2026 COMMUNITY HEALTH NEEDS ASSESSMENT

San Juan County, New Mexico

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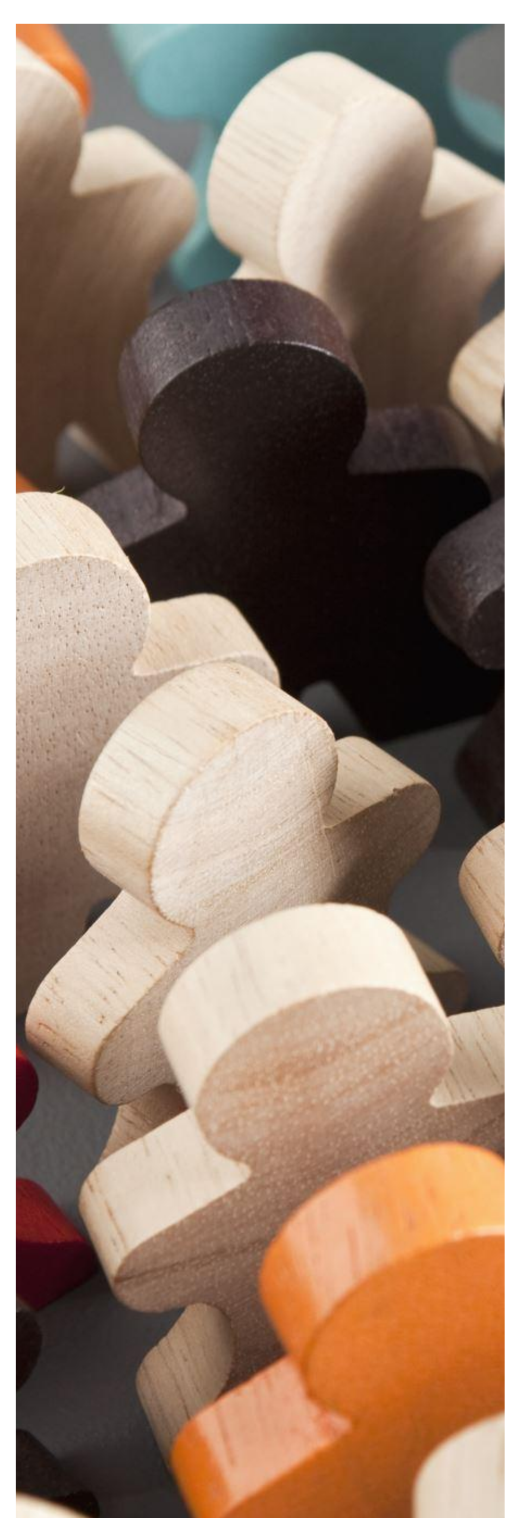
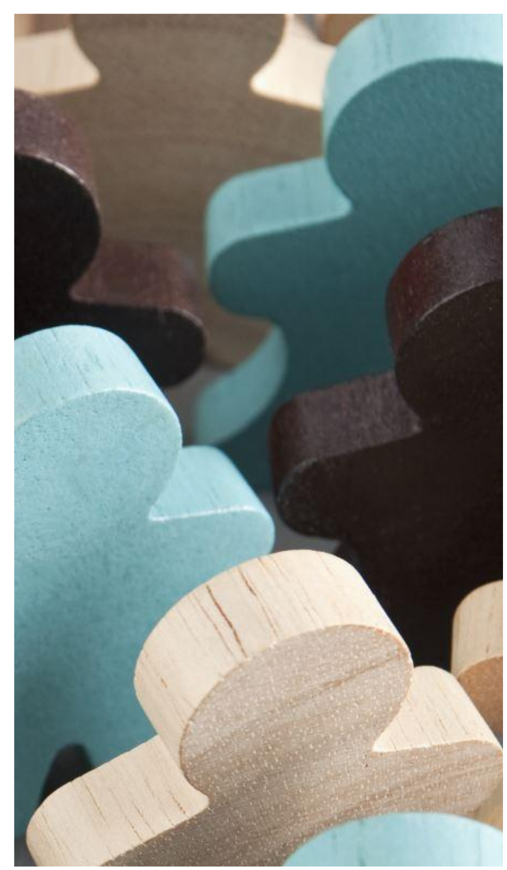




INTRODUCTION

PROJECT OVERVIEW

This Community Health Needs Assessment — a follow-up to similar studies conducted in 2008, 2011, 2014, 2017, 2020, and 2023 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in San Juan County, New Mexico. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness. A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of San Juan Regional Medical Center by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by San Juan Regional Medical Center and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort is defined as each of the residential ZIP Codes associated with **San Juan County, New Mexico**. This community definition was determined based on the ZIP Codes of residence of recent patients of San Juan Regional Medical Center and is segmented by the hospitals' primary (eastern) and secondary (western) service areas within the county, as outlined below.

SAN JUAN COUNTY			
PRIMARY SERVICE AREA (PSA)		SECONDARY SERVICE AREA (SSA)	
87037	87413	87364	87421
87401	87415	87416	87455
87402	87418	87417	87461
87410	87419	87420	
87412	87499		

Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a phone interview methodology was employed, the primary advantages of which are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a stratified random sample of 250 individuals age 18 and older in San Juan County, including 175 in the Primary Service Area and 75 in the Secondary Service Area. The surveys were administered from February to March 2026. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent San Juan County as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 250 respondents is ±6.2% at the 95 percent confidence level.

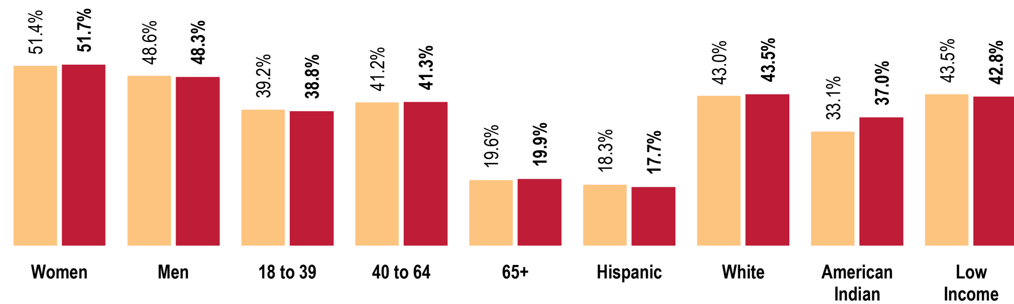
Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the San Juan County sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's health care needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(San Juan County, 2026)

▪ Actual Population ▪ **Final Survey Sample**



Sources: • US Census Bureau, 2016-2020 American Community Survey.
• 2026 PRC Community Health Survey, PRC, Inc.
Notes: • "Low Income" reflects those living under 200% FPL (federal poverty level, based on guidelines established by the US Department of Health & Human Services).

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by San Juan Regional Medical Center; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation.

In all, **73** community representatives took part in the Online Key Informant Survey.

KEY INFORMANT PARTICIPATION

23	3	23	1	23
PHYSICIANS	PUBLIC HEALTH REPRESENTATIVES	OTHER HEALTH CARE PROVIDERS	SOCIAL SERVICES PROVIDER	OTHER COMMUNITY LEADERS

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the following:

- Artifacts
- Child Protective Services
- Childhaven
- City of Bloomfield
- City of Farmington
- Family Foot Health Specialists of Farmington
- Farmington Chamber of Commerce
- Farmington Family Practice
- Farmington Municipal Schools Board of Education
- Farmington Municipal Schools Health Services
- Four Corners Economic Development
- Four Corners Radiology Associates
- La Mesa Chiropractic Center
- Manchester Agency Secure Insurance
- Merrion Oil & Gas
- Navigation Center
- New Mexico Department of Health, Farmington
- Orthopedic Associates
- Parker's Workplace Solutions
- Piñon Hills Ear, Nose & Throat
- Process Equipment & Service Company
- San Juan County
- San Juan County Partnership
- San Juan Independent Practice Association
- San Juan Regional Medical Center
- San Juan Regional Rehabilitation Hospital
- Small Business Development Center
- Totah Behavioral Health Authority

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Data

Trending

Similar surveys were administered in San Juan County in 2008, 2011, 2014, 2017, and 2023 by PRC on behalf of San Juan Regional Medical Center. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

New Mexico Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2026 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives (https://health.gov/healthypeople).

