.8)	0
Women	23.2 (2.1)	**27.1** (2.3)	27.4 (2.4)	14.1 (1.8)	6.9 (1.3)	1.3 (0.6)
<$30,000	22.3 (2.4)	**27.3** (2.7)	31.6 (2.8)	11.6 (2.0)	5.9 (1.4)	1.4 (0.7)
>$30,000	25.6 (2.2)	**26.7** (2.9)	23.6 (2.8)	16.6 (2.4)	7.6 (1.7)	0
County	**22.2%** (1.6)	**26.8%** (1.8)	**26.9%** (1.8)	**15.3%**(1.4)	**8.1%** (1.1)	**0.7%** (0.3)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Maternal/Child Health & CBPs

(See Tables 35-37)

In order to understand how effective CBPs may be intervening on maternal; child health, the survey included a two questions related to prenatal care and healthy families and one question about the importance of early childhood intervention for children with developmental delays.

Overall, and within each subgroup, at least 8 out of 10 respondents stated prenatal care was important or very important. Alamo had a higher number of "not sure" responses related to importance of prenatal care. About 8 out of 10 persons also would recommend or use a CBP for pregnant women or parents about having healthy family. Men (7.1% SE 1.7) and persons in rural areas (8.3% SE 2.4) were the groups with the highest percentages of responders not recommending such a program.

About 8 of 10 overall and within location, gender and income subgroups would recommend a person seek professional help if their child is not developing the same as other the same age. The one exception was Alamo (closer to 6 out of 10); Alamo had more "not sure" responses as well.

Table 35. Importance of Prenatal Care

[% (Standard Error)]

	Very Important	Important	Not Important	Not Sure
Alamo	63.0% (4.2)	19.3% (3.4)	2.2% (1.3)	15.6% (3.1)
Magdalena	79.3 (4.0)	14.2 (3.4)	3.8 (1.9)	2.8 (1.6)
Rural	81.3 (3.5)	14.8 (3.2)	1.6 (1.1)	2.3 (1.3)
Socorro	81.6 (2.2)	12.9 (1.9)	1.9 (0.8)	3.6 (1.1)
Veguita	80.9 (4.1)	10.6 (3.2)	2.1 (1.5)	6.4 (2.5)
<$30,000	81.6 (2.3)	14.2 (2.1)	1.5 (0.7)	2.7 (0.9)
>$30,000	82.5 (2.5)	11.3 (2.1)	2.0 (0.9)	4.2 (1.3)
Men	72.8 (2.8)	18.8 (2.5)	2.1 (0.9)	6.3 (1.5)
Women	85.4 (1.8)	10.1 (1.6)	2.0 (0.7)	2.5 (0.7)
County	**80.0%** (1.6)	**13.7%** (1.4)	**1.97%** (0.5)	**4.3%** (0.7)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment
Overall missing: 7.5% Rural had highest missing- 11.7%

Table 36. Whether Respondents Would Recommend or Use CBP Focused on Healthy Families

[% (Standard Error)]

	Would recommend or use	Would not recommend or use	Not sure
Alamo	70.6% (3.9)	4.4% (1.8)	25.0% (3.7)
Magdalena	85.7 (3.4)	6.7 (2.5)	7.6 (2.6)
Rural	78.8 (3.6)	8.3 (2.4)	12.9 (2.9)
Socorro	82.7 (2.2)	4.8 (1.2)	12.5 (1.9)
Veguita	84.2 (3.8)	2.1 (1.5)	13.7 (3.5)
<$30,000	80.3 (2.4)	5.6 (1.4)	14.2 (2.2)
>$30,000	85.5 (2.3)	6.2 (1.7)	8.3 (1.7)
Men	77.2 (2.7)	7.1 (1.7)	15.7 (2.3)
Women	83.2 (2.0)	4.2 (1.1)	12.6 (1.7)
County	**81.1%** (1.6)	**5.6%** (0.9)	**13.3%** (1.3)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment
Overall :6.5% missing. Rural had highest missing: 9%

Table 37. Importance of Seeing a Professional When Child Not Developing Like Children of Same Age

[% (Standard Error)]

	Very Important	Important	Not Important	Not Sure
Alamo	57.7 (4.2)	20.4 (3.5)	3.7 (1.6)	18.3 (3.3)
Magdalena	80.4 (3.9)	14.0 (3.4)	1.9 (1.3)	3.7 (1.8)
Rural	76.3 (3.7)	14.5 (3.1)	0.8 (0.8)	8.4 (2.4)
Socorro	80.0 (2.3)	14.2 (2.0)	1.3 (0.6)	4.5 (1.2)
Veguita	79.0 (4.2)	15.8 (3.8)	0	5.3 (2.3)
<$30,000	74.8 (2.6)	16.0 (2.1)	1.2 (0.7)	8.0 (1.7)
>$30,000	81.2 (2.6)	15.0(2.4)	1.2 (0.7)	2.6 (1.0)
Men	70.0 (3.0)	20.0 (2.6)	1.8 (.08)	8.2 (1.8)
Women	81.3 (2.0)	12.3 (1.7)	0.7 (0.4)	5.7 (1.2)
County	**77.4%** (1.6)	**14.9%** (1.4)	**1.2%** (0.4)	**6.6%** (1.0)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment
Overall: 6.6% missing; highest missing was from Rural population 9.7% missing

Mental Health Issues and CBPs

(See Tables 38-46)

For the purposes of this survey- mental health encompasses suicide, depression, anxiety, mental illness, alcohol abuse, illegal drug abuse, prescription drug abuse, senior mental health, child abuse, community and domestic violence.

The first questions evaluate the perception of seeking care from a health professional if there is a concern about a mental health issues. Then, the survey asks if the person has had a doctor ask about mental health issues of sadness, stress, anxiety, depression or sleep problems.

Respondents answered it was very important or important to seek professional care for mental health. At the county level, a little over 55% had been asked by their doctor about whether they had sadness, stress, anxiety, sleep issues or depression.

Five percent fewer people the lower income bracket responded that seeking care for mental health was "very important" compared to those with >$30,000/yr per household. Men marked "very important" less often and marked "important" more often than women.

Among locations, Veguita had the highest proportion feeling it was "very important" to see a professional for mental health issues and Alamo had the lowest proportion in the "very important" category. Veguita had the highest proportion (close to 77%) of respondents who had been asked by their doctor about mental health symptoms. Alamo had the least (about 40%).

The survey asked respondents to rank importance of specific mental health topics to their community. For each question, Alamo respondents marked "not sure" more than most. Very few answers had "not important" marked by more than 5% of respondents. The highest ranking of "not important" was among men when asked about adult suicide (8.2% se 1.9). The questions about illegal drugs and about alcohol abuse had the highest response rates (n>760); suicide questions had the lowest response rate (n<730).

Overall, 61.4% (SE 2.0) ranked teen suicide and 55.0% (SE 2.0) ranked adult suicide as "very important." For both topics, women (compared to men) and persons living in poverty (compared to those not) ranked both teen and adult suicide as very important more often than their counterparts. Residents of the City of Socorro ranked them as "very important" more often than persons in the other parts of the county.

Depression was considered "very important" among 59.0% (SE 2.00) of respondents. Very few (<3% marked as not important). Women marked it as "very important" more than men; those in the lower income level also marked it as "very" more often than other. Out of

locations, rural residents ranked it less as "very"; Magdalena had the highest percentage marking it as "very."

Alcohol Abuse had one of the highest percentages of "Very Important:" 77.2% (SE 1.7). Unlike for depression, those with incomes over $30,000 were much more likely to rank it as "very important" compared to those in the lower. Women were again making this as very important more than men. Veguita had the lower percent of respondents ranking it "very" and Magdalena had the highest.

Domestic Violence was also ranked as quite significant to the respondents' communities with 77.2% (SE 1.7) ranking it as "very important." Women ranked this at a higher level of importance than men. In Alamo and Veguita, about 10% fewer residents ranked it "very important" compared to the county average and other locations. Income level did not seem to impact response.

Child Abuse was ranked by 8 of 10 respondents countywide as "very important." Veguita, Magdalena and Alamo had a lower percentage of "very" important rankings compared to other locations. Those in lower income did rate this at a higher level of importance. Answers between men and women were more similar on this question.

Community Violence was ranked at the "very important" level by 65.0% (1.9) of respondents. Persons in poverty and those living within the City of Socorro ranked it at this highest level more often than their respective counterparts. Gender differences on rating community violence as very important were minimal. Illegal Drugs were more often ranked as "very important" (80.7% SE1.6). For illegal drug use, there were negligible differences based on income; women had a slightly higher level of concern. Alamo had the lower amount of "Very important," as well as many more "not sure."

Prescription Drug abuse was ranked "very" important by 72.8% (1.8) of respondents countywide. Fewer men than women and fewer persons from Veguita than other places ranked this as an "important" health issue for their community.

Senior mental health was less often ranked as "very" important compared to the other topics (62.1% SE 2.0). Veguita ranked it "very" less than the other locations. The percentage of women ranking senior mental health as "very important" was about 10% higher than men.

The next question allowed individuals to mark off any as many of the following organizations or resources to whom they would turn if facing a mental health issue: family & friends, doctor/nurse, tribal elder, Socorro Mental Health (SMF), Church/Religious Organization, Support Group, School, Heritage, Hotline (run by SMH), Not sure, Would Not See Care, or Other.

Countywide, about half of respondents would contact family & friends; the same also marked they would contact doctors & nurses. The next two most common sources for help were SMH and church/religious institution. Alamo had a higher proportion (24.3% SE 3.6) of respondents who would contact their church or religious group. Socorro and Veguita noted Support Group as a resource more than other locations. Women were more likely to contact doctors/nurses and Socorro Mental Health more than men. Those making over $30,000 income/yr were more likely to contact doctors/nurses than those making less.

Several respondents had write-in comments including for Alamo: traditional healer, two people said "keep to self;" others wrote in they would seek counseling, husband, psychiatrist. In Magdalena, one person wrote they would contact their neurology professor; another, Dr. Maddox in Hobbs. Rural, Magdalena and Socorro all had write-ins for using the Veteran's Administration (VA). One rural person wrote: "Family only! No one!" Another wrote that he/she would go to Colorado. Socorro had two people writing in "Police," two writing in they'd go to Albuquerque, one would call 911, one would go to the hospital and another would use the nurse hotline. Socorro had one write-in they would go to their therapist.

The one question specific to domestic violence asked what a person would do if a friend approached them after being hit by a family member or spouse. They could mark multiple answers. Options included calling police, health provider and El Puente, do not know and "do not tell anyone else." There were also options to check about the normalcy of hitting in a home: sometimes normal, never normal and "would not happen in a home."

Overwhelmingly, 70-80% of respondents would call the police. In Socorro (27.1% SE 2.5), rural (23.0% se 3.6) areas and countywide (21.5% SE 1.6), El Puente was the second most likely place to be called. Health Providers were the next most common call overall (15.0% SE 1.4) and the second call for those in Alamo, Magdalena and Veguita. Persons with incomes over $30,000 would call health care providers more than those with less. Almost twice as many women as men would call El Puente.

Less than 1% countywide did respondents mark that hitting is sometimes normal. Only 10-35% marked that it was never normal. Alamo (11.5% SE 2.7) had the fewest marking that hitting is never normal. The highest percentage of respondents stating hitting was not normal within locations was the City of Socorro (29.3% SE 2.5); by income, those making over $30,000 (33.3% SE 3.0); and, by gender, women (27.4% SE 2.3). About 11% said hitting would not happen in an home- though, due to many different interpretations of this answer- it will not be included in the discussion. Alamo had 3.6% (SE 1.6) stating not to tell anyone else; Alamo also had the highest of percentage of "Do Not Know" responses.

The domestic violence response question also allowed for persons to write in their own plan. In Magdalena, someone wrote “Get rid of him/her” or “call friends for support and back up while getting out,” “seek mental health therapy,” “stay with me,” “take that person to emergency at SGH.” Rural write-ins included “think about leaving,” “talk to cops, offer help,” “get out,” “pray,” “no police service here,” “circumstance. Socorro residents offered “leave,” “seek any help for friend,” “stay at my place for the night,” “suggest counseling,” “go look for them and hit them back,” “NO ANSWER (written to cross every possible response out for this question), “CYFD,” “Tell the offender never to do it again and ask for an apology,” “stay with me” “make them come with me,” “leave,” “suggest calling police.” depending on the situation I will give recommendation,” “get out,” “call police myself. ” Veguita respondents wrote “get to a shelter,” “go to a shelter if no other place,” “get friend as much help as I can,” “get far away from him.” Many verbal responses during survey administration were persons stating they would hit back but then saying they were just verbalizing and wouldn’t do that and one person who commented hitting a girl is not normal but hitting a brother might be normal.