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as unhoused persons, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

San Juan Regional Medical Center made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, San Juan Regional Medical Center had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. San Juan Regional Medical Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	25
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	117
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	10
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	11
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	121

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Specific Source of Ongoing Medical Care ▪ Outmigration for Health Care Services ▪ Emergency Room Utilization ▪ Ratings of Local Health Care ▪ *Key Informants ranked this issue as a top concern.*
CANCER	▪ Leading Cause of Death ▪ Prostate Cancer Deaths ▪ Female Breast Cancer Incidence ▪ Female Breast Cancer Screening ▪ Cervical Cancer Screening
DIABETES	▪ Diabetes Deaths ▪ Prevalence of Borderline/Pre-Diabetes ▪ *Key Informants ranked this issue as a top concern.*
DISABLING CONDITIONS	▪ Multiple Chronic Conditions
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Deaths ▪ Stroke Deaths ▪ High Blood Pressure Prevalence ▪ Overall Cardiovascular Risk
INFANT HEALTH & FAMILY PLANNING	▪ Prenatal Care ▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ○ Including Motor Vehicle Crash Deaths ▪ Homicide Deaths

— continued on next page —

AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Suicide Deaths ▪ *Key Informants ranked this issue as a top concern.*
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Overweight & Obesity [Adults] ▪ *Key Informants ranked this issue as a top concern.*
RESPIRATORY DISEASE	▪ Pneumonia/Influenza Deaths
SEXUAL HEALTH	▪ Chlamydia Incidence ▪ Gonorrhea Incidence
SUBSTANCE USE	▪ Cirrhosis/Liver Disease Deaths ▪ Alcohol-Induced Deaths ▪ Unintentional Drug-Induced Deaths ▪ *Key Informants ranked this issue as a top concern.*
TOBACCO USE	▪ Use of Vaping Products

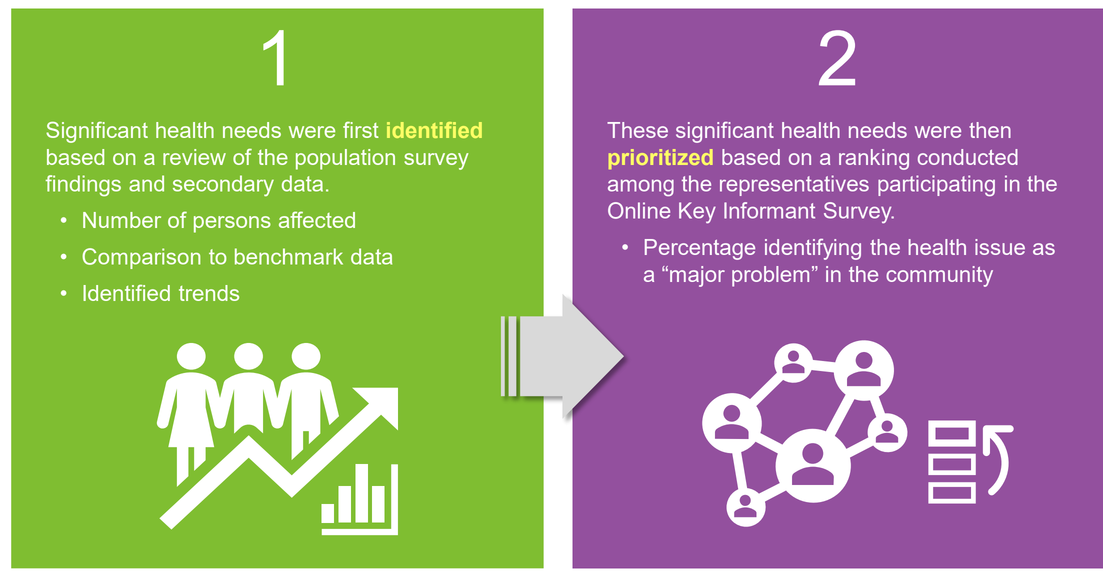
Community Feedback on Prioritization of Health Needs

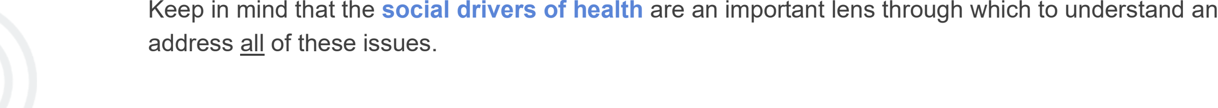
Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Substance Use
2. Mental Health
3. Diabetes
4. Nutrition, Physical Activity & Weight
5. Access to Health Care Services
6. Disabling Conditions
7. Heart Disease & Stroke
8. Tobacco Use
9. Injury & Violence
10. Infant Health & Family Planning
11. Sexual Health
12. Cancer
13. Respiratory Disease

IDENTIFICATION & PRIORITIZATION OF SIGNIFICANT HEALTH NEEDS





Keep in mind that the **social drivers of health** are an important lens through which to understand and address all of these issues.

Hospital Implementation Strategy

San Juan Regional Medical Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

- In the following tables, San Juan County results are shown in the larger, gray column.
- The columns to the left of the San Juan County column provide comparisons between the two service areas, identifying differences for each as "better than" (☼), "worse than" (☂), or "similar to" (☁) the opposing area.
- The columns to the right of the San Juan County column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether San Juan County compares favorably (☼), unfavorably (☂), or comparably (☁) to these external data.

TREND SUMMARY

(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 2008 (or earliest available data).

OTHER (SECONDARY) DATA INDICATORS:

Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DRIVERS OF HEALTH	GEOGRAPHIC DISPARITY		San Juan County	SAN JUAN CO. vs. BENCHMARKS			
	PSA	SSA		vs. NM	vs. US	vs. HP2030	TREND
Population in Poverty (Percent)			23.1	17.8	12.5	8.0	
Children in Poverty (Percent)			30.2	24.0	16.1	8.0	
No High School Diploma (Age 25+, Percent)			13.1	12.0	10.4		
Unemployment Rate (Age 16+, Percent)			4.7	4.2	4.1		
% Unable to Pay for a $400 Emergency Expense	21.7	36.9	24.9		21.3		
% Worry/Stress Over Rent/Mortgage in Past Year	28.5	29.9	29.0		31.0		34.4
% Food Insecure	26.7	50.5	31.9		29.3		27.1

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

OVERALL HEALTH	GEOGRAPHIC DISPARITY		San Juan County	SAN JUAN CO. vs. BENCHMARKS			
	PSA	SSA		vs. NM	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	19.2	30.2	21.6	21.5	21.4		18.2

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

ACCESS TO HEALTH CARE	GEOGRAPHIC DISPARITY		San Juan County	SAN JUAN CO. vs. BENCHMARKS			
	PSA	SSA		vs. NM	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	6.9	14.4	8.5	14.3	8.5	7.6	24.1
% Difficulty Accessing Health Care in Past Year (Composite)	44.5	42.4	44.1		50.4		55.5
% Difficulty Finding Physician in Past Year	9.3	21.4	11.9		20.6		14.9

ACCESS TO HEALTH CARE (continued)	GEOGRAPHIC DISPARITY		San Juan County	SAN JUAN CO. vs. BENCHMARKS			
	PSA	SSA		vs. NM	vs. US	vs. HP2030	TREND
% Difficulty Getting Appointment in Past Year	28.3	25.9	27.8		26.6		27.2
% Cost Prevented Physician Visit in Past Year	14.0	19.5	15.2	12.5	16.4		22.1
% Transportation Hindered Dr Visit in Past Year	7.2	14.2	8.8		13.3		13.8
% Inconvenient Hrs Prevented Dr Visit in Past Year	12.9	14.0	13.2		21.9		18.0
% Language/Culture Prevented Care in Past Year	1.5	1.7	1.6		2.6		2.4
% Cost Prevented Getting Prescription in Past Year	15.0	7.7	13.4		14.6		24.7
% Stretched Prescription to Save Cost in Past Year	11.8	11.8	11.8		17.1		21.8
% Difficulty Getting Child's Health Care in Past Year			2.8		8.3		4.9
Primary Care Doctors per 100,000			132.3	125.9	119.6		
% Have a Specific Source of Ongoing Care	69.9	58.1	67.3		67.9	95.1	76.2
% Outmigration for Health Care Services	32.0	32.3	32.1				24.7
% Routine Checkup in Past Year	69.2	64.5	68.2	70.3	74.0		59.2
% [Child 0-17] Routine Checkup in Past Year			83.2		85.9		77.9
% Two or More ER Visits in Past Year	16.8	22.9	18.1		14.9		8.3
% Rate Local Health Care "Fair/Poor"	31.5	16.3	28.1		19.7		30.1

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

	GEOGRAPHIC DISPARITY			SAN JUAN CO. vs. BENCHMARKS			
CANCER	PSA	SSA	San Juan County	vs. NM	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000			153.6	176.4	182.6		157.4
Lung Cancer Deaths per 100,000			23.8	27.6	38.9		
Prostate Cancer Deaths per 100,000			24.6	24.1	20.4		
Female Breast Cancer Deaths per 100,000			25.6	27.5	25.1		
Colorectal Cancer Deaths per 100,000			17.7	17.0	16.4		
Cancer Incidence per 100,000			324.3	372.9	448.6		
Female Breast Cancer Incidence per 100,000			86.1	115.9	69.4		
Prostate Cancer Incidence per 100,000			74.7	90.0	116.4		
Lung Cancer Incidence per 100,000			29.6	31.8	52.5		
Colorectal Cancer Incidence per 100,000			32.6	33.2	36.7		
% Cancer	9.2	8.6	9.0	11.0	10.7		6.1
% [Women 40-74] Breast Cancer Screening			66.7		78.0	80.3	59.5
% [Women 21-65] Cervical Cancer Screening			63.1		74.9	79.2	79.3
% [Age 45-75] Colorectal Cancer Screening			72.1		77.5	72.8	67.7

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

DIABETES	GEOGRAPHIC DISPARITY PSA	 SSA	San Juan County	SAN JUAN CO. vs. BENCHMARKS vs. NM	 vs. US	 vs. HP2030	 TREND
Diabetes Deaths per 100,000			48.4	36.4	28.8		35.9
% Diabetes/High Blood Sugar	12.7	28.8	16.2	12.3	15.4		11.5
% Borderline/Pre-Diabetes	18.4	8.7	16.3		13.2		7.3
Kidney Disease Deaths per 100,000			16.6	16.8	16.7		16.4
% Kidney Disease	3.5	8.5	4.6	3.5		11.4	2.8

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

DISABLING CONDITIONS	GEOGRAPHIC DISPARITY PSA	 SSA	San Juan County	SAN JUAN CO. vs. BENCHMARKS vs. NM	 vs. US	 vs. HP2030	 TREND
% 3+ Chronic Conditions	33.5	42.8	35.5				27.2
% Activity Limitations	25.1	8.3	21.4		32.0		18.3
Alzheimer's Disease Deaths per 100,000			12.7	31.6	34.7		22.9
% Caregiver to a Friend/Family Member	29.0	30.6	29.3		28.1		27.7