Table 38. Importance of Seeking Professional Care for Mental Health [% (Standard Error)]

	Seeking MH Care Very Important	Seeking MH Care Important	Seekling MH Care Not Important
Alamo 6.2%missing	59.6% (4.2)	21.3% (3.5)	2.9% (1.5)
Magdalena 4.5%missing	70.1 (4.5)	24.3 (4.2)	0.9 (0.9)
Rural 9.0%missing	68.2 (4.1)	22.7 (3.7)	1.5 (1.1)
Socorro 6.0%missing	75.0 (2.5)	21.8 (2.3)	1.3 (0.6)
Veguita 5.0%missing	81.3 (4.0)	14.6 (3.6)	1.0 (1.0)
<$30,000 4.2%missing	70.3 (2.8)	22.0 (2.5)	2.0 (0.8)
>$30,000 3.1%missing	76.8 (2.7)	20.9 (2.7)	0.7 (0.6)
Men 6.6%missing	64.4 (3.1)	28.2 (2.9)	2.4 (1.0)
Women 5.6%missing	77.6 (2.2)	1.70 (2.0)	0.8 (0.5)
County 6.2%missing	**72.5 %** (1.8)	**21.4%** (1.6)	**1.4%** (0.5)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 39. Whether Doctor Has Asked About Anxiety, Sadness, Stress, Depression, Sleep Problems

[% (Standard Error)]

	Doctor Asked	Doctor Has Not Asked	Not If Doctor Has Asked
Alamo 11.7% missing	39.9% (4.2)	**52.2% (4.3)**	8.0% (2.3)
Magdalena 9.8%missing	58.4 (4.9)	36.6 (4.8)	5.0 (2.2)
Rural 11.0%missing	55.0 (4.4)	38.8 (4.3)	6.2 (2.1)
Socorro 5.4%missing	54.8 (2.8)	40.1 (2.8)	5.1 (1.2)
Veguita 6.9%missing	**77.7 (4.3)**	19.2 (4.1)	3.2 (1.8)
<$30,000 3.9%missing	57.6 (3.0)	36.4 (2.9)	6.1 (1.5)
>$30,000 2.7%missing	59.9 (3.2)	37.7 (3.1)	2.4 (1.0)
Men 7.5%missing	54.5 (3.2)	41.5 (3.2)	5.0 (1.4)
Women 6.6%missing	58.2 (2.6)	35.6 (2.5)	6.2 (1.3)
County 7.1% missing	**56.5%** (2.0)	**38.2%** (1.9)	**5.4%** (0.9)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 40. Rating Importance of Teen and Adult Suicide for the Respondent's Community (%, (SE))

	Teen Suicide Very Important	Teen Suicide Important	Teen Suicide Not Important	Teen Suicide Not Sure	Adult Suicide Very Important	Adult Suicide Important	Adult Suicide Not Important	Adult Suicide Not Sure
Alamo	55.4 (4.5)	29.8 (4.2)	3.3 (1.6)	11.6(2.9)	54.0(4.5)	29.8 (4.1)	6.5 (2.2)	9.7 (2.7)
Magdalena	55.6 (5.0)	32.3 (4.7)	2.0 (1.4)	10.1(2.0)	46.9(5.1)	38.8 (4.9)	3.1 (1.8)	11.2 (3.2)
Rural	62.5 (4.4)	25.0 (4.0)	4.2 (1.8)	8.3 (2.5)	53.8(4.6)	32.8 (4.3)	5.0 (2.0)	8.4 (2.6)
Socorro	63.1 (2.8)	27.7 (2.6)	3.1 (1.0)	6.1 (1.4)	56.8(2.9)	32.1 (2.7)	5.1 (1.3)	6.1 (1.4)
Veguita	56.7 (5.3)	30.0 (4.9)	3.3 (1.9)	10.0(3.2)	54.6(5.3)	30.7 (4.9)	4.6 (2.2)	10.2 (3.3)
<$30,000	66.3 (2.9)	25.2 (2.7)	2.5 (0.9)	6.0 (1.5)	59.7(3.0)	30.0 (2.8)	4.4 (1.2)	5.8 (1.4)
>$30,000	59.45 (3.2)	29.3 (3.0)	4.4 (1.4)	6.9 (1.6)	51.7(3.3)	35.4 (3.2)	6.3 (1.7)	6.6 (1.6)
Male	57.8 (3.3)	29.8 (2.1)	6.1 (1.7)	6.2(1.6)	50.3(3.4)	35.5 (3.2)	8.2 (1.9)	6.1 (1.6)
Female	63.4 (2.6)	26.22 (2.3)	1.9 (0.7)	8.6 (1.5)	57.7(2.7)	30.4 (2.5)	3.3 (0.9)	8.6 (1.5)
County	**61.4%** (2.0)	**27.6%** (1.8)	**3.4%** (0.8)	**7.7%** (1.1)	**55.0%** (2.0)	**32.3%** (1.9)	**5.0%** (0.9)	**7.7%** (1.1)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment
Missing data: teen suicide question, 13.4%missing; adult suicide, 13.2%

Table 41. Importance of Depression & Anxiety and Alcohol Abuse to Respondents' Community [% (Standard Error)]

	Depression/ Anxiety Very Important	Depression/ Anxiety Important	Depression / Anxiety Not Important	Depression / Anxiety Not Sure	Alcohol Abuse Very Important	Alcohol Abuse Important	Alcohol Abuse Not Important	Alcohol Abuse Not Sure
Alamo	58.7 (4.4)	27.0 (4.0)	4.8 (1.9)	9.5 (2.6)	73.7 (3.8)	17.3 (3.3)	2.3 (1.3)	6.8 (2.3)
Magdalena	66.3 (4.8)	27.6 (4.5)	0	6.1 (2.4)	86.4 (3.4)	10.7 (3.1)	0	2.9 (1.7)
Rural	54.8 (4.5)	36.5 (4.3)	3.2 (1.6)	5.6 (2.05)	76.4 (3.8)	18.9 (3.5)	2.4 (1.4)	2.4 (1.4)
Socorro	61.3 (2.8)	33.4 (2.7)	2.3 (0.9)	3.0 (1.0)	78.32 (2.4)	18.1 (2.2)	1.6 (0.7)	1.9 (0.8)
Veguita	56.0 (5.2)	39.6 (5.2)	1.1 (1.1)	3.3 (1.9)	71.4 (4.8)	24.2 (4.5)	1.1 (1.1)	3.3 (1.9)
<$30,000	65.8 (2.9)	29.6 (2.8)	2.0 (0.8)	2.6 (1.0)	76.3 (2.6)	19.5 (2.4)	2.1 (0.9)	2.1 (0.9)
>$30,000	56.0 (3.3)	37.5 (3.2)	3.5 (1.3)	3.1 (1.1)	81.6 (2.5)	15.6 (2.3)	1.4 (0.8)	1.5 (0.8)
Male	48.2 (3.4)	44.9 (3.3)	3.9 (1.3)	2.9 (1.0)	70.5 (3.0)	24.5 (2.8)	2.8 (1.1)	2.2 (0.9)
Female	65.8 (2.5)	27.4 (2.4)	1.3 (0.6)	5.5 (1.2)	81.6 (2.0)	15.1 (1.9)	0.5 (0.3)	2.9 (0.9)
County	**59.0%** (2.0)	**34.3%** (1.9)	**2.5%** (0.6)	**4.3%** (0.8)	**77.2%**(1.7)	**18.5%**(1.6)	**1.7%**(1.6)	**2.6%**(0.6)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment
Missing Data: depression question, 11.0%; alcohol,8.6% missing

Table 42. Importance of Domestic Violence and Child Abuse to Respondent Community [% (Standard Error)]

	Domestic Violence Very Important	Domestic Violence Important	Domestic Violence Not Important	Domestic Violence Not Sure	Child Abuse Very Important	Child Abuse Important	Child Abuse Not Important	Child Abuse Not Sure
Alamo	67.4 (4.1)	22.7 (3.7)	2.3 (1.3)	7.6 (2.3)	70.0 (4.0)	18.5 (3.4)	2.3 (1.3)	9.2 (2.6)
Magdalena	80.2 (4.0)	14.9 (3.6)	0	5.0 (2.2)	75.8 (4.3)	18.2 (3.9)	0	6.1 (2.4)
Rural	78.6 (3.7)	16.7 (3.3)	2.4 (1.4)	2.4 (1.4)	80.6 (3.5)	14.0 (3.1)	2.3 (1.3)	3.1 (1.5)
Socorro	79.4 (2.3)	17.3 (2.2)	1.3 (0.7)	2.0 (0.8)	83.4 (2.1)	13.6 (2.0)	0.7 (0.5)	2.3 (0.9)
Veguita	68.1 (4.9)	26.4 (4.6)	1.1 (1.1)	4.4 (2.2)	70.7 (4.8)	25.0 (4.5)	0	4.4 (2.1)
<$30,000	78.5 (2.5)	17.1 (2.3)	1.8 (0.8)	2.6 (1.0)	80.6 (2.4)	15.3 (2.2)	1.1 (0.7)	3.0 (1.0)
>$30,000	79.7(2.61)	17.2 (2.5)	1.5 (0.9)	1.6 (0.7)	81.6 (2.4)	15.3 (2.3)	0.5 (0.5)	2.6 (1.0)
Men	70.6 (3.0)	24.0 (2.8)	3.2 (1.2)	8.0 (2.16)	77.7 (2.7)	17.8 (2.5)	1.7 (0.9)	2.8 (1.0)
Women	81.6 (2.0)	14.9 (1.9)	0.2 (0.1)	3.4 (0.9)	81.4 ()	14.5 (1.8)	0.4 (0.3)	3.7 (1.0)
County	**77.2%** (1.7)	**18.3%** (1.5)	**1.6% (0.5)**	**2.9%** (0.6)	**80.1%** (1.6)	**15.5%** (1.4)	**1.1%** (0.5)	**3.4%** (0.7)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment
Overall missing data: DV, 9.5% (note, Rural has 26.9%missing; men 10.5%missing); Child abuse, 9.2% (Alamo 10.3%, Magdalena 11.6%, Rural 11.0%)

Table 43. Importance of Community Violence and Illegal Drugs in Respondent's Community [% (Standard Error)]

	Community Violence Very Important	Community Violence Important	Community Violence Not Important	Community Violence Not Sure	Illegal Drugs Very Important	Illegal Drugs Important	Illegal Drugs Not Important	Illegal Drugs Not Sure
Alamo	60.3 (4.3)	29.0 (4.0)	2.3 (1.3)	8.4 (2.4)	72.0 (3.9)	16.7 (3.3)	3.8 (1.7)	7.6 (2.3)
Magdalena	62.6 (4.9)	28.3 (4.6)	3.0 (1.7)	6.1 (2.4)	86.7 (3.3)	7.6 (2.6)	1.9 (1.3)	3.8 (1.9)
Rural	62.2 (4.3)	28.4 (4.0)	3.9 (1.7)	5.5 (2.0)	82.4 (3.3)	13.0 (3.0)	2.3 (1.3)	2.3 (1.3)
Socorro	68.6 (2.7)	27.4 (2.6)	0.7 (0.5)	3.5 (1.1)	80.8(2.2)	16.4 (2.1)	0.3 (0.3)	2.6 (0.9)
Veguita	60.4 (5.2)	33.0 (5.0)	1.1 (1.1)	5.5 (2.4)	78.5 (4.3)	18.3 (4.0)	1.1 (1.1)	2.2 (1.5)
<$30,000	70.3 (2.8)	25.1 (2.7)	0.9 (0.6)	3.8 (1.2)	80.8 (2.4)	15.3 (2.2)	1.4 (0.7)	2.4 (1.0)
>$30,000	61.7 (3.2)	32.4 (3.1)	2.5 (1.1)	3.5 (1.1)	83.2 (2.4)	13.9(2.3)	1.2 (0.7)	1.7 (0.8)
Men	63.1 (3.2)	31.4 (3.1)	2.7 (1.2)	2.8 (1.0)	77.2 (2.7)	19.8 (2.6)	1.6 (0.8)	1.5 (0.7)
Women	67.3 (2.5)	25.9 (2.3)	1.0 (0.5)	5.8 (1.3)	84.3 (1.9)	11.8 (1.7)	0.7 (0.4)	3.3 (0.9)
County	**65.0%** (1.9)	**28.4%** (1.8)	**1.9%** (0.6)	**4.7%** (0.9)	**80.7%** (1.6)	**15.2%**(1.4)	**1.3%** (0.4)	**2.8%**(0.6)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment
Overall missing data: CV, 11.6% (rural 12.4%, Socorro 12.7%); Drugs, 7.4% (Alamo 14.5%, Rural 9.7%)

Table 44. Prescription Drug Abuse & Senior Health Importance within Respondent's Community [% (Standard Error)]