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

	GEOGRAPHIC DISPARITY			SAN JUAN CO. vs. BENCHMARKS			
HEART DISEASE & STROKE	**PSA**	**SSA**	**San Juan County**	**vs. NM**	**vs. US**	**vs. HP2030**	**TREND**
Heart Disease Deaths per 100,000			**178.8**	213.1	205.0		151.0
Stroke Deaths per 100,000			**47.2**	48.5	49.1		37.9
% Heart Disease	6.3	8.7	**6.8**	6.3	9.5		7.7
% Stroke	1.3	0.3	**1.1**	2.9	5.6		4.2
% High Blood Pressure	38.9	42.2	**39.6**	34.1	41.5	41.9	29.8
% High Cholesterol	31.0	26.9	**30.2**		36.2		27.0
% 1+ Cardiovascular Risk Factor	91.8	90.2	**91.4**		86.7		88.5

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

	GEOGRAPHIC DISPARITY			SAN JUAN CO. vs. BENCHMARKS			
INFANT HEALTH & FAMILY PLANNING	**PSA**	**SSA**	**San Juan County**	**vs. NM**	**vs. US**	**vs. HP2030**	**TREND**
No Prenatal Care in First 6 Months (Percent of Births)			**9.6**	11.9	6.1		10.6
Low Birthweight (Percent of Births)			**7.8**	9.4	8.4		
Infant Deaths per 1,000 Births			**5.4**	5.4	5.5	5.0	6.3
Teen Births per 1,000 Females 15-19			**24.4**	22.3	15.5		

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

INJURY & VIOLENCE	GEOGRAPHIC DISPARITY PSA	SSA	San Juan County	SAN JUAN CO. vs. BENCHMARKS vs. NM	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000			116.3	93.4	64.2		89.7
Motor Vehicle Crash Deaths per 100,000			36.5	21.8	12.8		
Homicide Deaths per 100,000			16.3	13.3	6.7		9.1
% Victim of Violent Crime in Past 5 Years	2.7	4.4	3.1		7.1		6.3

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

MENTAL HEALTH	GEOGRAPHIC DISPARITY PSA	SSA	San Juan County	SAN JUAN CO. vs. BENCHMARKS vs. NM	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	21.2	15.4	20.0		20.0		10.2
% Diagnosed Depression	29.0	10.2	24.9	19.2	30.7		20.0
% Diagnosed Anxiety	30.7	11.7	26.6		31.6		
% Diagnosed Anxiety and/or Depression	38.3	15.8	33.4		40.2		
% Signs/Symptoms of Anxiety	13.6	11.7	13.2		22.1		
% Signs/Symptoms of Depression	15.9	25.5	17.9		18.0		
% Signs/Symptoms of Anxiety and/or Depression	11.8	11.9	11.8		17.9		
Suicide Deaths per 100,000			35.1	24.3	14.6		30.2
Mental Health Providers per 100,000			332.1	520.8	340.5		

MENTAL HEALTH (continued)	GEOGRAPHIC DISPARITY PSA	SSA	San Juan County	SAN JUAN CO. vs. BENCHMARKS vs. NM	vs. US	vs. HP2030	TREND
% Receiving Mental Health Treatment	15.6	4.3	13.1		23.2		12.9
% Unable to Get Mental Health Services in Past Year	4.4	5.4	4.6		9.1		4.8

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	GEOGRAPHIC DISPARITY PSA	SSA	San Juan County	SAN JUAN CO. vs. BENCHMARKS vs. NM	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	23.2	23.2	23.2		25.4		21.9
% No Leisure-Time Physical Activity	20.9	23.4	21.4	21.7	22.3	21.8	29.1
% Meet Physical Activity Guidelines	34.4	37.7	35.1	30.4	29.2	29.7	29.5
% [Child 2-17] Physically Active 1+ Hours per Day			54.0		35.8		46.1
% Overweight (BMI 25+)	75.9	81.5	77.1	63.1	66.4		65.1
% Obese (BMI 30+)	39.4	58.6	43.6	34.5	37.5	36.0	27.1
% [Child 5-17] Overweight (85th Percentile)			45.0		32.2		35.0
% [Child 5-17] Obese (95th Percentile)			26.3		21.0	15.5	17.2

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

ORAL HEALTH	GEOGRAPHIC DISPARITY PSA	SSA	San Juan County	SAN JUAN CO. vs. BENCHMARKS vs. NM	vs. US	vs. HP2030	TREND
% Lack of Dental Insurance	16.9	25.6	18.8		24.8	25.0	47.7
% Dental Visit in Past Year	62.6	58.8	61.8	61.7	63.5	45.0	59.6
% [Child 2-17] Dental Visit in Past Year			87.7		85.1	45.0	78.8

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

RESPIRATORY DISEASE	GEOGRAPHIC DISPARITY PSA	SSA	San Juan County	SAN JUAN CO. vs. BENCHMARKS vs. NM	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000			43.4	51.5	43.5		46.3
Pneumonia/Influenza Deaths per 100,000			22.4	17.8	13.9		12.7
% Asthma	12.5	17.5	13.6	10.4	17.2		9.2
% [Child 0-17] Asthma			11.7		15.2		7.6
% COPD (Lung Disease)	8.1	2.6	6.9	6.5	8.7		11.5

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

SEXUAL HEALTH	GEOGRAPHIC DISPARITY PSA	SSA	San Juan County	SAN JUAN CO. vs. BENCHMARKS vs. NM	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000			148.0	224.3	386.6		
Chlamydia Incidence per 100,000			747.5	523.6	492.2		
Gonorrhea Incidence per 100,000			248.6	169.0	179.0		

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse

SUBSTANCE USE	GEOGRAPHIC DISPARITY PSA	SSA	San Juan County	SAN JUAN CO. vs. BENCHMARKS vs. NM	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease Deaths per 100,000			68.8	36.6	15.8		
Alcohol-Induced Deaths per 100,000			79.6	40.2	14.5		48.4
Unintentional Drug-Induced Deaths per 100,000			32.9	41.5	26.8		12.2
% Excessive Drinking	12.5	12.9	12.6	16.3	25.1		13.7
% Used Marijuana/THC in Past Year	22.2	19.6	21.6		26.4		
% Used an Illicit Drug in Past Month	1.7	0.0	1.3		3.9		1.3
% Ever Sought Help for Alcohol or Drug Problem	7.6	3.9	6.8		8.2		8.8
% Personally Impacted by Substance Use	48.2	33.9	45.0		46.8		47.2

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

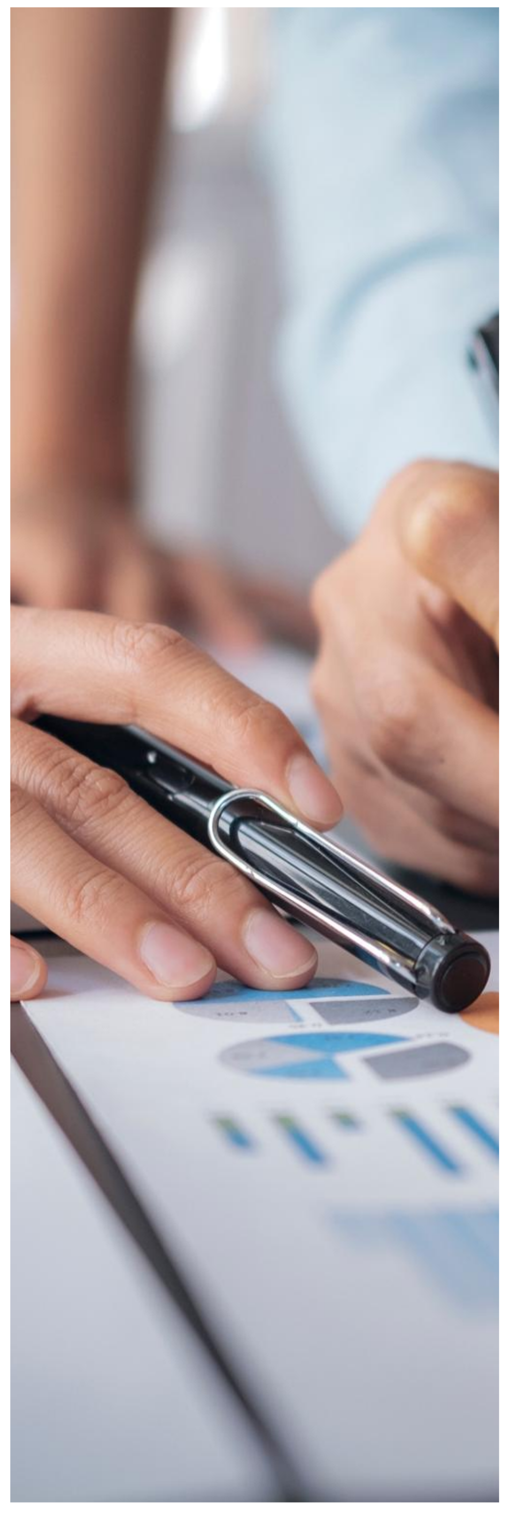
better similar worse

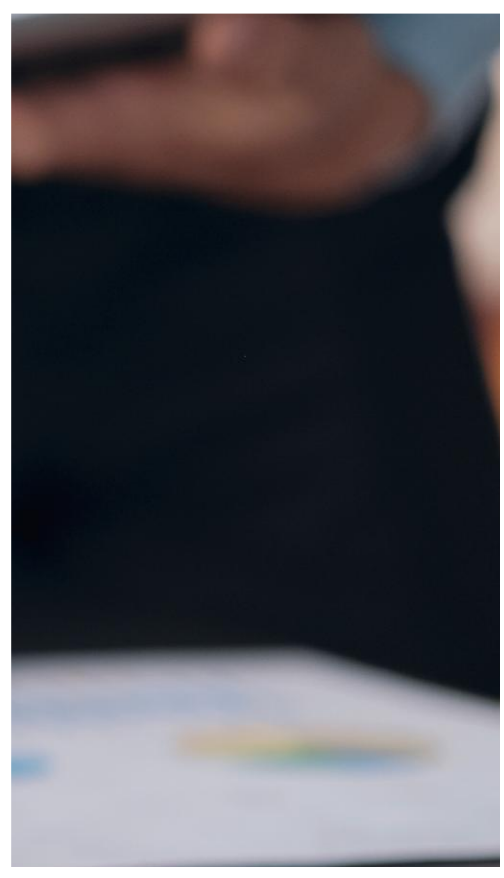
TOBACCO USE	PSA	SSA	San Juan County	vs. NM	vs. US	vs. HP2030	TREND
	GEOGRAPHIC DISPARITY			SAN JUAN CO. vs. BENCHMARKS			
% Smoke Cigarettes	similar 10.2	similar 18.5	12.0	similar 12.0	better 20.5	worse 6.1	better 21.4
% Use Vaping Products	similar 10.5	similar 5.9	9.5	similar 8.2	better 15.3		worse 5.5

Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Note: In the section above, primary and secondary service areas are each compared against the other.

better similar worse





DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY DESCRIPTION

Demographic Summary

The following table outlines key demographic characteristics of the community. Note that:

- A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.
- It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.
- Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.
- Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

Core Demographic Summary

		San Juan County	New Mexico	US
Total Population		**120,942**	2,120,246	334,922,499
% Population Change, 2010-2020		**-6.5**	+2.8	+7.1
Age	*0-17 (%)*	**24.9**	21.8	22.0
	18-64 (%)	**58.1**	58.9	60.8
	65+ (%)	**17.0**	19.3	17.2
	Median Age	**38.3**	39.4	38.9
Ethnicity	*Hispanic (%)*	**19.8**	48.4	19.3
Race	*White (%)*	**39.9**	47.8	61.0
	American Indian or Alaska Native (%)	**39.6**	9.5	0.9
	Asian (%)	**0.8**	1.8	6.0
	Black (%)	**0.6**	2.1	12.2
	Native Hawaiian/Pacific Islander (%)	**0.03**	0.09	0.19
Percent of Population Living in Areas Designated as Urban (%)		**64.8**	74.6	80.0

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Note:
- People who identify their origin as Hispanic may be of any race.
- Urban areas are identified using population density, count, and size thresholds; urban areas also include territory with a high degree of impervious surface (development).
  Rural areas are all areas that are not urban.

Social Drivers of Health

ABOUT SOCIAL DRIVERS OF HEALTH

Social drivers of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social drivers of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

– Healthy People 2030

Poverty, Education & Unemployment

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to overall health.

Poverty, Education & Unemployment

	San Juan County	New Mexico	US
% of Total Population Living Below 100% of the Federal Poverty Level	**23.1**	17.8	12.5
% of Children (<Age 18) Living Below 100% of the Federal Poverty Level	**30.2**	24.0	16.1
% of Population Age 25+ Without a High School Diploma	**13.1**	12.0	10.4
Unemployment Rate (December 2025)*	**4.7**	4.2	4.1

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Notes:
- *Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

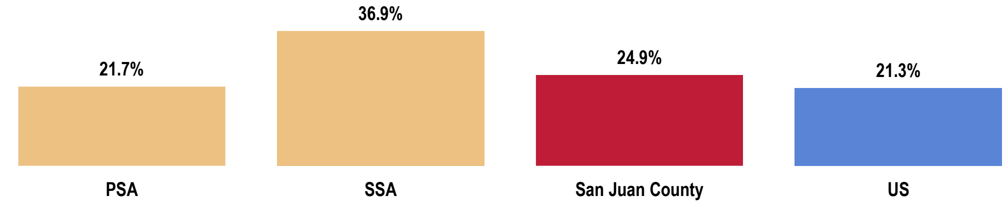
Financial Resilience

PRC SURVEY ▶ "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

Survey findings in this report may be segmented by the key demographic characteristics of the respondents (see also the definitions that follow).

The following details "no" responses in San Juan County in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status], and race/ethnicity).

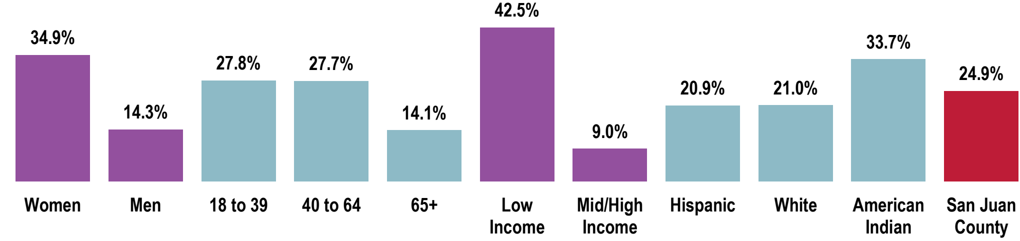
Do Not Have Funds on Hand to Cover a $400 Emergency Expense



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 50]
• 2026 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Do Not Have Funds on Hand to Cover a $400 Emergency Expense
(San Juan County, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 50]

Notes: • Asked of all respondents.
• Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

INCOME & RACE/ETHNICITY

INCOME ▶ Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2025 guidelines place the poverty threshold for a family of four at $32,150 annual household income or lower). In sample segmentation: “low income” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

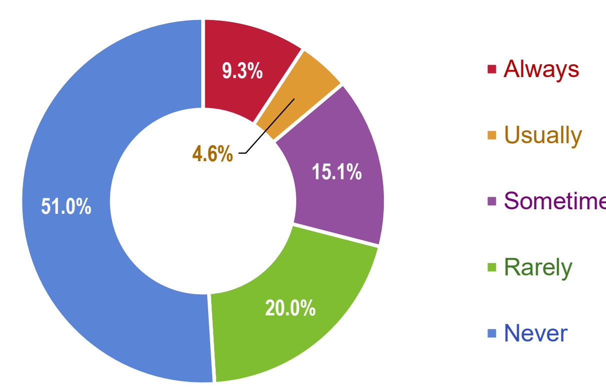
RACE & ETHNICITY ▶ In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Data are also detailed for individuals identifying with a race category, without Hispanic origin. “White” reflects those who identify as White alone, without Hispanic origin; “American Indian” reflects those who identify as American Indian alone, without Hispanic origin.

Housing

Housing Insecurity

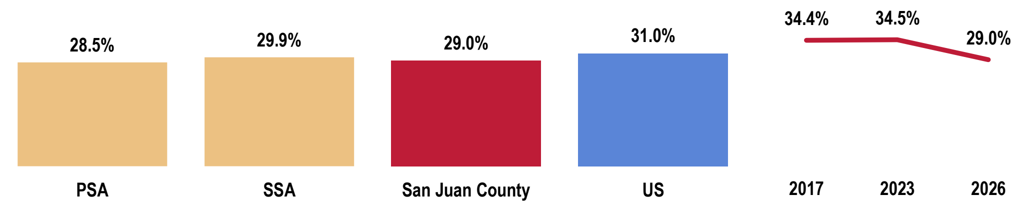
PRC SURVEY ▶ “In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?”

Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year
(San Juan County, 2026)



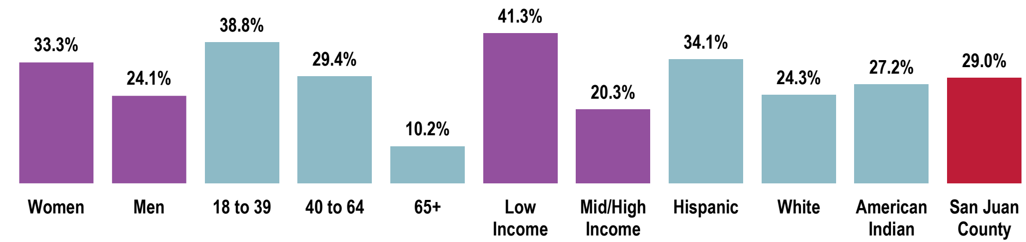
Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: • Asked of all respondents.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 52]
• 2026 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year (San Juan County, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: • Asked of all respondents.

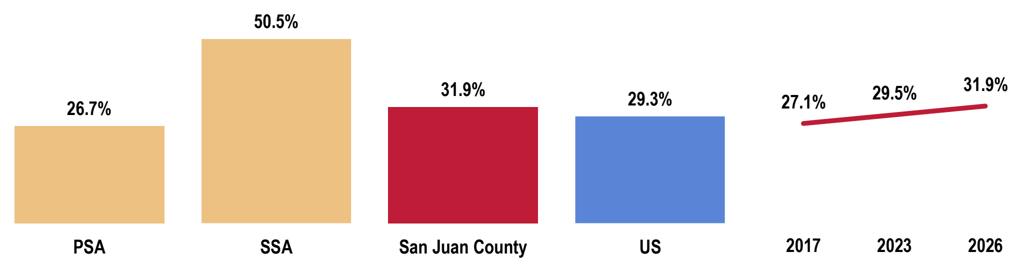
Food Insecurity

PRC SURVEY ▶ "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- 'I worried about whether our food would run out before we got money to buy more.'
- 'The food that we bought just did not last, and we did not have money to get more.'"