	RX Drug Abuse Very Important	RX Drug Abuse Important	RX Drug Abuse Not Important	RX Drug Abuse Not Sure	Senior Mental Health Very Important	Senior Mental Health Important	Senior Mental Health Not Important	Senior Mental Health Not Sure
Alamo	68.7 (4.1)	19.9 (3.5)	1.5 (1.1)	9.9 (2.6)	60.5 (4.4)	24.2 (3.9)	4.8 (1.9)	10.5 (2.8)
Magdalena	76.0 (4.3)	17.0 (3.8)	1 (1)	6.0 (2.4)	62.0 (4.9)	31.0 (4.7)	1 (1)	6.0 (2.4)
Rural	71.3 (4.0)	23.3 (3.7)	2.3 (1.3)	3.1 (1.5)	64.3 (4.3)	29.4 (4.1)	3.2 (1.6)	3.2 (1.6)
Socorro	74.5 (2.5)	19.9 (2.3)	2.0 (0.8)	3.6 (1.1)	61.9 (2.8)	32.4 (2.7)	1.7 (0.7)	4.0 (1.1)
Veguita	64.8(5.0)	24.2 (4.5)	5.5 (2.4)	5.5 (2.4)	58.2 (5.2)	34.1 (5.0)	1.1 (1.1)	6.6 (2.1)
<$30,000	75.4 (2.6)	19.5 (2.4)	2.5 (0.9)	2.6 (1.0)	66.9 (2.9)	26.9 (2.7)	3.1 (1.0)	3.0 (1.0)
>$30,000	71.8 (2.9)	21.2 (2.7)	2.5 (1.0)	4.5 (1.3)	61.0 (3.2)	33.4 (3.1)	1.5 (0.9)	4.0 (1.2)
Men	67.8 (2.1)	25.6 (2.9)	3.1 (1.1)	3.6 (1.2)	55.1 (3.3)	37.9 (3.2)	3.2 (1.2)	3.8 (1.2)
Women	75.4(2.3)	18.3 (2.0)	1.6 (0.7)	4.7 (1.1)	66.7 (2.5)	27.0 (2.4)	1.2 (0.6)	5.2 (1.1)
County	**72.8%** (1.8)	**1.2%** (1.7)	**2.4%** (0.6)	**4.2%**(0.8)	**62.1%** (2.0)	**31.2%** (1.9)	**2.2%** (0.60)	**4.6%** (0.8)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment
Missing data overall: RX abuse, 9.3%, (Alamo 9.7%, Rural 11.0%, Magdalena 10.7%), Veguita 9.9%,) Senior MH 11.4% (Alamo 14.5%, Rural 13.1%)

Table 45. Resources Respondents Would Utilize if Faced with Mental Health Issue [% (Standard Error)]

	Family & Friends	Doctor/ Nurse	Tribal Elder	SMH	Church/ Religious	Support Group	Would Not Seek Help	School	Heritage	Hotline (SMH)	Not sure	Other
Alamo	**45.7**%	**28.6**%	7.1%	**30.7%**	24.3%	7.1%	7.1%	4.3%	3.6%	9.3%	23.4%	2.2%
3.4%missing	(4.2)	(3.8)	(2.2)	(3.9)	(3.6)	(2.2)	(2.2)	(1.7)	(1.6)	(2.5)	(3.6)	(1.3)
Magdalena	**57.9**	**49.5**	0	16.8	13.1	4.7	0.9	0.9	0	1.9	9.9	1.9
4.5%missing	(4.8)	(4.9)		(3.6)	(3.3)	(2.1)	(0.9)	(0.9)		(1.3)	(3.0)	(1.4)
Rural	**46.3**	**50.0**	3.7	**24.6**	16.4	8.2	3.7	0	0.8	7.5	5.3	1.5
7.6%missing	(4.3)	(4.3)	(1.6)	(3.7)	(3.2)	(2.4)	(1.6)		(0.8)	(2.3)	(2.0)	(1.1)
Socorro	**56.0**	**50.6**	1.3	**33.3**	17.9	12.3	2.5	3.1	1.57	7.9	9.9	0.7
4.2%missing	(2.8)	(2.8)	(0.6)	(2.7)	(2.2)	(1.8)	(0.9)	(1.0)	(0.7)	(1.5)	(1.7)	(0.5)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Table 46. How a Person Would Respond if a Friend Says Hit By Family Member or Spouse [% (Standard Error)]

	Call Police	Call Health Provider	Call El Puente	"Hitting is sometimes normal"	"Hitting is Never Normal"	"Hitting would not happen in a home"	Do not tell anyone else	Do not know
Alamo 4.1%missing	**69.8** (3.9)	**11.5** (2.7)	5.0 (1.9)	2.2 (1.2)	11.5 (2.7)	11.5 (2.7)	3.6 (1.6)	16.6 (3.2)
Magdalena 4.5%missing	**76.6** (4.1)	**15.9** (3.6)	14.0 (3.4)	0.9 (0.9)	20.6 (3.9)	6.5 (2.4)	0	8.4 (2.7)
Rural 6.9%missing	**80.0** (3.5)	17.8 (3.3)	**23.0** (3.6)	1.5 (1.0)	26.7 (3.8)	8.9 (2.5)	0.7 (0.7)	4.4 (1.8)
Socorro 4.5%missing	**77.9** (2.3)	14.5 (2.0)	**27.1** (2.5)	0	29.3 (2.6)	13.9 (1.9)	0.6 (0.5)	3.8 (1.1)
Veguita 4.0%missing	**82.5** (3.9)	**11.3** (3.2)	5.2 (2.3)	2.1 (1.5)	16.5 (3.8)	7.2 (2.6)	1.0 (1.0)	5.2 (2.3)
<$30,000 1.1%missing	**78.2** (2.5)	12.4 (1.9)	**22.8** (2.5)	1.2 (0.6)	19.3 (2.3)	11.6 (1.9)	0.8 (0.5)	5.9 (1.3)
>$30,000 0.3%missing	**81.0** (2.5)	18.0 (2.5)	**22.1** (2.7)	0.8 (0.6)	33.3 (3.0)	10.1 (1.9)	0.4 (0.2)	2.6 (1.0)
Men 6.2%missing	**81.4** (2.5)	**12.2** (2.2)	12.1 (2.2)	0.8 (0.6)	22.7 (2.8)	8.0 (1.7)	0.4 (0.2)	5.8 (1.5)
Women 3.7%missing	**77.4** (2.2)	16.7 (1.9)	**27.4** (2.3)	0.8 (0.5)	27.4 (2.3)	13.0 (1.8)	1.3 (0.6)	4.4 (0.9)
County 4.8%missing	**78.4%** (1.6)	**15.0%** (1.4)	**21.5%** (1.6)	**0.8%** (0.4)	**25.6%** (1.7)	**11.2%**(1.2)	**0.9%** (0.3)	**5.2%** (0.8)

Based on SUDAAN weighted estimates from data collected during the 2011 Socorro County, New Mexico Community Needs Assessment

Priority Needs Identified

Priority Access to Care

Poverty

- Poverty impacts Socorro County Disproportionately
  - >50% household income < $30,000 (135% federal poverty level)
  - Over 70% of families in Alamo live in poverty
  - Lower income associated with lower literacy levels

- Poverty is an Obstacle to Healthcare
  - 1 in 10 persons in poverty have not seen a doctor in 5 years
  - 10% fewer respondents in poverty had a regular doctor
  - Over 40% identify cost as a barrier to accessing care
  - Over 10% do not have a phone to call for doctor appointment
  - Almost 30% responded lack of insurance is barrier to care
  - Many would use community-based programs (CBPs) if funded

- Respondents living in poverty had poorer self-reported health. Compared to those with household incomes >$30,000:
  - Almost 50% fewer assess health as "excellent"
  - Fewer healthy days in the past 30 days
  - More days with mental health symptoms during the past 30 days
  - More days unable to do work or activities due to health

Time and Distance

- People travel up to 3 hours to reach PSGH
- 1 in 4 rate distance a barrier to care; more so among the poor
- Almost 1 in 5 rate lack of transportation a barrier
- 1 in 4 (more for rural) cannot get time off work to seek care
- Over 35% have trouble getting an appointment
- Many need an after-hours or weekend hours clinic & CBPs

Culture and Language

- 1 in 10 and almost 1 in 5 (among the poor) note language as a barrier
- Over 9% rank citizenship concerns as barrier to care
- 1 in 4 in Veguita and 1 in 10 in Alamo would use CBPs more if the provider spoke their language
- Confidentiality is a key factor for at least 1 in 4 countywide

Diabetes

- 1 in 4 cite this as the top preventable issue for Socorro County
- Identified as the #1 issue for self or family
- Less than 50% have been had doctor discuss risks of diabetes
- Majority support use of CBP for diabetes care & health improvement
- Close to 1% report self or relative using a CBP for diabetes
- Need for diabetes education & local dialysis mentioned by respondents

Tobacco & Secondhand Smoke (SHS)

- 23% smoke currently countywide; 27% in the city of Socorro
- 6 in 10 smokers had a doctor discuss quitting this past year
- Smokeless tobacco use is extremely high—almost 10% countywide
- In Alamo, more use smokeless than smoke tobacco
- Over 7% of nonsmokers are being exposed to SHS at home, 8% exposed in the car
- Despite regulations prohibiting indoor smoking in most venues, 5% of nonsmokers are exposed to SHS at work
- Countywide, respondents think healthcare providers are
    - Very good at educating about health problems with SHS
    - Good (overall lower ratings) at getting people to quit smoking

Mental Health

- Over 50% state rank drug & alcohol abuse as priority for county
- Over 15% rank domestic violence as a county priority
- More days of mental health symptoms than the rest of US
- Top ranked mental health concerns:
    - Alcohol Abuse
    - Illegal Drug Abuse
    - Prescription Drug Abuse
    - Domestic Violence
    - Child Abuse
- All mental health topics supermajority ranked as at least important
- Access to local inpatient care lacking
- Prescription drug abuse growing concern
- 70%: "very important" to seek health professional for mental health
- 10% do not know where to go for help on mental health issues
- 40% never asked by a doctor about mental health issues
- Countywide perception common that violence & substance abuse are law enforcement, not health issues

Maternal Child Health

- Close to 20% cite teen pregnancy as top issue countywide
- 5-7% cite vaccines & childhood issues as county and family priority
- 8 in 10 would recommend programs to help build healthy families
- 8 in 10 state prenatal care important to very important
- 8 in 10 support professional health providers for addressing childhood development concerns

Suggestion Starters

Since many needs identified do not fall in the direct purview of PSGH, the recommended post-assessment is for PSGH to host multiple meetings with stakeholders to identify how each entity may play a unique role in addressing needs. The goal will be for CNA findings to be used in program development and grant proposals. By bringing community partners together, future efforts will build on the existing individual and collective strengths. Identifying existing evidence-based programs and collecting data to evaluate current programs is recommended. Due to findings in the report and background research on topics, the recommended stakeholder action team topics and initial actions item would include, but not be limited to, the following short and long-term suggestions:

Health Care & Poverty

- Short term
    - Identify existing funded health programs
    - Prepare simple, bilingual 1-page handout about programs
        - Distribute through community groups, medical offices, churches, schools, water bill or local stores
        - Target Veguita and Alamo due to higher poverty rates
    - Increased outreach about no or lost cost events such as county health fairs, diabetes testing clinics
    - Provide outreach for community facilities with phones people can use to schedule appointments- especially in Alamo and Veguita
    - Continue programs such as Puerto Seguro and St. Vincent de Paul (Veguita) to provide sufficient food and support for families in poverty

- Long term
    - Local small businesses develop group health insurance policy
    - Creation of regional economic development plans and actions
    - Continue farmer's market diabetes program
    - Build other programs for healthy, affordable food sources countywide
    - Reduce economic disparities
    - Consider cooperative childcare for sick children, children of persons at medical care among local businesses
    - Develop additional CBPs as lower cost preventative service

Time & Distance

- Short term
    - Consider adapting hours available for local transport to care—including number of trips per day from Alamo
    - Create local forum for carpool sign-ups in Alamo, Veguita, rural
    - Increase CBPs to improve on-site prevention services
    - EMS-discuss potential additional volunteer locations in the eastern part of the county, identify funding sources to strengthen existing services in Magdalena and the city of Socorro.
    - Work with local community leaders in Veguita and rural areas to encourage use of house numbers to expedite responses
    - Improve GPS capability among EMTs countywide to expedite responses
    - Provide first aid/CPR in rural areas (and possible AEDs)

- Long term
    - Increased public transit countywide
    - Additional full-time EMS– particularly in Veguita, east county
    - Re-establish official agreement with Valencia County EMS
    - Pilot telemedicine-EMS program to improve care during long transport and upon arrival at hospital
    - Increase retention of providers in area; increase total number of providers

Culture & Language

- Short term
  - Increasing awareness of medical translation needs
  - Develop forum with health providers and community leaders from Socorro's different cultural groups to improve cultural awareness for addressing health topics including mental health, maternal child health, smoking and diabetes

- Long term
  - Increase number of local health professionals certified in medical translation
  - Develop basic medical Navajo & Spanish course or field materials for EMTs and local health providers

Diabetes

- Short term
  - Increase outreach on improving diabetes through CBP participation
    - Through small local community events, Alamo radio and Socorro & Magdalena newspaper, churches/schools
  - Continue local diabetes- education programs
  - Continue farmer's market diabetes program and build other programs for healthy, affordable food sources countywide
  - Increased health screenings--including for diabetes
  - Ensure providers discuss risk of diabetes with all patients
  - Identify ways to increase activity level beyond City of Socorro and Alamo (which have exercise facilities) including
    - Building local team sports
    - Funding for kids who live outside the city to participate in city summer fitness activities
    - Develop incentive programs for kids and adults to improve fitness
    - Create "Healthy Activity" Map for biking, running, hiking countywide