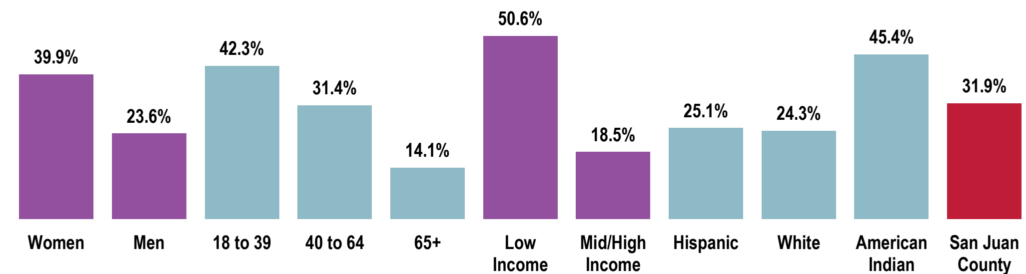
Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecure



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 98]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

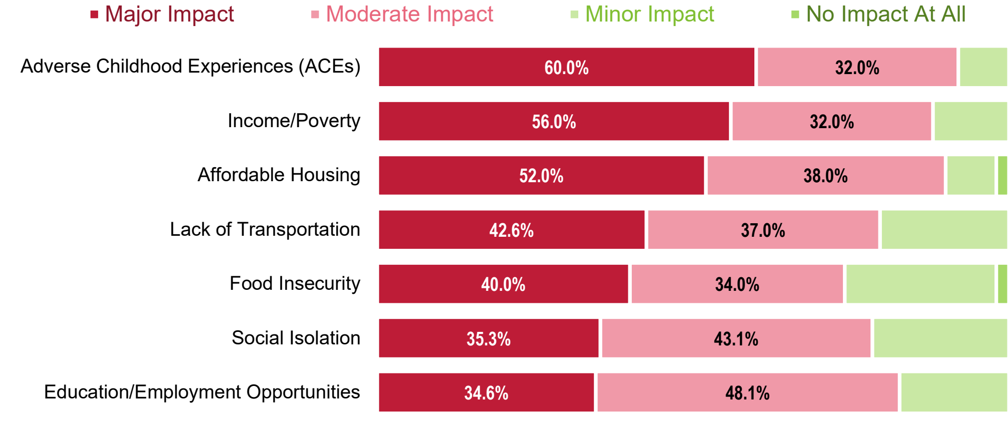
Food Insecure
(San Juan County, 2026)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 98]
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Key Informant Input: Social Drivers of Health

Key informants taking part in the Online Key Informant Survey acknowledge that various social drivers of health have significant impact on community health.



Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

When asked what social driver of health is most important for community organizations to address, respondents shared the following:

Income and Poverty

> Income and poverty. — Physician
>
> Low income in the setting of high inflation. — Physician
>
> Poverty affects populace ability to care for their basic needs, so they neglect their health care needs. — Health Care Provider
>
> Poverty and lack of housing in San Juan County. — Social Services Provider
>
> Poverty. This is statewide, evidenced by New Mexico relying on government health care for nearly 50% of its citizens. Other aspects flow from this area. — Community Leader
>
> Financial insecurity and lack of affordability effects all aspects of life, triggering physical, mental and interpersonal distress. — Physician
>
> Economic stability, Steady work and income. — Community Leader
>
> Poverty. — Physician
>
> Low income. — Community Leader

Affordable Housing

> Affordable housing. — Community Leader
>
> Affordable housing. Without housing, an individual will struggle to maintain health, habits, and survival. — Community Leader
>
> Affordable housing. — Health Care Provider
>
> Affordable housing. Costly housing decreases financial independence requiring more application for help from additional social support for food/clothing. — Physician
>
> Lack of affordable housing. The lack of affordable real estate inventory and high cost of rent forces multi-generations into communal living. We all dream of having a home of our own. It is not the current reality. — Community Leader

Education

> Education and employment opportunities. Leads to poverty, poor health literacy, and directly impacts other social drivers of health. — Physician
>
> Health is how people see themselves Education and compliance. People need to know years in advance on how to prevent long-term illness by managing their health. Education needs to start early. — Community Leader

> Health care literacy. A large portion of the local population do not understand the reasoning for why their conditions need to be treated. Leading to noncompliance and worse outcomes. — Physician
>
> Health literacy. — Health Care Provider
>
> Education: Looking at student proficiency rates, in all categories, less than 50% are proficient in any topic (possibly there is newer data that is different from what I referenced). This will affect the rest of their life and future families including health to socioeconomic, etc. There are studies that show communities that have more education have lower mortality rates. — Health Care Provider

Adverse Childhood Experiences (ACEs)

> Dysfunctional families, and inadequate role modeling in high authority level figures in social systems, such as schools, businesses, government entities, etc.; perpetuate the unhealthy patterns of behaviors that individuals repeat unconsciously (sometimes consciously), and cause constant distress, interpersonal difficulties, and poor emotion regulation for individuals affected by the lack of guidance and truth in their life. For example, if one has had adverse childhood experiences, or someone continues to function with poor role modeling, it will be very difficult to reverse the damage done psychologically and reorient the individual in a positive direction, it will take time to deconstruct the unhealthy patterns of behavior and re-establish a sense of health and harmony of the individual suffering from the various dysfunctions. And certainly, no drug treatment could restore and heal those individuals affected by past and present neglect or abuse. — Physician
>
> Because I believe that food insecurity is being worked on, I would say adverse childhood experiences. — Community Leader
>
> Family spiritual and mental health: because of family dysfunction, too many kids are brought up in environments where they have little to no chance of future life success. Most things exist outside the family structure to help with that success including churches, education, jobs, government and nonprofit assistance, etc., but parents choose to be ineffective in raising kids to be successful. — Community Leader
>
> Adverse childhood experiences associated with impaired parenting skills, teen pregnancy, poor educational and work achievement, depression, obesity, chronic illness, substance use, etc. — Public Health Representative

Housing

> Housing. — Public Health Representative
>
> Housing with food insecurity is a large problem noted with children especially. — Health Care Provider
>
> Housing insecurity. We have over 2,000 unhoused patients in Farmington with an average age of death 41 years old. This is our most vulnerable population. They need help and we are failing them. Housing is health care. — Physician

Behavioral Health

> Social media has caused the mental health care crisis. It contributes to social isolation. It contributes to depression, weight gain, etc. Without people placing limits on themselves or their kids it won't get better. — Community Leader
>
> Victim mentality and a sense of entitlement. — Community Leader
>
> Behavioral health, which is both mental health and substance use issues and barriers towards receiving adequate treatment at all levels from outpatient to inpatient treatment or acute psychiatric, including readily available meds and med management. — Community Leader

Transportation

> Lack of transportation. Our clinic has a high level of missed visits because of lack of reliable transportation. When patients miss visits, they do not get the care and support they need to optimally manage their health needs. Individuals with transportation insecurity often have difficulty picking up their prescriptions or getting to the store to get groceries compatible with their dietary needs. — Health Care Provider
>
> Transportation. — Community Leader

Food Insecurity

> Food insecurity: lack of access to healthy food choices leads to illness, cannot afford health care. — Community Leader
>
> Food insecurity. Lack of affordable, healthy food leads to eating cheaper, highly processed food, which leads to nutritional deficiencies and poor health. — Health Care Provider

Access to Care

> Lack of providers. — Health Care Provider
>
> Access to primary care and mental health issues. — Physician

Employment Opportunities

> Employment opportunities. — Physician

Community Belonging

> Sense of community is most important. Where you live, work and attend school should give you a sense of belonging and pride. There is more alienation and apathy it seems. There are organizations and churches who are kind and caring, trying their best to help the downtrodden, the poor, the neglected, the abused, the ones struggling and it's hard to help those who don't seem motivated to help themselves. Rent is high, medical and oral care is expensive. We live in a dangerous and violent world and the US president models a lack of civility, unkindness, blame, hate and exclusion. — Community Leader

Loneliness

> Loneliness. Patients are using health appointments for social contact. They can feel unsatisfied if appointments are ended early because there is not enough time to discuss life issues that are not related to their medical care. — Health Care Provider

Domestic Violence

> Domestic violence, driven by poverty and substance abuse, which creates adverse childhood experiences for the next generation. — Community Leader

Access to Outpatient Follow Up

> Access to outpatient follow up, people are not getting the outpatient care from specialists like GI, neurology, ENT, cardiology. They need to leave our community to find other resources. — Physician

Obesity

> Obesity and healthier food options. — Physician

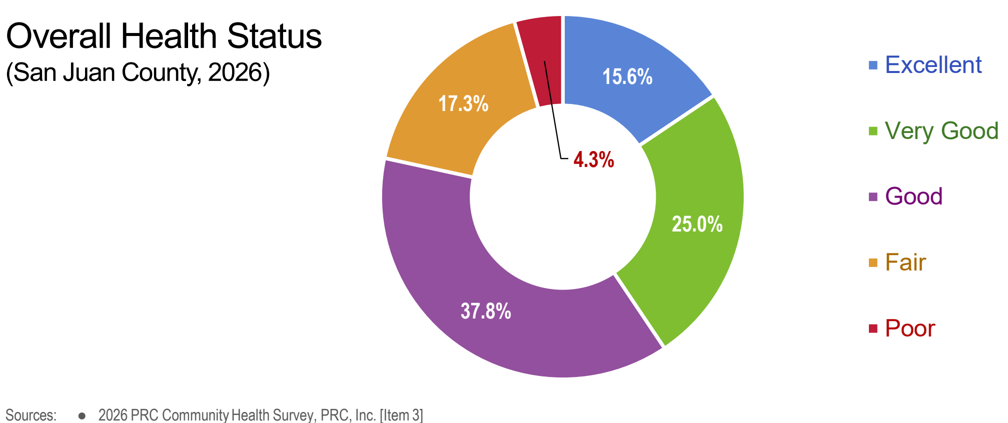
Physical Health

> Physical health from an early age. — Physician

HEALTH STATUS

Overall Health

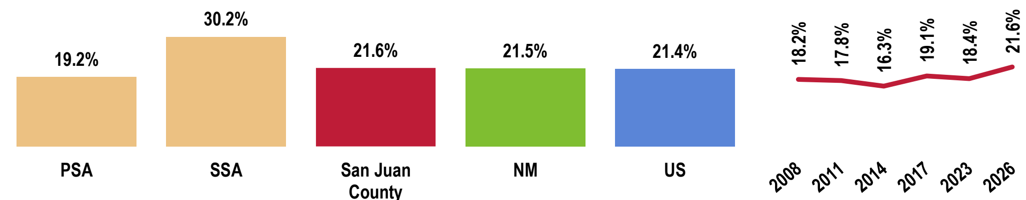
PRC SURVEY ▶ "Would you say that, in general, your health is: excellent, very good, good, fair, or poor?"



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 3]
Notes: ● Asked of all respondents.

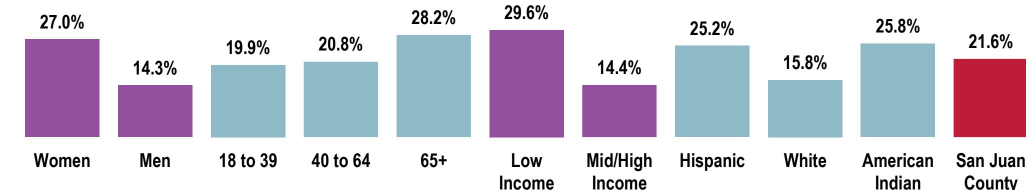
Experience "Fair" or "Poor" Overall Health

San Juan County



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 3]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(San Juan County, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 3]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

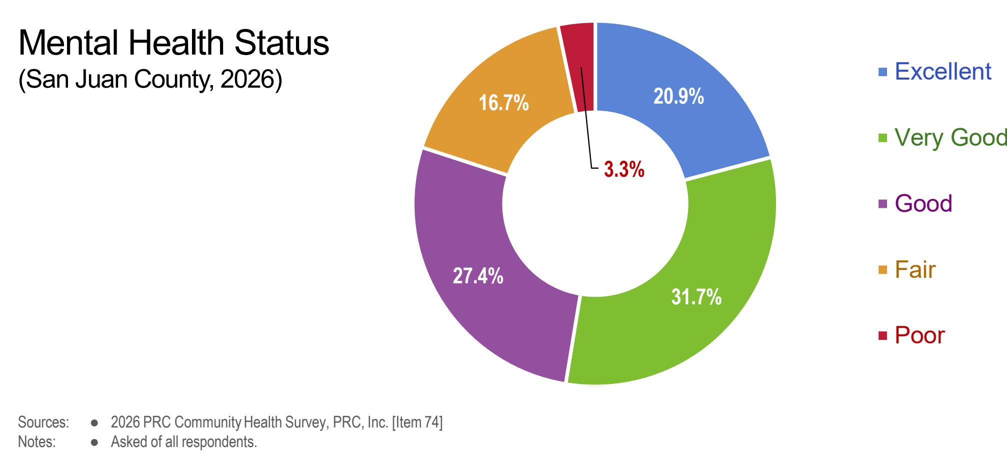
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030

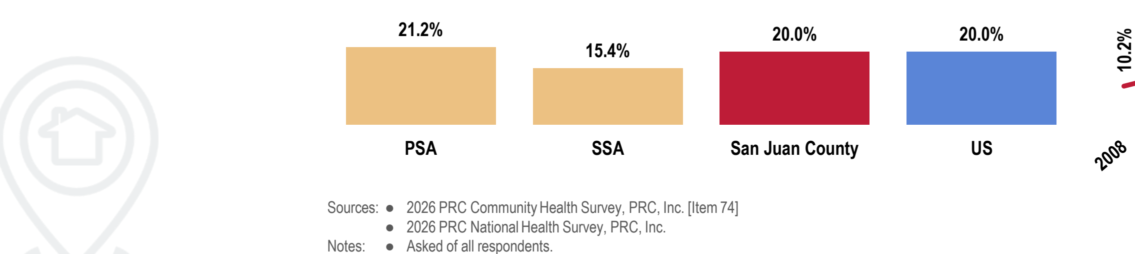
Mental Health Status

PRC SURVEY ▶ "Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Experience "Fair" or "Poor" Mental Health

San Juan County



Anxiety & Depression

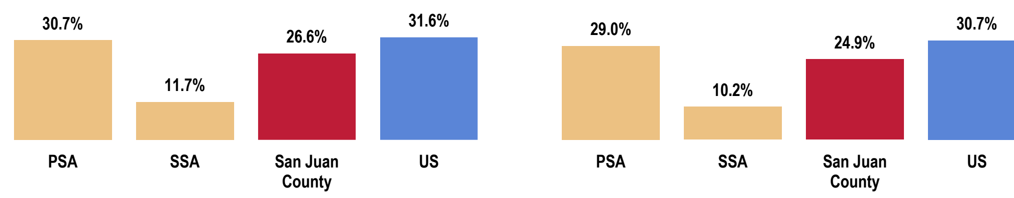
Diagnosed Anxiety & Depression

PRC SURVEY ▶ "Has a doctor, nurse, or other health professional ever told you that you have an anxiety disorder, including acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, posttraumatic stress disorder, or social anxiety disorder?"

PRC SURVEY ▶ "Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"

Have Been Diagnosed With an Anxiety Disorder

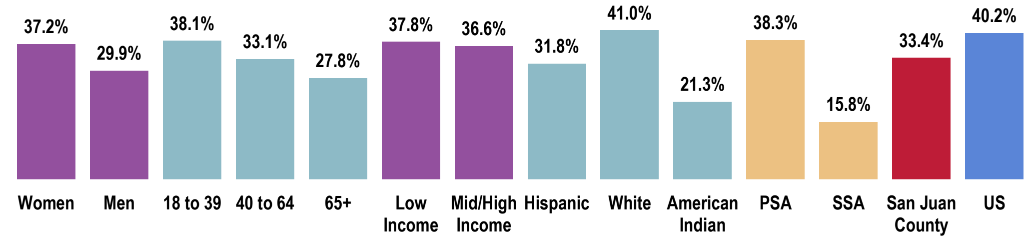
Have Been Diagnosed With a Depressive Disorder



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Items 75-76]
• 2026 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Anxiety disorders include acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, posttraumatic stress disorder, or social anxiety disorder.
• Depressive disorders include depression, major depression, dysthymia, or minor depression.

Diagnosed With Anxiety and/or Depression
(San Juan County, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 131]
• 2026 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
• Anxiety disorders include acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, posttraumatic stress disorder, or social anxiety disorder; depressive disorders include depression, major depression, dysthymia, or minor depression.

The Patient Health Questionnaire-4 (PHQ-4) was developed in order to address anxiety and depression, two of the most prevalent illnesses among the general population and often comorbid in nature.

The PHQ-4 is a four-item questionnaire allowing for ultra-brief and accurate measurement of core symptoms/signs of depression and anxiety. An elevated PHQ-4 score is not diagnostic but is an indicator for further inquiry to establish the presence or absence of a clinical disorder warranting treatment.

Signs or Symptoms of Anxiety & Depression

PRC SURVEY ▶ "During the past two weeks, how often have you been bothered by the following problems: feeling nervous, anxious, or on edge? Would you say nearly every day, more than half the days, several days, or not at all?"

PRC SURVEY ▶ "During the past two weeks, how often have you been bothered by the following problems: not being able to stop or control worrying? Would you say nearly every day, more than half the days, several days, or not at all?"

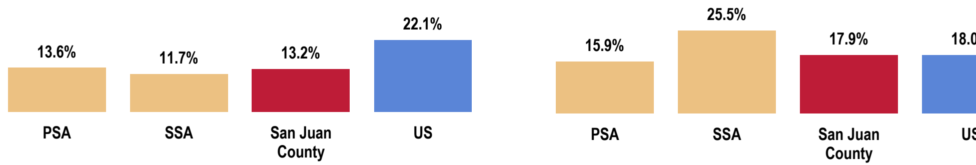
PRC SURVEY ▶ "During the past two weeks, how often have you been bothered by the following problems: feeling down, depressed, or hopeless? Would you say nearly every day, more than half the days, several days, or not at all?"

PRC SURVEY ▶ "During the past two weeks, how often have you been bothered by the following problems: feeling little interest or pleasure in doing things? Would you say nearly every day, more than half the days, several days, or not at all?"

Responses were scored according to how frequently each was experienced in the previous two weeks (nearly every day, more than half the days, several days, or not at all). Signs or symptoms of **anxiety** is determined based on the first two of these questions; signs or symptoms of **depression** is based on the last two.