- Long term
  - Hire additional certified diabetes educators
  - Consider dialysis unit locally or improved transport to dialysis
  - Build fitness center and/or provide healthy eating courses in Veguita

Tobacco and SHS

- Short term
    - Reduce smokeless tobacco use and smoking prevalence
        - Countywide
        - Especially with Alamo to identify and implement culturally appropriate programs to address severely high levels of smokeless tobacco use and high smoking prevalence
    - Encourage providers ask all patients about smoking and discuss cessation
    - Offer continuing education to health professionals on current cessation best practices
    - Address compliance issues with smoking in the workplace

- Long term
    - Reinstitute CBP outreach to youth to prevent smoking and smokeless use targeting kids at school, church, through community activities
    - Increased enforcement of illegal sales of tobacco and smokeless products to youth
    - Healthy homes/cars program to reduce SHS exposure

Mental Health – Including Substance Abuse and Violence

- Short term
    - Offer psychological first aid course in schools, workplaces
    - Community outreach/education to reduce stigma and explain violence and substance abuse are health – not just law enforcement issues
    - Provide health professionals standard operating procedure on potential domestic violence (emotional or physical) abuse and/or continuing education about current best practices
    - Continue partnerships with local law enforcement on all related issues
    - Incorporate domestic violence, child abuse and substance abuse into existing community based program outreach related to family health
    - Ensure domestic and family violence programs incorporate evidence-based strategies and data collected to provide evidence for evaluation and continued growth and improvement of services

- Long term
    - Develop local substance abuse/mental health inpatient care
    - Develop additional domestic violence shelter capacity, transportation for domestic violence support groups
    - Evaluation and Monitoring of existing domestic violence support program, perpetrator intervention program and recidivism
    - Consider adopting program similar to Project Lazarus in North Carolina for addressing opiate prescription abuse

Maternal Child Health

- Short term
    - Teen pregnancy CBP incorporating best practices, taking into consideration local cultures
    - Collaboration of schools, NMDOH and CBPs on youth pregnancy prevention efforts
    - Community specific outreach regarding role of Early Childhood intervention programs
    - Increase screenings for developmental issues in coordination with early childhood CBP
    - Continue efforts of schools to improve school nutrition
    - Continue First Born and prenatal care programs countywide

- Long term
    - Qualitative follow-up with teens and parents regarding teen pregnancy prevention and prenatal care
    - Expand FB to provide services for young families; possible start a program for not-first-time parents
    - Expand efforts to encourage health eating and exercise among youth through programs beyond the city

Lessons Learned

1) Community Involvement is Critical

The very challenges which make providing care in a rural, diverse community make it a challenge to adequately survey the community. Promotoras helped make sampling of Alamo and Veguita, in particular, much more feasible. Working with community leaders from Alamo, Magdalena, Socorro city and county enabled the team to best understand how to assess the community needs. Business involvement and school system assistance provided the outreach which very likely significantly improved our response rates.

2) Convenience Sampling May Make Better Sense In Rural Communities

Through working closely with community leaders and members, the survey methodology was adapted away from a systematic sampling technique. While this makes it more of a challenge to generalize the findings on a county-wide basis, the difficulty accessing properties and the time required to reach rural homes would have severely limited the data collected. In fact, with an over 80% response rate at convenience locations which were carefully chosen, the resulting sample provided the demographic representation which we had strived for when designing the project.

3) Asking health stakeholders during pre-assessment was helpful, but community or patient input would have been helpful at identifying some issues – such as EMS needs- which did not arise until later in the study

4) Never enough pilots

Due to timeframe and extensive revisions of the survey using a stakeholder review, we did limited pilot surveys which were not collected in the home setting. We learned quickly that working in a very conscientious community led to home visits taking up to an hour per survey instead of the 20 minutes we had estimated from the pilot. Home pilots would be recommended for any door-to-door survey in this community. Additionally, certain questions ended up okay- but could have been better with clarification or changes. Under where people work, we did not provide a place to put "retired;" making it tough to break out those out of work and retired in analysis. We did not include choices for multiple races—though many simply checked two boxes or wrote-in an answer. Placing the literacy question earlier may have helped us identify additional people who would have benefited from having

the survey read aloud. Hospital choices would have been more thorough had we included the V.A. as a separate category. Questions 37 & 38 did not include "do not know" as options, which certain people wrote in was a problem. The domestic violence question addressed more than one topic- creating two questions would have improved response. One of the top issues with the survey was due to the strong feeling that so many people expressed that they could not chose 1 top priority health issue for self, family or the county. Consequently, these questions required complete recoding and each topic was addressed as a dichotomous variable. Since those following directions only checked one box, we may have undercounted certain percentages of persons who would have checked additional boxes.

5) Volunteers are amazing

   Most volunteers consisted of PSGH CBP staff which was wonderful as they had relationships in the community. However, given the busy schedules of CBP staff, the additional hours on weekends and holidays collecting surveys was above and beyond the normal duties. Prior to future similar assessments, adjustments may need to be made in personnel responsibilities so that they do not have to spend too much additional work time on the assessment during non-work hours. Additionally, training survey administrator volunteers early in the process may improve volunteer recruitment. NM Tech or UNM students may be another great source for future project.

6) Organization is critical.

With the short time-frame and over 800 surveys, the systematic organization was essential to ensuring all findings were included, coded correctly. Having a dedicated person on data entry also minimized any error in that process and improved consistency. In the future, if possible, online surveys with laptops or other tablet-technology can save the step of data entry.

7) Response rate is a challenge in a longer survey

Challenges in analyses are due to the missing data on questions. In the future, having a set up with either fewer questions (which was not possible in this situation) or where we can encourage all questions to be answered (perhaps, by surveying everyone out loud) on each survey, data quality will be even better.

Appendix 1: Maps

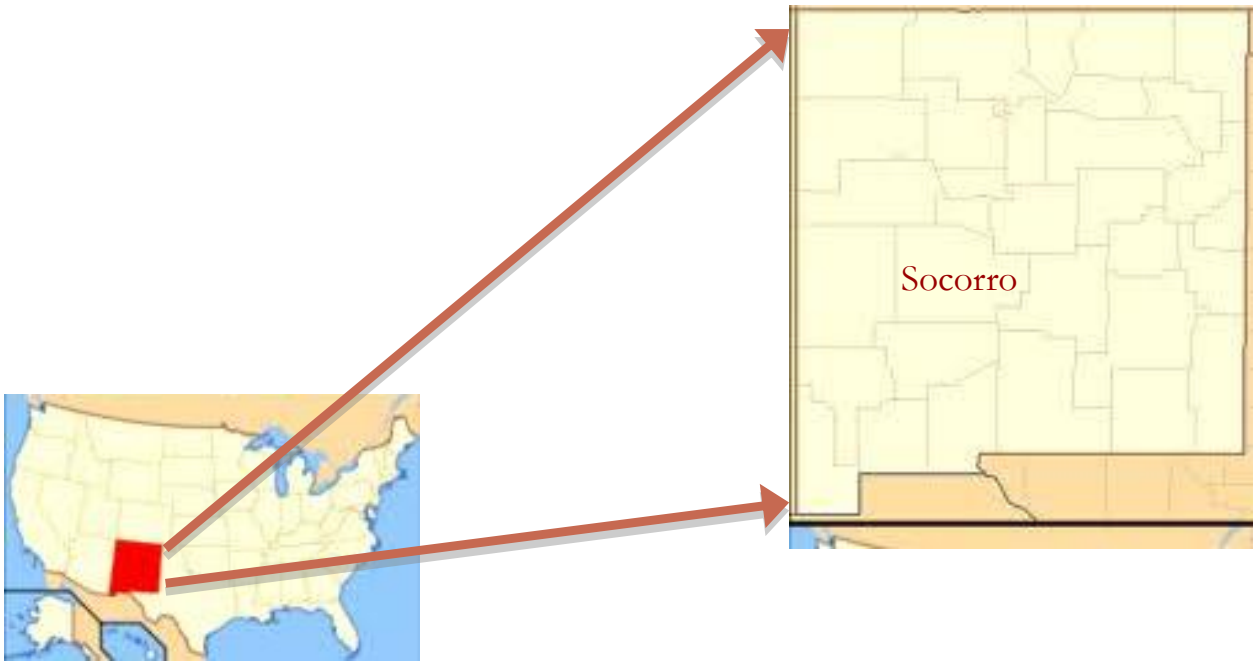


Figure 1. Map 1: Socorro County location in the Southwestern Quadrant of New Mexico

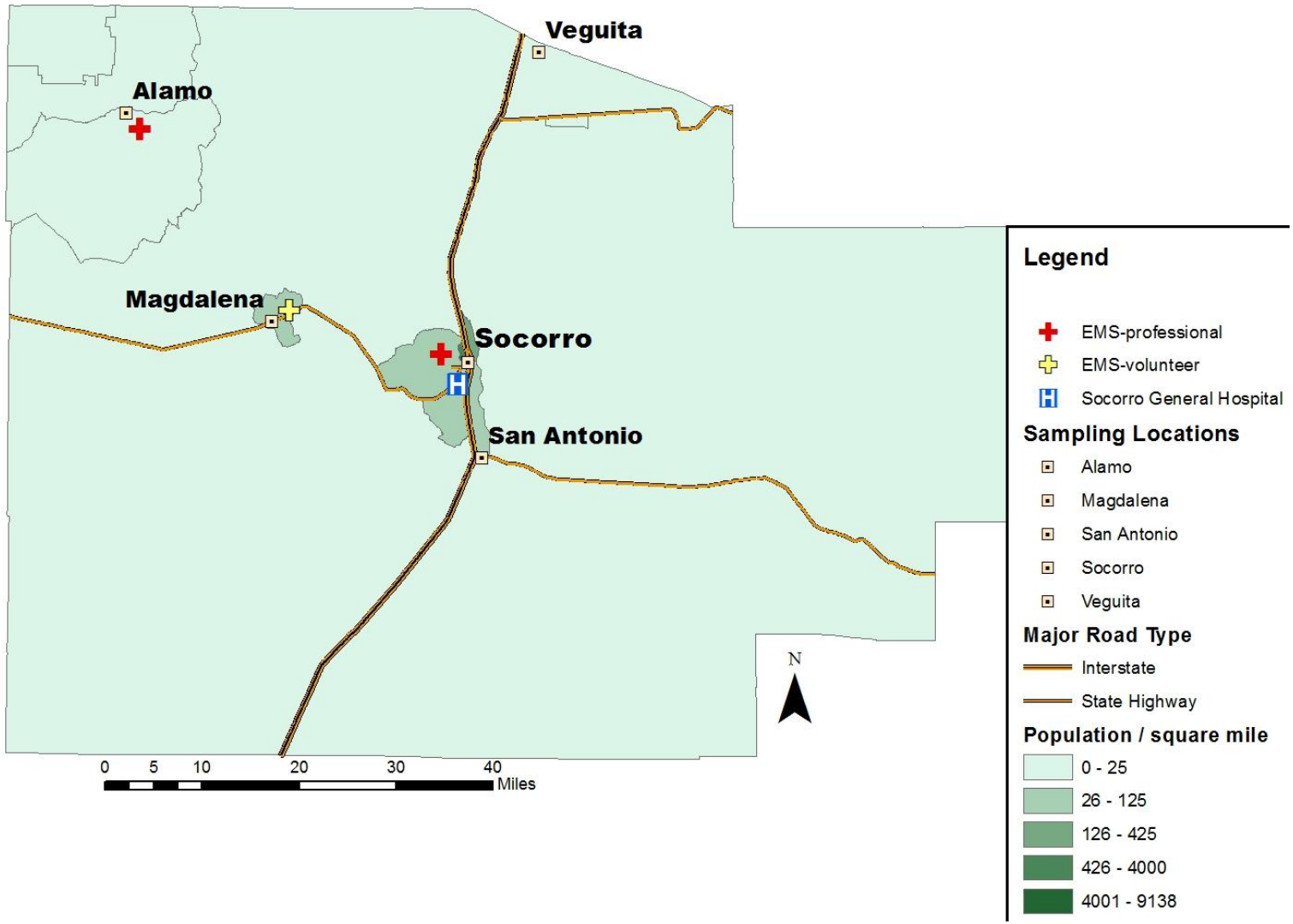


Figure 2. Map 2: Sampling Sites for the 2011 Socorro County Community Needs Assessment
Map developed with ARC-GIS using of data from the 2000 U.S. Census from the New Mexico Resource Geographic Information System (rgis.unm.edu). Population by census blocks.

Appendix 2: Survey in English and Spanish

ID NUMBER _____ page 1

Thank you for helping us learn how we can improve our community's health. **The survey is confidential**. The survey is optional. If at any time you would like to stop the survey, let us know. **There are no right or wrong answers.**
Please let us know if you have any trouble reading the survey or understanding a question.

☐ Read aloud Staff _____ Date _____

I. GENERAL BACKGROUND

1) What is your zipcode? _____ ☐ Not sure (99)

2) Where do you live?

☐ (01) Alamo ☐ (02) Magdalena ☐ (03) Ranch/Farm/Rural ☐ (04) San Antonio ☐ (05) Socorro (City) ☐ (06) Veguita ☐ (77) Other _____

3) Where do you work?