Signs/Symptoms of Anxiety in the Past Two Weeks

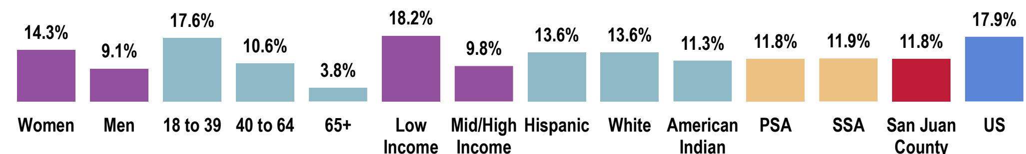
Signs/Symptoms of Depression in the Past Two Weeks



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 107-108]
● 2026 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents.
● Signs/symptoms of anxiety include being bothered by these problems in the past two weeks: feeling nervous, anxious, or on edge, and/or not being able to stop or control worrying.
● Signs/symptoms of depression include being bothered by these problems in the past two weeks: feeling down, depressed, or hopeless, and/or feeling little interest or pleasure in doing things.

Signs/Symptoms of Moderate-to-Severe Anxiety/Depression
(San Juan County, 2026)

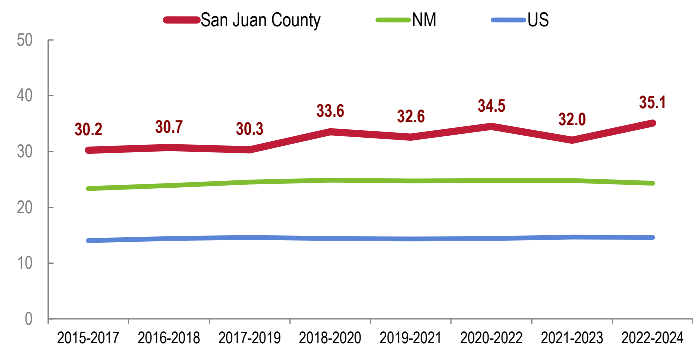


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 106]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Based on an elevated PHQ-4 score.

Suicide

The following chart outlines the most current mortality rates attributed to suicide in our population.

Suicide
Mortality Trends
(Annual Average Deaths per 100,000 Population)

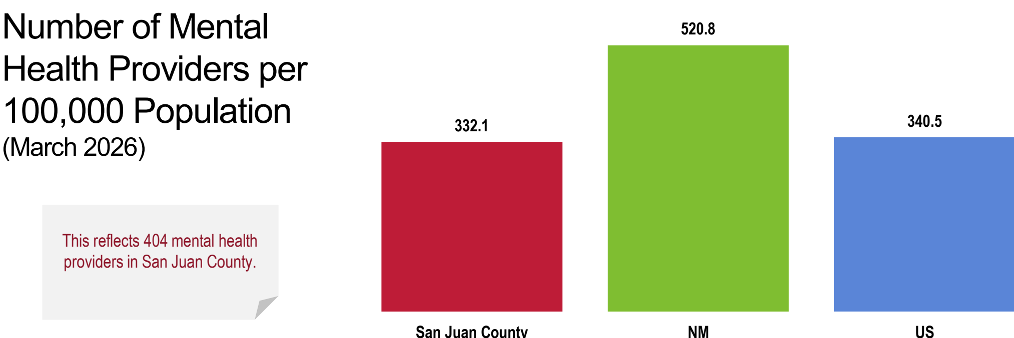


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Note that this indicator only reflects providers practicing within the study area and residents within the study area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

Mental Health Treatment

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) per 100,000 residents.

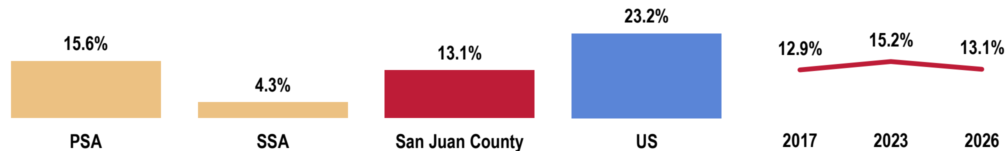


Sources: ● Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Notes: ● This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

PRC SURVEY ▶ "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

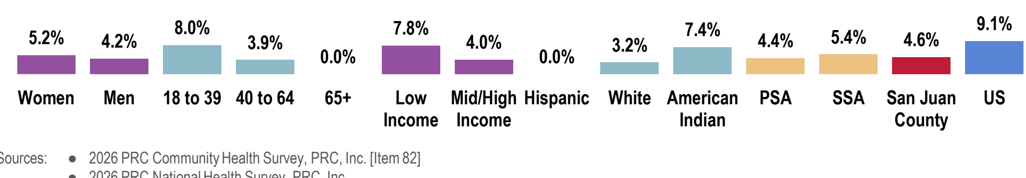


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 81]
● 2026 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents.
● Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

PRC SURVEY ▶ "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Unable to Get Mental Health Services
When Needed in the Past Year
(San Juan County, 2026)

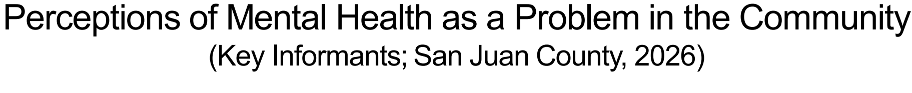


Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 82]
• 2026 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of Mental Health as a Problem in the Community
(Key Informants; San Juan County, 2026)



Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Lack of resources, not enough doctors. Not a big enough behavioral health program. — Health Care Provider
>
> There are long wait times and limited provider availability. There is no psychiatric provider in Aztec, which is needed. Many patients in Aztec need a local community psychiatric provider because of travel limitations/barriers. We are no longer able to put up education signs in our clinic about available services and support for mental health services or ways to reduce stress, because they do not follow our marketing guidelines. There are a lot of important education signs that we need up to help educate patients that our organization does not have. — Health Care Provider
>
> Access to care in general. — Physician
>
> Access to care. — Physician

> In the Four Corners region, we do not have any facilities to assist with mental health holds or proper evaluation. Patients who are a threat to themselves or others are generally processed through the hospital then must be moved to facilities hundreds of miles away. This is costly and very disruptive for the patients and family members. — Community Leader
>
> Access, limited providers, limited community resources. — Health Care Provider
>
> Getting into a provider as a new or urgent concern. The psychiatrists are mainly wanting to control medications, leaving the follow up to the psychologists, which are too few and busy. Any urgent concerns are simply sent to the ER, which will overload that system and generally involve multiple hours. Any inpatient services require significant travel to either Albuquerque, Santa Fe, or Las Cruces. — Community Leader
>
> Difficulty with access to care, very poor social support network. — Physician
>
> Inpatient beds, especially the elderly. — Health Care Provider
>
> Long wait times to get patients access to care; six months or more to get in with a counselor, similar wait times for seeing a psychiatrist/behavioral health specialist. — Health Care Provider
>
> Accessing regular care and obtaining needed prescriptions. — Physician
>
> Too many causes and not enough resources. — Health Care Provider
>
> Immediate access and availability of all levels of mental health services, lack of a statewide system of care for children/youth, autism spectrum disorder treatments, lack of licensed therapists, lack of evidence-based practices being required and trainings given to therapists, sometimes on the job learning and lack of practical skills. — Community Leader
>
> Access to mental health care. — Public Health Representative
>
> Access to crisis services. — Community Leader
>
> Lack of access to counseling and support. — Health Care Provider
>
> Not enough mental health especially for kids. — Health Care Provider
>
> Access to care. — Community Leader
>
> Access to care and quality Inpatient treatment. — Community Leader
>
> Access to mental health resources and providers throughout the state and the nation. There is just a lack of providers, and it can take months to get an appointment. There is still a stigma around sharing that you need to see a counselor or therapist. Inpatient medical care for mental health issues, especially for youth and children, is often provided outside of Farmington which makes it difficult for families or support systems. — Community Leader
>
> Extreme lack of access. People in crisis can again wait months and then have to travel out of the area for proper treatment. — Community Leader
>
> Access to care/not enough providers. — Community Leader
>
> The biggest challenge is the lack of longer-term behavior health clinicians, facilities, and after-care treatment. This is worse for juvenile mental health care. San Juan County is making strides, but the resources are not currently available. — Community Leader
>
> Lack of access. — Health Care Provider

Lack of Providers

> Not enough providers and even less providers providing excellent care. — Physician
>
> There are not enough mental health providers to meet the need of the community. — Health Care Provider
>
> Lack of providers. We finally now have two psychiatrists however that's likely not enough for our population. — Physician
>
> Scarcity of counselors and providers. — Physician
>
> Not enough counselor/psychiatrist/psychologist available to meet the need. — Health Care Provider
>
> Providers. — Health Care Provider
>
> Lack of providers and facilities, especially for children. — Health Care Provider
>
> Pediatric psychiatrists need. — Physician
>
> A critical shortage of behavioral health providers and resources. High rates of substance abuse, suicide, depression. — Community Leader

Trauma

> There are countless people with underlying childhood traumas with resultant depression and anxiety driving drinking and homelessness. We need a robust and culturally thoughtful addiction resource. Additionally, while building people with mental health issues like schizophrenia and bipolar often have significant difficulties in accessing care. — Physician

Prevention/Screening

> Mental illness is a pervasive problem. Furthermore, there are not many preventative efforts. Some mental illness will happen either way. Other mental illnesses may result from trauma or benefit from early intervention. We lack enough psychiatric providers. Many therapists do not accept Medicare. — Community Leader

Poverty

> There is a lack of social health for those who feel alienated, alone and rejected because participating in activities can take money. Children don't have a sense of neighborhood unless they are in an organization, youth team, church or big family. Many are on an iPad, social media or phone app. Unless parents get them to be more social, they appear to be isolated and keep to themselves. With the elderly, as they become widows or widowers, and as more friends of their generation die off, I guess the Senior Center provides a social outlet ... otherwise, it's the casino slots. — Community Leader

Emergency Department

> Mental health. Patients go in and out of emergency department getting a Band-Aid but no real treatment. — Community Leader

Psychological Growth

> Psychological growth at each individual level, which engenders responsibility, integrity, maturity, compassion and many other virtues. — Physician

Access for Medicare/Medicaid Patients

> Access to behavioral health professionals who accept Medicare and Medicaid. — Health Care Provider

Diagnosis/Treatment

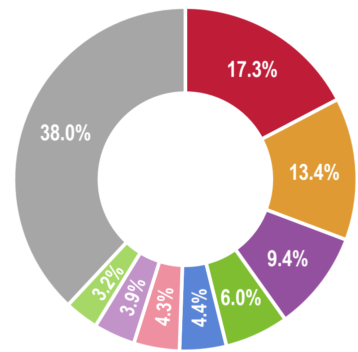
> Counseling and follow up from emergency care. — Physician

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

The following outlines leading causes of death in the community.