☐ (01) Alamo ☐ (02) Magdalena ☐ (03) Ranch/Farm/Rural ☐ (04) San Antonio ☐ (05) Socorro (City) ☐ (06) Veguita ☐ (07) Not working ☐ (08) Work in more than 1 place

4) What is your age? (check appropriate box)

☐ (01) Under 18 years ☐ (02) 18-24 years ☐ (03) 25-44 years ☐ (04) 45-64 years ☐ (05) 65+ years

5) Gender? ☐ (01) Male ☐ (02) Female

6) What is your ethnicity?

☐ (01) American Indian/Alaska Native ☐ (02) Asian/Pacific Islander ☐ (03) Black/African American ☐ (04) Hispanic/Latino ☐ (05) White ☐ (99) Not Sure ☐ (77) Other _____ ☐ (88) Do not want to answer

7) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

☐ (01) Never ☐ (02) Rarely ☐ (03) Sometimes ☐ (04) Often ☐ (05) Always

II. YOUR OPINION ABOUT HEALTH CARE AND HEALTH PROBLEMS IN SOCORRO COUNTY

8) What do you believe is the most important preventable health issue in Socorro County? (CHECK 1)

☐ (01) Cancers ☐ (02) Diabetes ☐ (03) Drug& Alcohol abuse ☐ (04) Domestic violence ☐ (05) Heart& Lung Diseases ☐ (06) Injuries & accidents ☐ (07) Mental health & Suicide ☐ (08) Obesity ☐ (09) Teen pregnancy ☐ (10) Vaccines/Childhood Illness ☐ (99) Don't Know ☐ (77) Other _____

9) What do you believe is the most important health issue for you and your family members? (CHECK 1)

☐ (01) Cancers ☐ (02) Diabetes ☐ (03) Drug& Alcohol abuse ☐ (04) Domestic violence ☐ (05) Heart & Lung Diseases ☐ (06) Injuries & accidents ☐ (07) Mental health& Suicide ☐ (08) Obesity ☐ (09) Teen pregnancy ☐ (10) Vaccines/Childhood Illness ☐ (99) Don't Know ☐ (77) Other _____

10) How many children under the age of 18 live in your household? _____ number of children

11) About how long has it been since you last visited a doctor for a routine checkup (not an exam for a specific injury, illness)?

☐ (01) Within past year ☐ (02) 1-2 years ago ☐ (03) 2-5 years ago ☐ (04) Over 5 years ☐ (05) Never ☐ (99) Don't Know

12) Do you have one person you think of as your personal doctor or health care provider?

☐ (01) Yes, only one ☐ (02) More than one ☐ (03) No ☐ (99) Not Sure

13) If you or someone you knew was sick but it was not an emergency, where would you go? (CHECK 1)

☐ (01) Acupuncture/homeopathic ☐ (02) Albuquerque Hospital/Clinic ☐ (03) Bhasker Medical Clinic ☐ (04) County public health ☐ (05) Indian Health Services ☐ (06) Magdalena Clinic/PMS ☐ (07) Belen Private Practice Clinic ☐ (08) Socorro Clinic/PMS ☐ (09) Socorro General Hospital /PHS ☐ (10) Socorro General Medical Group ☐ (11) Traditional healer ☐ (12) Would not seek care ☐ (99) Don't Know ☐ (98) No opinion ☐ (77) Other_____

14) In a medical emergency, where would you go? (CHECK 1)

☐ (01) Albuquerque Hospital/Clinic ☐ (03) Socorro General Hospital ☐ (05) Would not seek care ☐ (98) No opinion
☐ (02) Indian Health Services ☐ (04) Traditional Healer ☐ (06) Truth or Consequences ☐ (77) Other_____

15) In general, would you say your health is

☐ (01) Excellent ☐ (02) Very Good ☐ (03) Good ☐ 04) Fair ☐ (05) Poor

16) During the past 30 days, how many days were you very healthy and full of energy? _____ days (#0-30)

17) During the past 30 days, how many days did you feel sad, anxious, depressed, or worried? _____ days (#0-30)

18) During the past 30 days, how many days did health problems, sadness, depression or anxiety keep you from doing your usual activities, such as work and recreation? _____ days (#0-30)

19) There are many reasons people decide to not seek medical care when they are sick.
Do any of the following reasons make it <u>difficult</u> for you to seek medical care for yourself or family member?

a) No transportation to the doctor's office/hospital/clinic	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)
b) Long distance to the doctor's office/hospital/clinic	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)
c) Difficulty scheduling an appointment	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)
d) Speaking different language from health care provider	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)
e) Not having health insurance	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)
f) Cost of medical care	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)
g) Ability to take time from work	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)
h) Concerns about citizenship	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)
i) Access to phone to call health care provider	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)
j) Unable to find a quality childcare	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)
k) Clinic not open nights and weekends	☐ **Yes** (01)	☐ **No** (02)	☐ **Not Sure** (99)

☐ **Other reasons that make seeking healthcare more difficult when you or a family member is sick:**

_____

20) Did you know Socorro General Hospital has Community-Based Programs to help with some preventable diseases?

☐ Yes (01) ☐ No (02) ☐ Not sure (99)

21) Where did you first learn about the Socorro General Hospital's Community-Based Programs?

☐ (01) Ad/Phonebook ☐ (04) Friend ☐ (07) Radio ☐ (77) Other_____
☐ (02) Doctor/Healthworker ☐ (05) Internet ☐ (08) School ☐ (98) Haven't heard of them
☐ (03) Family member ☐ (06)Newspaper ☐ (09) Brochure ☐ (99) Not sure

22) If you are interested in learning about health services, which 3 sources do you trust the most ? (check up to 3)

☐ (01) Ad/Phonebook ☐ (04) Friend ☐ (07) Radio ☐ (08) School
☐ (02) Doctor/Healthworker ☐ (05) Internet ☐ (08) Social Network/Facebook ☐ (77) Other_____
☐ (03) Family member ☐ (06) Newspaper ☐ (09) Brochure ☐ (99) Not sure

23) Which of the following program have you or a member of your household has used within the last year? (Check any)

☐ (01) Casa Alegre / Early Intervention ☐ (05) Heritage Program for Senior Adults ☐ (09) TUPAC (tobacco)
☐ (02) DWI Program ☐ (06) Home Care / Hospice ☐ (10) WIC
☐ (03) First Born Socorro ☐ (07) Socorro Community Diabetic Program ☐ (11) Did not use any of the programs
☐ (04) Healthy Family Initiative ☐ (08) Socorro Mental Health ☐ (98) Not interested in services
☐ (99) Not sure

24) Which of the following factors would make you more likely to use a community-based program? (Check all)

☐ (01) Close to home ☐ (04) Doctor, nurse recommends ☐ (07) Open Mon-Fri 8-5pm ☐ (77) Other_____
☐ (02) Confidentiality ☐ (05) Free/No charge ☐ (08) Open nights/weekends ☐ (99) Not sure
☐ (03) Covered by insurance ☐ (06) In my primary language ☐ (09) Transportation available

III. Questions about Specific Programs: Diabetes, Smoking, Maternal/Child Health, Mental Health

25) Has a doctor talked to you about your risks for diabetes?

☐ (01) Yes ☐ (02) No ☐ (03) Only during pregnancy ☐ (98) No answer

26) How important is it to see a healthcare professional regularly if you have diabetes?

☐ (01) Very important ☐ (02) Important ☐ (03) Not important ☐ (99) Not sure

27) Do you think it is possible for community outreach programs to help people with diabetes care?

☐ (01) Yes ☐ (02) No ☐ (99) Not sure

28) Would you participate in or recommend to a friend a program on diabetes prevention and care?

☐ (01) Yes ☐ (02) No ☐ (99) Not sure

29) Do you believe participating in a health program can improve the health of a person living with diabetes?

☐ (01) Yes ☐ (02) No ☐ (99) Not sure

30) Do you now smoke cigarettes (*not* traditional tobacco)?

☐ (01) Every day ☐ (02) Some days ☐ (03) Not at all ☐ (99) Not sure

31) Do you now use smokeless tobacco (snuff, dip, chewing tobacco *not* including traditional tobacco)?

☐ (01) Every day ☐ (02) Some days ☐ (03) Not at all ☐ (99) Not sure

32) Has your doctor or healthcare provider talked with you in the last 12 months about how to quit smoking?

☐ (01) Yes ☐ (02) No ☐ (99) Not sure ☐ (98) Don't Smoke

33) In the past 7 days, how many days has someone smoked in your home (not including patio, outside)? _____days

34) In the past 7 days, how many days were you in a car or vehicle with someone who was smoking? ____days

35) In the past 7 days, how many days has anyone at your workplace smoked inside? _____days

36) Would you participate in or recommend to a friend a program that helps people stop smoking?

☐ (01) Yes ☐ (02) No ☐ (99) Not sure

37) How effective do you think a healthcare worker, nurse, or doctor can be in educating about health problems related to secondhand smoke?

☐ (01) Excellent ☐ (02) Very Good ☐ (03) Good ☐ (04) Fair ☐ (05) Poor

38) How effective do you think a healthcare worker, nurse, or doctor can be in helping people stop smoking?

☐ (01) Excellent ☐ (02) Very Good ☐ (03) Good ☐ (04) Fair ☐ (05) Poor

39) How important is prenatal care (seeing a doctor, nurse or healthcare worker during pregnancy)?

☐ (01) Very important ☐ (02) Important ☐ (03) Not important ☐ (99) Not Sure

40) Would you participate in or recommend to a friend a program to help pregnant women or new parents learn about how to have a healthy family?

☐ (01) Yes ☐ (02) No ☐ (99) Not sure

41) How important is it for a person to seek professional help if their child isn't developing the same way as kids of the same age?

☐ (01) Very important ☐ (02) Important ☐ (03) Not important ☐ (99) Not sure

42) How important do you think it is for a person to go to a doctor or health professional for mental health issues?

☐ (01) Very important ☐ (02) Important ☐ (03) Not important ☐ (99) Not sure

43) Has a doctor ever asked you if you have had anxiety, sadness, stress, depression, or sleep problems?

☐ (01) Yes ☐ (02) No ☐ (99) Not sure

44) Please rate the following health issues on their importance to your community

	(01) Very Important	*(02) Important*	*(03) Not Important*	*(98) No Opinion*	*(99) Not sure*
a) Teen suicide	☐ Very important	☐ Important	☐ Not important	☐ No opinion	☐ Not sure
b) Adult suicide	☐ Very important	☐ Important	☐ Not important	☐ No opinion	☐ Not sure
c) Depression/anxiety	☐ Very important	☐ Important	☐ Not important	☐ No opinion	☐ Not sure
d) Alcohol abuse	☐ Very important	☐ Important	☐ Not important	☐ No opinion	☐ Not sure
e) Domestic Violence	☐ Very important	☐ Important	☐ Not important	☐ No opinion	☐ Not sure
f) Child abuse	☐ Very important	☐ Important	☐ Not important	☐ No opinion	☐ Not sure
g) Community Violence	☐ Very important	☐ Important	☐ Not important	☐ No opinion	☐ Not sure
h) Illegal Drug Use	☐ Very important	☐ Important	☐ Not important	☐ No opinion	☐ Not sure
i) Prescription Abuse	☐ Very important	☐ Important	☐ Not important	☐ No opinion	☐ Not sure
j) Senior Mental Health	☐ Very important	☐ Important	☐ Not important	☐ No opinion	☐ Not sure

45) If you were to face one of the health issues listed above, who would you trust and/or go to for help? (Check any)

☐ (01) Family/friend ☐ (04) Socorro Mental Health ☐ (07) Would not seek help ☐ (10) 24 Hour Hotline (SMH)

☐ (02) Doctor/Nurse ☐ (05) Church/religious group ☐ (08) School personnel ☐ (99) Not sure

☐ (03) Tribal leader/elder ☐ (06) Support Group ☐ (09) Heritage Program for Senior Adults ☐ (77) Other____

46) If a friend came to you after being hit by a family member or spouse, what would you tell the friend? (Check any)

☐ (01) Call police ☐ (04) Hitting at home is sometimes normal ☐ (07) Do not tell anyone else

☐ (02) Call Health Provider ☐ (05) Hitting at home is never normal ☐ (99) Do not know

☐ (03) Call El Puente Center ☐ (06) This does not happen at home ☐ (77) Other_____

47) Please check off the box closest to your annual household Income?

☐ (01) <$10,000 ☐ (03) $20,000-$29,000 ☐ (05) $40,000-$49,000 ☐ (07) $60,000-$69,000

☐ (02) $10,000-$19,000 ☐ (04) $30,000-$39,000 ☐ (06) $50,000- $59,000 ☐ (08) >$70,000

48) How long does it usually take you to drive to the Socorro General Hospital? _____minutes /hours average

Would you like to share any other thoughts about health care in Socorro County or your health needs?

_____

_____

_____

_____

_____

Thank you so much for your time!

Please fill out the raffle ticket and place in the separate envelope. Prizes will be mailed after the July 25th raffle drawing.

ID NUMBER _____ page 1

Gracias por ayudarnos a encontrar como podemos mejorar la salud en nuestra comunidad. Esta encuesta es confidencial. **La encuesta es opcional**. Informe si en algún momento necesita dejar la encuesta. **No hay respuestas correctas o incorrectas. Por favor avísenos si tiene problemas leyendo o entendiendo alguna pregunta en la encuesta.**

☐ Leer en voz alta Staff initials_____ Date/Fecha_____

I. ANTECEDENTES GENERALES. (INDIQUE 1 POR CADA PREGUNTA)

1) Cual es su código postal? _____ ☐ No estoy seguro (99)

2) Donde vive?

☐ (01) Álamo ☐ (03) Rancho/Granja/Rural ☐ (05) Socorro (Ciudad) ☐ (77) Otro _____
☐ (02) Magdalena ☐ (04) San Antonio ☐ (06) Veguita

3) Donde trabaja?

☐ (01) Álamo ☐ (03) Rancho/Granja/Rural ☐ (05) Socorro (Ciudad) ☐ (07) No trabaja
☐ (02) Magdalena ☐ (04) San Antonio ☐ (06) Veguita ☐ (08) Trabaja en más de un lugar

4) Cual es su edad? (indique la opción apropiada)

☐ (01) Menos de 18 años ☐ (02) 18-24 años ☐ (03) 25-44 años ☐ (04) 45-64 años ☐ (05) + 65 años

5) Sexo? ☐ (01) Masculino ☐ (02) Femenino

6) Su origen étnico?

☐ (01) Indio Americano/Nativo de Alaska ☐ (03) Afroamericano ☐ (05) Caucásico/Blanco ☐ (77) Otro_____
☐ (02) Asiático/Islas del Pacifico ☐ (04) Hispano/Latino ☐ (99) No está seguro ☐ (88) Prefiero no contestar

7) Que tan frecuentemente necesita ayuda para leer instrucciones, folletos, u otro material escrito de su doctor o farmacia?

☐ (01) Nunca ☐ (02) Casi nunca ☐ (03) A veces ☐ (04) Frecuentemente ☐ (05) Siempre

II. SU OPINIÓN RESPECTO A SERVICIOS DE SALUD Y PROBLEMAS DE SALUD.

8) Cual cree usted que es el problema de salud más importante que se puede prevenir en el condado de Socorro? (INDIQUE 1)

☐ (01) Cáncer ☐ (04) Violencia domestica ☐ (07) Salud mental y suicidio ☐ (10) Vacunas/Enfermedades de la infancia
☐ (02) Diabetes ☐ (05) Enfermedades de pulmón y corazón ☐ (08) Obesidad ☐ (99) No sé
☐ (03) Abuso de drogas y alcohol ☐ (06) Lesiones y accidentes ☐ (09) Embarazo en adolescencia ☐ (77) Otro _____ No sé

9) Cual cree usted que es el problema de salud más importante para usted y su familia? (INDIQUE 1)

☐ (01) Cáncer ☐ (04) Violencia domestica ☐ (07) Salud mental y suicido ☐ (10) Vacunas/Enfermedades de la infancia
☐ (02) Diabetes ☐ (05) Enfermedades de pulmón y corazón ☐ (08) Obesidad ☐ (99) No sé
☐ (03) Abuso de drogas y alcohol ☐ (06) Lesiones y accidentes ☐ (09) Embarazo en adolescencia ☐ (77) Otro _____

10) Cuantos niños menores de 18 años viven en su casa? _____

11) Aproximadamente cuanto hace que visito a su doctor para una revisión de rutina (no por motive de enfermedad o lesión)? (INDIQUE 1)

☐ (01) Durante el año pasado ☐ (03) Hace 2-5 años ☐ (05) Nunca
☐ (02) Hace 1-2 años ☐ (04) Más de 5 años ☐ (99) No sé

12) Tiene alguna persona que considera su médico particular? (INDIQUE 1)

☐ (01) Sí, sólo uno ☐ (02) Más de uno ☐ (03) No ☐ (99) No estoy seguro

13) Sí usted o alguien que conoce esta enfermo pero no es una emergencia, a donde iría? (INDIQUE 1)

☐ (01) Acupuntura/homeopáticos ☐ (06) Clínica en Magdalena /PMS ☐ (11) Curandero
☐ (02) Hospital/Clínica en Albuquerque ☐ (07) Clínica en Belens ☐ (12) No buscaría atención
☐ (03) Bhasker Medical Clinic, Socorro ☐ (08) Clínica en Socorro /PMS ☐ (99) No sé
☐ (04) Servicios de salud del condado ☐ (09) Socorro General Hospital /PHS ☐ (98) No opino
☐ (05) Indian Health Services ☐ (10) Socorro General Medical Group ☐ (77) Otro _____

14) En una emergencia médica a donde iría? (INDIQUE 1)

☐ (01) Hospital/Clínica en Albuquerque ☐ (03) Socorro General Hospital/PHS ☐ (05) No buscaría ayuda ☐ (98) No opino
☐ (02) Indian Health Services ☐ (04) Curandero ☐ (06) Truth or Consequences ☐ (77) Otro ___

15) Como considera su salud en general?

☐ (01) Excelente ☐ (02) Muy buena ☐ (03) Buena ☐ (04) Regular ☐ (05) Mala

16) Durante los últimos 30 días, cuantos días estuvo saludable y lleno de energía? _____ días (#0-30)

17) Durante los últimos 30 días, cuantos días se sintió triste, ansioso, deprimido, estresado o preocupado? _____ días (#0-30)

18) Durante los últimos 30 días, cuantos días los problemas de salud física o mental le impidieron realizar sus actividades habituales como trabajar o recrearse?_____ días (#0-30)

19) Hay muchas razones por las que la gente decide no buscar atención médica cuando están enfermos. (Por cada linea- INDIQUE 1)
Alguna de las siguientes razones hacen que sea difícil obtener atención médica para usted o su familia?

a) No hay transporte para la oficina del doctor/hospital/clínica	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)
b) La oficina del doctor/hospital/clínica está muy lejos	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)
c) Es difícil programar una cita	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)
d) Habla diferente idioma que el personal médico	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)
e) No tiene seguro médico	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)
f) Costo de atención médica	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)
g) No puede tomar tiempo fuera del trabajo	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)
h) Le preocupa la ciudadanía	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)
i) Acceso a teléfono para llamar a la clínica	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)
j) No puede encontrar cuidado de calidad para los niños	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)
k) Clínicas no estan abiertas durante noches y fines de semanas	☐ Sí (01)	☐ No (02)	☐ No estoy seguro (99)

☐ **Hay otra razón que le dificulta obtener atención medica cuando usted o su familia están enfermos:**

_____

20) Sabía usted que el Hospital General de Socorro tiene programas comunitarios que ayudan a prevenir algunas enfermedades?

☐ (01) Sí ☐ (02) No ☐ (99) No estoy seguro

21) Donde escucho por primera vez acerca de los programas comunitarios del hospital? (INDIQUE 1)

☐ (01) Anuncio/directorio telefónico ☐ (04) Amigo ☐ (07) Radio ☐ (98) No ha oído hablar de ellos
☐ (02) Doctor/trabajador de salud ☐ (05) Internet ☐ (08) Escuela ☐ (99) No estoy seguro
☐ (03) Miembro de su familia ☐ (06) Periódico ☐ (09) Folleto ☐ (77) Otro_____

22) Si usted está interesado en aprender acerca de los servicios de salud, cuales serian las tres Fuentes en que confía más?(INDIQUE 3)

☐ (01) Anuncio/directorio telefónico ☐ (04) Amigo ☐ (07) Radio ☐ (10) Escuela
☐ (02) Doctor/trabajador de salud ☐ (05) Internet ☐ (08) Red social/Facebook ☐ (99) No estoy seguro
☐ (03) Miembro de su familia ☐ (06) Periódico ☐ (09) Folleto ☐ (77) Otro_____

23)En el último año cual de los siguientes programas ha usado usted o algún miembro de su familia? (INDIQUE ALGUNO)

☐ (01) Casa Alegre / Early Intervention ☐ (06) Heritage Program for Senior Adults ☐ (11) WIC
☐ (02) DWI Program ☐ (07) Positive Outcomes ☐ (12) Ninguno
☐ (03) First Born Socorro ☐ (08) Socorro Community Diabetic Program ☐ (98) No estoy interesado
☐ (04) Healthy Family Initiative ☐ (09) Socorro Mental Health ☐ (99) No estoy seguro
☐ (05) Home Care / Hospice ☐ (10) TUPAC (tobacco) ☐ (77) Otro_____

24) Cual de los siguientes factores lo inclinarían mas usar un programa comunitario? (INDIQUE ALGUNO)

☐ (01) Cerca de su casa ☐ (04) Doctor, enfermera lo recomiendan ☐ (07) Abren de lunes a viernes de 8-5pm ☐ (99) No estoy seguro
☐ (02) Confidencialidad ☐ (05) Gratis/ no cobra ☐ (08) Abren los fines de semana ☐ (77) Otro_____
☐ (03) Cubierto por el seguro ☐ (06) Que hablen mi idioma ☐ (09) Hay transporte disponible

III. PREGUNTAS SOBRE PROGRAMAS ESPECIFICOS: DIABETES, FUMAR, SALUD DE LOS NIÑOS Y LAS MADRES, SALUD MENTAL (INDIQUE 1 POR CADA PREGUNTA)

25) Algún doctor ha hablado con usted sobre el riesgo de la diabetes?

☐ (01) Sí ☐ (02) No ☐ (03) Solo durante el embarazo ☐ (98) No tengo respuesta

26) Que tan importante es visitar a un profesional de la salud regularmente cuando tiene diabetes?

☐ (01) Muy importante ☐ (02) Importante ☐ (03) No es importante ☐ (99) No estoy seguro

27) Cree que sea posible que los programas de extensión comunitaria ayuden a las personas con diabetes?

☐ (01) Sí ☐ (02) No ☐ (99) No estoy seguro

28) Usted participaría o recomendaría a un amigo un programa sobre cuidado y prevención de la diabetes?

☐ (01) Sí ☐ (02) No ☐ (99) No estoy seguro

29) Usted cree que participar en un programa de salud puede mejorar la vida de una persona con diabetes?

☐ (01) Sí ☐ (02) No ☐ (99) No estoy seguro

30) Actualmente, usted fuma cigarros? (sin incluir tabaco tradicional/cermonial))

☐ (01) Todos los días ☐ (02) Algunos días ☐ (03) No, nunca ☐ (99) No estoy seguro

31) Actualmente, usted usa algún producto de tabaco sin humo, como tabaco de mascar o "snuff"? (sin incluir tabaco tradicional/cermonial)

☐ (01) Todos los días ☐ (02) Algunos días ☐ (03) No, nunca ☐ (99) No estoy seguro

32) En los últimos 12 meses su doctor o proveedor de atención médica le ha hablado sobre como dejar de fumar?

☐ (01) Sí ☐ (02) No ☐ (99) No estoy seguro ☐ (98) No fuma

33) En los últimos 7 días, cuantos días alguien ha fumado en su hogar (sin incluir el patio, afuera)? _____días

34) En los últimos 7 días, cuantos días estuvo en su coche o vehículo con alguien fumando? ____ días

35) En los últimos 7 días, cuantos días ha fumado alguien dentro de su lugar de trabajo? _____ días

36) Usted participaría o recomendaría a un amigo un programa que ayuda a dejar de fumar?

☐ (01) Sí ☐ (02) No ☐ (99) No estoy seguro

37) Que tan efectivo cree usted que un trabajador de la salud, enfermera o doctor pueden ser en educar a la gente sobre los problemas de salud relacionados con el humo de segunda mano?

☐ (01) Excelente ☐ (02) Muy bueno ☐ (03) Bueno ☐ (04) Regular ☐ (05) Malo

38) Que tan efectivo cree usted que un trabajador de la salud, enfermera o doctor pueden ser en ayudar a la gente a dejar de fumar?

☐ (01) Excelente ☐ (02) Muy bueno ☐ (03) Bueno ☐ (04) Regular ☐ (05) Malo

39) Que tan importante es el cuidado prenatal (visitar a un doctor, enfermera o trabajador de la salud durante el embarazo)?

☐ (01) Muy importante ☐ (02) Importante ☐ (03) No es importante ☐ (99) No estoy seguro

40) Usted participaría o recomendaría a un amigo un programa que ayuda a mujeres embarazadas y a nuevos padres como tener una familia saludable?

☐ (01) Sí ☐ (02) No ☐ (99) No estoy seguro

41) Que tan importante es conseguir ayuda profesional si su hijo no se esta desarrollando al mismo nivel que otros niños de la misma edad?

☐ (01) Muy importante ☐ (02) Importante ☐ (03) No es importante ☐ (99) No estoy seguro

42) Que tan importante cree que sea para una persona ver a un doctor o profesional de salud si tiene problemas de salud mental?

☐ (01) Muy importante ☐ (02) Importante ☐ (03) No es importante ☐ (99) No estoy seguro

43) Alguna vez un doctor le ha preguntado si ha tenido ansiedad tristeza, depresión o problemas de sueño?

☐ (01) Sí ☐ (02) No ☐ (99) No estoy seguro

44) Por favor califique los problemas de salud de acuerdo a la importancia para su comunidad. (Por cada linea, INDIQUE 1)

	(01) Muy importante	*(02) Importante*	*(03) No es importante*	*(98) No opino*	*(99) No estoy seguro*
a) Suicidio en adolecentes	☐ Muy importante	☐ Importante	☐ No es importante	☐ No opino	☐ No estoy seguro
b) Suicidio en adultos	☐ Muy importante	☐ Importante	☐ No es importante	☐ No opino	☐ No estoy seguro
c) Depresión/ansiedad	☐ Muy importante	☐ Importante	☐ No es importante	☐ No opino	☐ No estoy seguro
d) Abuso de alcohol	☐ Muy importante	☐ Importante	☐ No es importante	☐ No opino	☐ No estoy seguro
e) Violencia domestica	☐ Muy importante	☐ Importante	☐ No es importante	☐ No opino	☐ No estoy seguro
f) Abuso infantil	☐ Muy importante	☐ Importante	☐ No es importante	☐ No opino	☐ No estoy seguro
g) Violencia en la comunidad	☐ Muy importante	☐ Importante	☐ No es importante	☐ No opino	☐ No estoy seguro
h) Abuso de drogas ilegales	☐ Muy importante	☐ Importante	☐ No es importante	☐ No opino	☐ No estoy seguro
i) Abuso de medicamentos prescritos	☐ Muy importante	☐ Importante	☐ No es importante	☐ No opino	☐ No estoy seguro
j) Salud mental en ancianos	☐ Muy importante	☐ Importante	☐ No es importante	☐ No opino	☐ No estoy seguro

45) Si usted tuviera que enfrentar alguno de los problemas de salud antes mencionados, en quien confiaría o pediría ayuda?(INDIQUE ALGUNA)

☐ (01) Familia/amigo ☐ (04) Socorro Mental Health ☐ (07) No buscaría ayuda ☐ (10) 24hr linea de ayuda (SMH)
☐ (02) Doctor/enfermera ☐ (05) Iglesia/grupo religioso ☐ (08) Personal de la escuela ☐ (99) No estoy seguro
☐ (03) Líder de tribu/anciano ☐ (06) Grupo de apoyo ☐ (09) Heritage Program for Senior Adults ☐ (77) Otro____

46) Si un amigo(a) recurre a usted después de ser golpeado por un familiar o cónyuge, que le diría a su amigo(a) ? (INDIQUE ALGUNA)

☐ (01) Llame a la policía ☐ (04) Los golpes a veces son normales en el hogar ☐ (07) No le diga a nadie más
☐ (02) Llame a su doctor ☐ (05) Los golpes nunca son normales en el hogar ☐ (99) No sé
☐ (03) Llame al "El Puente" ☐ (06) Eso no pasa en el hogar ☐ (77) Otro _____

47) Qual es el ingreso de su casa en un año ? (INDIQUE 1)

☐ (01) <$10,000 ☐ (03) $20,000-$29,000 ☐ (05) $40,000-$49,000 ☐ (07) $60,000-$69,000
☐ (02) $10,000-$19,000 ☐ (04) $30,000-$39,000 ☐ (06) $50,000- $59,000 ☐ (08) >$70,000

48) Cuanto tiempo le toma manejar para llegar al Hospital General de Socorro? _____minutos /horas promedio

Le gustaría compartir alguna idea acerca del servicios de salud en el Condado de Socorro o/y de sus necesidades de salud?

_____
_____
_____
_____
_____

Muchas gracias por su tiempo! Por favor llene el boleto de la rifa y póngalo en el sobre que se dio por separado.
La rifa se llevara a cabo el 25 de Julio y los premios se enviaran por correo a los ganadores.

Appendix 3. Fact Sheet

Community Needs Assessment
Fact Sheet

Socorro General Hospital
Community Based Programs
308 N California Street
Socorro NM 87801
(575) 835-8707

Goals of the Community Needs Assessment

- **Identify our county's health priorities**
- **Find what prevents people from being able to get health care and services**
- **Develop strategies to fill the gaps**
  - Improve access to care
  - Increase use of community programs
  - Address the community's top concerns
  - Develop targeted health education & outreach

How will the community benefit from the assessment?

- A unique opportunity for the community to share what they would like to see improved in healthcare
- Funding for identified community health needs
- Strategies to make it easier for *everyone* to receive quality healthcare in the short and long term

What We Know So Far: The Pre-Assessment

From January- May 2011, we analyzed data from past state, local and federal studies and talked to stakeholders to identify priority healthcare issues for Socorro County.

We looked at what health problems affect our community at higher rates than the rest of the U.S and which problems we can help with outreach and preventative medical care.

The Community Needs Assessment will ask Socorro County residents their opinions about these priorities:

- **Diabetes**
  - Twice as many people die from diabetes here compared to the rest of the country
- **Mental Health**
  - Twice as many drug-related deaths & suicides
- **Maternal-Child Health**
  - High teen pregnancy rate, low birthweight babies
- **Tobacco/Secondhand smoke**
  - 31.9% of our teens smoke, nationally--19.5%
- **Access to Healthcare**
  - Barriers: poverty, limited transportation, language

Socorro General (H) serves over 18,000 people across almost 6700 sq miles of Socorro County. Next closest hospital: 75+ miles .
(www.socorro-nm.com)

Plan of Action

- **Conduct Survey**
  - June & July
  - Where?
    - Socorro
    - Veguita
    - Alamo
    - San Antonio
    - Magdalena
- **Analyze Survey Results**
- **Conduct Focus Groups**
  - Deeper look into needs identified in survey
  - Help develop creative solutions to address needs
- **CNA Report prepared**
  - Completed January 2012
  - Share with Community

WHAT YOU CAN DO
Volunteer
Share ideas
Ask questions

Contact us anytime:
Carrie McNeil **cmcneil@phs.org**
Kayla Cline **kcline3@phs.org**

Appendix 4. Outreach flier distributed by schools, in church bulletins & water bill

COMMUNITY NEEDS ASSESSMENT SURVEY
We Need Your Help

What Is It? A community needs assessment is a way to find out what health issues are important to you, whether or not it is easy for you to seek healthcare and your ideas about certain community-based programs. The assessment includes a survey which will be done door-to-door and at certain local businesses. THE SURVEY IS ANONYMOUS!

Why Should I Participate? *Your participation is critical!* By filling out the survey, we can find out how best to meet your needs in accessing healthcare. We want to help improve the health of our community—but need your help filling out the survey!

When: June- July 2011 **Where:** All of Socorro County

Who Will Be Coming By? Staff from Socorro General Hospital and volunteers may be coming to your door or talking to you at local businesses to ask you to fill out the survey.

What is the Raffle? When you do a survey, you'll be asked to fill out a raffle ticket (note, your name and address will only be on the raffle ticket, not the survey). We will be collecting donations from local businesses. At the end of July, we will draw the raffle and mail out or call you if you have won one of the many raffle prizes.

How Else Can I Help?
Email: Kayla Cline @ kcline3@phs.org
Carrie McNeil @ cmcneil@phs.org

Phone: (575) 835 -8707

We are in need of VOLUNTEERS and your help will greatly be appreciated!!

References

[i] Altshuld, JW and Kumar D.D. *Needs Assessment: An Overview.* Thousand Oaks, California: SAGE Publications, 2010.

[ii] http://www.city-data.com/city/Socorro-New-Mexico.html. Accessed 1/10/2012.

[iii] U.S. Census State and USA Quick Facts. http://quickfacts.census.gov/qfd/states/00000.html. Accessed 3/24/2012.

[iv] Reynnells L et al. *What is Rural?* U.S. Department of Agriculture, National Agriculture Library, 2008. www.nal.usda.gov/ric/ricpubs/whatisrural.shtml. Accessed 6/9/2011.

[v] United States Census Bureau. *Income, Poverty and Health Insurance Coverage 2009.* http://www.census.gov/prod/2010pubs/p60-238.pdf. Accessed 1/10/2012 at 2017.

[vi] Ibid.

[vii] South Central Council of Governments, New Mexico Planning District 7. *Socorro County Statistical Profile 2010.* http://sccog-nm.com/files/Socorro_County_Statistical_Profile-2010.pdf. Accessed 1/10/2012 at 2028.

[viii] Ibid.

[ix] Centersfor Disease Control and Prevention. Behavioral Risk Factor Surveillance System. http://www.cdc.gov/brfss/index.htm. Accessed 3/26/2011.

[x] New Mexico Department of Public Health. Pregnancy Risk Assessment and Monitoring Surveillance Report 2008. http://nmhealth.org/phd/prams/documents/DOH%20PRAMS%202008.pdf. Accessed 3/24/2012.

[xi] National Health Information Center. http://www.health.gov/nhic/. Accessed 3/24/2012.

[xii] Substance Abuse and Mental Health Services Administration. http://www.samhsa.gov/data/. Accessed 3/24/2012.

[xiii] IBIS Community Health Highlight Report for Socorro County. http://ibis.health.state.nm.us/community/highlight/report/GeoCnty/53.html. Accessed 3/24/2012.

[xiv] Socorro County Options, Prevention and Education. Socorro County Health Profile 2009. http://www.nmscope.org/Index.Html. Accessed 3/1/2011.

[xv] http://nmhealth.org/erd/HealthData/pdf/SPF-SIG_State_Epi_Report_v3.2.pdf. Accessed 3/24/2012.

[xvi] 2005 Vital Statistics Summary, Bureau of Vital Records and Health Statistics.

[xvii] http://nmhealth.org/erd/HealthData/pdf/SPF-SIG_State_Epi_Report_v3.2.pdf

[xviii] Socorro County Options, Prevention and Education. Socorro County Health Profile 2009.

[xix] http://ibis.health.state.nm.us/view?xslt=html/community/snapshot/ReportPage.xslt&xml=community/GeoCnty.xml&community=53&indicatorSetName=AllIndicators. Accessed 3/24/2012.

[xx] Ibid.

[xxi] Socorro County Options, Prevention and Education. Socorro County Health Profile 2009.

[xxii] http://nmhealth.org/ERD/HealthData/documents/HumanPlagueinNMbyCounty1949-2011.pdf. Accessed 3/23/2012.

[xxiii] http://nmhealth.org/ERD/HealthData/documents/HantavirusinNMbycounty_003.pdf. Accessed 3/23/2012.

[xxiv] http://ibis.health.state.nm.us/community/highlight/InfluenzaPneumoDeath.Cnty/GeoCnty/53.html

[xxv] http://ibis.health.state.nm.us/view?xslt=html/community/snapshot/ReportPage.xslt&xml=community/GeoCnty.xml&community=53&indicatorSetName=AllIndicators

[xxvi] http://nmhealth.org/erd/HealthData/pdf/SPF-SIG_State_Epi_Report_v3.2.pdf

[xxvii] http://ibis.health.state.nm.us/view?xslt=html/community/snapshot/ReportPage.xslt&xml=community/GeoCnty.xml&community=53&indicatorSetName=AllIndicators

[xxviii] U.S. Centers for Disease Control and Prevention. Injury Prevention and Control: Motor Vehicle Safety. http://www.cdc.gov/motorvehiclesafety/index.html. Accessed 11/12/2011.

[xxix] Committee on Weather Research for Surface Transportation: the Roadway Environment. Abstract: Weather Research for Surface Transportation: The Roadway Environment. American Meteorological Survey Conference. July 2003. http://parker.ou.edu/~jsnow/present/Abstract%20-%20AMS%20IIPS%20Conf%2004.pdf Accessed 11/18/2011.

[xxx] Pisano P, Goodwin L, Stern A. Surface Transportation Safety and Operations: The Impacts of Weather within the Context of Climate Change. Workshop of the Potential Impacts of Climate Change on Transportation. U.S. Department of Transportation. 2002. http://climate.dot.gov/documents/workshop1002/pisano.pdf Accessed 11/16/2011.

[xxxi] Eisenberg D, Warner KE. Effects of snowfalls on motor vehicle collisions, injuries and fatalities. Am J Public Health. 2005; 95: 120-124..

[xxxii] http://www.nhtsa.gov/people/injury/airbags/BUASBRuralWeb/. Accessed 3/23/2012.

[xxxiii] Socorro County Options, Prevention and Education. Socorro County Health Profile 2009.

[xxxiv] http://ibis.health.state.nm.us/view?xslt=html/community/snapshot/ReportPage.xslt&xml=community/GeoCnty.xml&community=53&indicatorSetName=AllIndicators

[xxxv] Socorro County Options, Prevention and Education. Socorro County Health Profile 2009.

[xxxvi] Ibid.

[xxxvii] http://ibis.health.state.nm.us/community/highlight/DrugIndDth.Cnty/GeoCnty/53.html

[xxxviii] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm.

[xxxix] http://www.cdc.gov/HomeandRecreationalSafety/pdf/poison-issue-brief.pdf

[xl] http://www.centerfornonprofitexcellence.org/nonprofit-directory/el-puente-del-socorro. Accessed 5/10/2012.

[xli] http://www.nmjustice.net/nmsc/juvenile/program.php?id=63. Accessed 5/14/2012.

[xlii] US DHHS HRSA: Shortage Areas: HPSA by State. http://hpsafind.hrsa.gov/HPSASearch.aspx 10/12/2-10.

[xliii] Derksen D: The Health Workforce & the Affordable Care Act. NM Health Policy Commission. 10/14/2010. http://www.hsd.state.nm.us/pdf/hcr/101410%20Derksen%20ACA%20Health%20Workforce.PDF

[xliv] Ibid.

[xlv] Ibid.

[xlvi] US Census 2010. http://quickfacts.census.gov/qfd/states/35/35053.html.

[xlvii] http://www.cdc.gov/vitalsigns/HealthcareAccess/LatestFindings.html accessed 1/2/2012.

[xlviii]
http://ibis.health.state.nm.us/view?xslt=html/community/snapshot/ReportPage.xslt&xml=community/GeoCnty.xml&community=53&indicatorSetName=AllIndicators.

[xlix] Ibid.

[l] Healthy Family Initiative Report, SGH. Based on US Census data.

[li] US Census 2010. http://quickfacts.census.gov/qfd/states/35/35053.html.

[lii] SCOPE 2009: Socorro County Health Profile Socorro County Options, Prevention and Education.

[liii] Board of County Commissioners, Socorro County. *Resolution 2005-52: A Resolution Adopting the Socorro County Version of "The Code of the West."* June 2005.

[liv] Flores G et al. Access barriers to health care for latino children. *Arch Pediatr Adolesc Med.* 1998; 152:1119-1125

[lv] Flores G, Tomany-Korman SC. Racial and ethnic disparities in medical and dental health, access to care and use of services in US children . *Pediatrics* 2008; 121; e286.

[lvi] Ibid.

[lvii] Arcury TA et al. Access to transportation and health care utilization in a rural region. *Jo Rural Health*. 2005: 21: 31- 38.

[lviii] Flores G, Tomany-Korman SC. 2008.

[lix] Ibid.

[lx] Phillips CD and McLeroy KR. Health in rural America—remembering the importance of place. Editorial. *AJPH*. 2004: 94: 1661-1663.

[lxi] Gamm et al. Rural healthy people 2010—evolving interactive practice. *AJPH.* 2004; 94:

1711–1712.

[lxii] Probst JC et al. Person and Pace: the Compounding Effects of Race/Ethnicity and Rurality on Health. *AJPH*. 2004; 94: 1695-1703.

[lxiii] Arcury TA et al.

[lxiv] Higgs ZR. Health care access: a consumer perspective. *Public Health Nursing*. 2001; 18: 3-12.

[lxv] Magilvy, JK. et al. Caring for our own: Health Care Experiences of Rural Hispanic Elders*. Jo of Aging Studies.* 2000; 14: 171-190.

[lxvi] Higgs ZR. 2001.

[lxvii] Averill, J. 2003.Keys to the Puzzle: Recognizing Strengths in a Rural Community. *Public Health Nursing.* 20: 449-455.

[lxviii] Probst JC et al. 2004.

[lxix] Averill, J. Voices from the Gila: health care issues for rural elders in south-western New Mexico. *J of Advanced Nursing*. 2002; 40: 654-662.

[lxx] Centers for Disease Control and Prevention. *Diabetes Fact Sheet 2011.* www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf. Accessed 2/1/2012.

[lxxi] Ibid.

[lxxii] Ibid.

[lxxiii] www.cdc.gov/vitalsigns/HealthcareAccess/LatestFindings.html. Accessed 1/2/2012.

[lxxiv] Crandall et al. The Prevention of type 2 diabetes. *Nature Clinical Practice Endocrinology and Metabolism*. 2008; 4: 382-393.

[lxxv] CDC. *2008 Age- adjusted estimates of adults who are physical inactivity in New Mexico.* apps.nccd.cdc.gov/DDT_STRS2/CountyPrevalenceData.aspx?StateId=35&mode=PHY accessed 2/2/2012.

[lxxvi] http://ibis.health.state.nm.us/view?xslt=html/community/snapshot/ReportPage.xslt&xml=community/GeoCnty.xml&community=53&indicatorSetName=AllIndicators

[lxxvii] Deshpande AD et al. Environmental correlates of physical activity among individuals with diabetes in the rural Midwest. *Diabetes Care.* 2005; 28: 1012-1018.

[lxxviii] Dansky KH, Dirani R. The use of health care services by people with diabetes in rural areas. *J of Rural Health*. 2008; 14: 129-137.

[lxxix] Satterfield DW et al. Community-based lifestyle programs to prevent type 2 diabetes. September 2003. *Diabetes Care.* 2003; 6: 2642-2652.

[lxxx] Lorig K et al. Community-based peer-led diabetes self-management*. The Diabetes Educator*. 2009; 35: 641-651.

[lxxxi] Zhou et al. A nationwide community-based lifestyle program could delay or prevent type 2 diabetes cases and save $5.7 billion in 25 years. *Health Affairs.*2012; 31: 50-60.

[lxxxii] Mier N et al. A pilot walking program for Mexican-American women living in colonias at the border. *Am J Health Promot.* 2011; 25: 172-175.

[lxxxiii] CDC. Vital Signs- Tobacco Use. http://www.cdc.gov/vitalsigns/TobaccoUse/SecondhandSmoke. Accessed 1/3/2012.

[lxxxiv 1] U.S. Department of Health and Human Services. The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General—Executive Summary. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

[lxxxv] CDC. Vital Signs- Tobacco Use. http://www.cdc.gov/vitalsigns/TobaccoUse/SecondhandSmoke. Accessed 1/3/2012.

[lxxxvi] CDC Vital Signs- Adult Smoking. www.cdc.gov/vitalsigns/AdultSmoking. Accessed 1/3/2012.

[lxxxvii] New Mexico Tobacco Use Prevention and Control. 2012 TUPAC Factsheet. www.nmtupac.com. Accessed 2/3/2012.

[lxxxviii] CDC. Tobacco and Pregnancy Risk Assessment Monitoring System. www.cdc.gov/prams/TobaccoandPrams.htm. Accessed 2/3/2012.

[lxxxix] Centers for Disease Control and Prevention. Based on PRAMS 2005. http://ibis.health.state.nm.us.

[xc] CDC. Best Practices for Tobacco Control Programs 2007. http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm Accessed 2/1/2012.

[xci] Stoops WW et al. An Internet-based abstinence reinforcement smoking cessation intervention in rural smokers. *Drug and Alcohol Dependence*. 2009; 105: 56-62.

[xcii] Polosa R. Smoking cessation and reduction through e-mail counseling. *Respiratory Medicine*. 2008; 102: 632.

[xciii] New Mexico's Indicator Based Information System. More Information and References for Tobacco Use: Adult Smokeless Tobacco Prevalence. ibis.health.state.nm.us/indicator/other_resources/TobaccoSmokelessAdult.html. accessed 2/3/12.

[xciv] CDC. Smokeless Tobacco Fact Sheet. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/smokeless_facts/index.htm. Accessed 2/1/2012.

[xcv] National Survey on Drug Use and Health 3/5/2009. http://www.oas.samhsa.gov/2k9/smokelesstobacco/smokelesstobacco.htm. Accessed 1/12/2012.

[xcvi] http://ibis.health.state.nm.us/indicator/view/SuicDeath.Year.NM_US.html

[xcvii] NM IBIS. 2007 data on Prenatal Care. http://ibis.health.state.nm.us/indicator/view_numbers/PrenCare.Year.NM_US.html. Accessed 2/3/2012.

[xcviii] NM PRAMS Surveillance Report 2001-02. http://nmhealth.org/phd/prams/report_surveillance/09_prenatal.pdf. Accessed 2/1/2012.

[xcix] Johnson K et al. Recommendations to improve preconception health and health care- United States. *Morbidity and Mortality Weekly Review.* April 21, 2006; 55 (RR06); 1-23.

[c] Santelli, JS. Et al. Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use. *AJPH*. 2007; 97: 150-156.

[ci] CDC. Teen Pregnancy Prevention 2011-2015. www.cdc.gov/TeenPregnancy/PreventTeenPreg.htm. Accessed 2/1/2012.

[cii] CDC. Teens. http://www.cdc.gov/parents/teens/index.html

[ciii] American Academy of Pediatrics. Healthy Children: Teens. http://www.healthychildren.org/English/ages-stages/teen/dating-sex. Accessed 2/1/2012.

[civ] New Mexico Dept. of Health. Family Planning Program. http://nmhealth.org/PHD/FP/teen_pregnancy_evidence_based.shtml

[cv] Szekely, A. Maximizing the Impact of State Early Childhood Home Visitation Programs. National Governor's Association brief, March 2011. www.nga.org/files/live/sites/NGA/files/pdf/1103HOMEVISIT.PDF, Accessed 5/1/2012.

[cvi] Ibid.

[cvii] The New Mexico Early Learning Advisory Council. May 2011. *Mapping the Social Ecology of Early Childhood in New Mexico*, page 23.

[cviii] Making Sure All Kids Count: The Earlier the Better, New Mexico's Home Visiting/Parent Mentoring Programs. http://www.nmvoices.org/wp-content/uploads/2012/01/nmkc-homevisiting-report-web.pdf

[cix] Ibid.

[cx] Ibid.

[cxi] ibis.health.state.nm.us/view?xslt=html/community/snapshot/ReportPage.xslt&xml=community/GeoCnty.xml&community=53&indicatorSetName=AllIndicators

[cxii] New Mexico Department of Public Health. Youth Risk and Resiliency Survey. http://nmhealth.org/erd/HealthData/yrrs.shtml

[cxiii] http://ibis.health.state.nm.us/indicator/graphic/GroupedBar/DrugIndDth.RacEth.350.jpeg

[cxiv] Socorro County Options, Prevention and Education. Fiscal Year 2011-2014; Socorro County Health Improvement Plan. 2009.. http://www.nmscope.org/Index.Html. Accessed 3/1/2011.

[cxv]
ibis.health.state.nm.us/view?xslt=html/community/snapshot/ReportPage.xslt&xml=community/GeoCnty.xml&community=53&indicatorSetName=AllIndicators

[cxvi] Roberts LW, Battalgia J and Epstein RS. Frontier ethics: mental health care needs and ethical dilemmas in rural communities. *Psychiatr Serv*. 1999; 50:497-503.

[cxvii] Kilbourne AM et al. Management of mental disorders in VA primary care practices. *Administration and Policy in Mental Health and Mental Health Services Research*. 2006; 33: 208-214.

[cxviii] Roberts LW, Battalgia J and Epstein RS. 1999.

[cxix] Quintero GA et al. Substance abuse treatment provider views of "culture": implications for behavioral health in rural settings. *Qualitative Health Research.* 2007; 17: 1256-1267

[cxx] CDC. Pain Killer Overdoses in the US. *CDC Vital Signs* 2011, November. http://www.cdc.gov/vitalsigns/PainkillerOverdoses/index.html accessed 1/2/2012.

[cxxi] www.projectlazarus.com . Accessed 5/1/2012.

[cxxii] http://nationalsubstanceabuseindex.org/new-mexico/facilities.php

[cxxiii] http://www.ncadv.org/files/DomesticViolenceFactSheet(National).pdf. Accessed 5/14/2012.

[cxxiv] Durborow N et al. 2010. Compendium of State Statutes and Policies on Domestic Violence and Health Care. http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf. Accessed 5/10/2012.

[cxxv] Caponera B. Domestic Violence Trends in New Mexico, 2005-2009.http://nmhealth.org/injury/reports/Betty_Caponera_DV_Trends_in_NM_2005-2009_Report_web.pdf. Accessed 5/15/2012.

[cxxvi] http://www.childwelfare.gov/systemwide/domviolence/casework_practice/evidence_based.cfm. Accessed 5/10/2012.

[cxxvii] University of Iowa School of Social Work. National Resource Center for Family Centered Practice

—Committed to Excellence Through Supervision 2009*. The University of Iowa Module IV – Clinical Practice Supervision Domestic Violence* . www.uiowa.edu/~nrcfcp/training/documents/Domestic%20Violence%20interventions%20Handouts.pdf. Accessed 5/14/2012.

[cxxviii] Morris NS. The single item literacy screener: evaluation of a brief instrument

to identify limited reading ability. *BMC Family Practice*. 2006; 7:21.

[cxxix] CDC. Behavioral Risk Factor Surveillance System. http://www.cdc.gov/brfss/index.htm. Accessed 3/26/2011.

[cxxx] CDC. Hispanic-Latino Adult Tobacco Survey Guide. http://www.cdc.gov/tobacco/data_statistics/surveys/hispanic_latino_ats_guide/index.htm accessed 4/1/2011.

[cxxxi] http://www.hsd.state.nm.us/pdf/isd/ISD%20017%20Income%20Eligibility%20Guidelines%20Oct11-Sept12%20doc%20(2).pdf.

[cxxxii] http://www.livingwage.geog.psu.edu/counties/35053.

[cxxxiii] Charash, WE. Telemedicine to a moving ambulance improves outcome after trauma in simulated patients. *The Journal of Trauma Injury, Infection, and Critical Care.* 2011; 1: 49-51