Leading
Causes of Death
(San Juan County, 2024)



- Heart Disease
- Cancer
- Unintentional Injuries
- Liver Disease
- Lung Disease
- Stroke
- Suicide
- Diabetes
- Various Other

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes: • Lung disease includes deaths classified as chronic lower respiratory disease.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

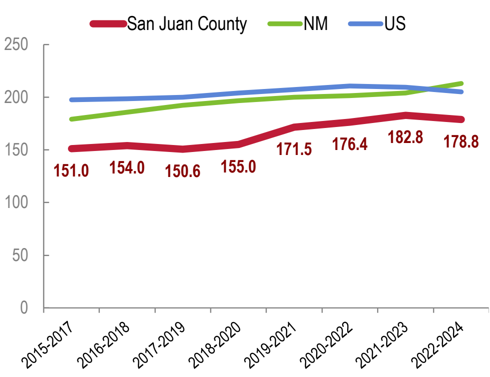
In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

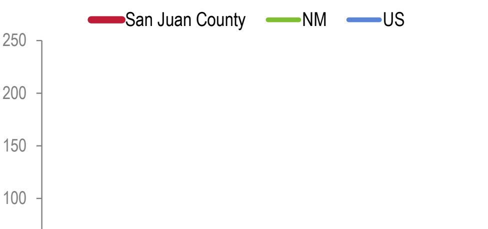
– Healthy People 2030

Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

The following charts outline mortality rates for heart disease and for stroke in our community.





Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

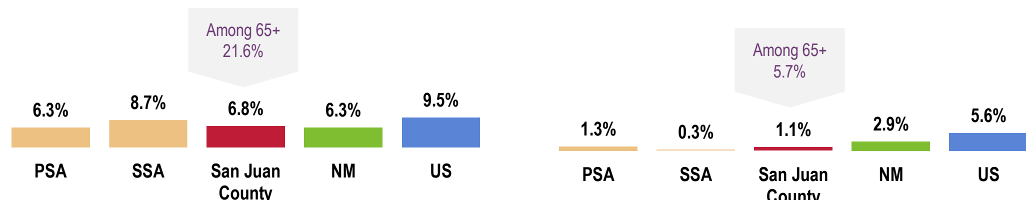
Prevalence of Heart Disease & Stroke

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with a stroke?"

Prevalence of Heart Disease

Prevalence of Stroke

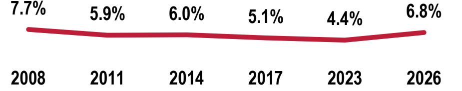


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 21-22]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
● 2026 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents.
● Heart disease includes diagnoses of heart attack, angina, or coronary heart disease.

Prevalence of Heart Disease
(San Juan County)

Prevalence of Stroke
(San Juan County)



4.2% 2.9% 3.0% 3.3% 4.9% 1.1%

2008 2011 2014 2017 2023 2026

Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 21-22]

Notes: ● Asked of all respondents.
● Heart disease includes diagnoses of heart attack, angina, or coronary heart disease.

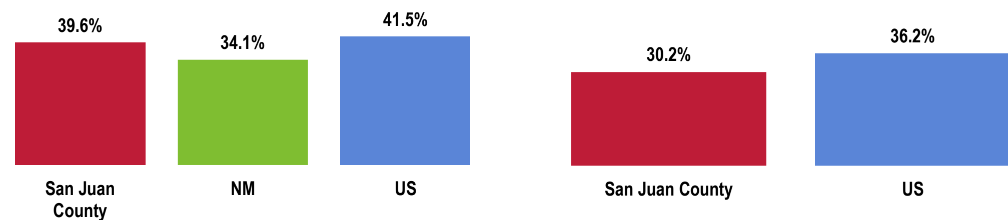
Blood Pressure & Cholesterol

PRC SURVEY ▶ "Have you ever been told by a doctor, nurse, or other health professional that you had high blood pressure?"

PRC SURVEY ▶ "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?"

Prevalence of
High Blood Pressure
Healthy People 2030 = 41.9% or Lower

Prevalence of
High Blood Cholesterol

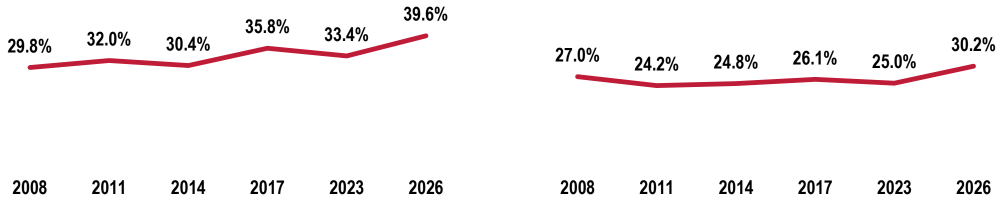


San Juan County | NM | US | San Juan County | US

Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Mexico data.
● 2026 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030.
Notes: ● Asked of all respondents.

Prevalence of
High Blood Pressure
(San Juan County)
Healthy People 2030 = 41.9% or Lower

Prevalence of
High Blood Cholesterol
(San Juan County)



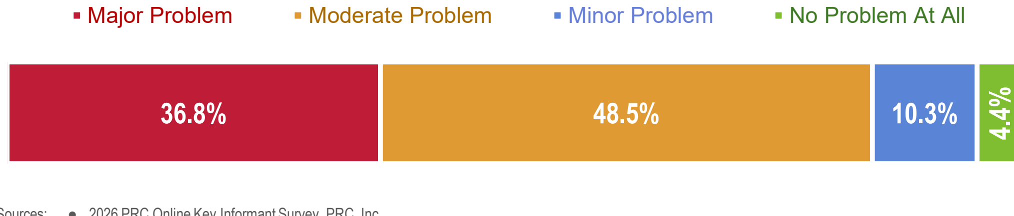
2008 2011 2014 2017 2023 2026 | 2008 2011 2014 2017 2023 2026

Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● US Department of Health and Human Services. Healthy People 2030.
Notes: ● Asked of all respondents.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:

Perceptions of Heart Disease & Stroke as a Problem in the Community
(Key Informants; San Juan County, 2026)



Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Unhealthy population with lots of risk factors for heart diseases and stroke. — Health Care Provider
>
> A friend who retired in May died of a massive stroke on Jan. 23. I come across people in their 60s and 70s who mentioned that they had a minor stroke, went through rehab and appear to be doing fine. Deaths from heart attacks or surgeries to stay alive seem more common. — Community Leader
>
> Patient population. — Health Care Provider
>
> Lots of patients with them. — Physician
>
> High prevalence. — Physician
>
> Heart disease is still a major problem across the country. Even with all of the education and PR around eating healthy and exercise, many people still are affected. Also, strokes are becoming more common in younger people ages 20 to 40. — Community Leader

Access to Care/Services

> I had chest pain in March and called SJHP Cardiology and they couldn't see me until July, so I went to Durango. — Health Care Provider
>
> Lack of providers and facilities. — Health Care Provider
>
> Because it takes literally months to get in to see a cardiologist. When you do see them, they look exhausted all the time. — Community Leader
>
> Lack of primary care to prevent this. — Health Care Provider

Comorbidities

> Both are comorbidities related to diabetes, obesity, lack of exercise, and poor nutrition, which are prevalent in our community. — Health Care Provider
>
> Patients are admitted to the hospital daily with heart disease and stroke, which are driven by preventable risk factors including diabetes, hypertension, hyperlipidemia. Many of the presenting patients struggle with affordability of medications and access to care which further exacerbates the problem. — Physician
>
> Due to a combination of high prevalence risk factors, including smoking and socioeconomics. Key reasons, prevalence of risk factors, diabetes rates, lifestyle factors, environmental factors, social determinants of health, aging population. — Community Leader

Lifestyle

> Diet, lack of exercise, health literacy. — Health Care Provider
>
> Usually, our older patients are less active and overweight along with improper diet all in which will contribute to heart disease. These are the biggest contributors to heart disease. — Community Leader

Prevention

> Lack of early intervention, poor diets and exercise, hard to access health foods for rural populations. Many people do not access preventive care or do not access care until it is too late. — Community Leader

Health Literacy

> Poor health literacy, poor access to healthy diets, lack of physical activity. People are not able to afford medications and food. — Health Care Provider

Affordable Care/Services

> These conditions lead to socioeconomic difficulties with managing the long-term outcomes of these conditions. — Community Leader

Cancer

ABOUT CANCER

The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social drivers of health, including education, economic status, and access to health care.

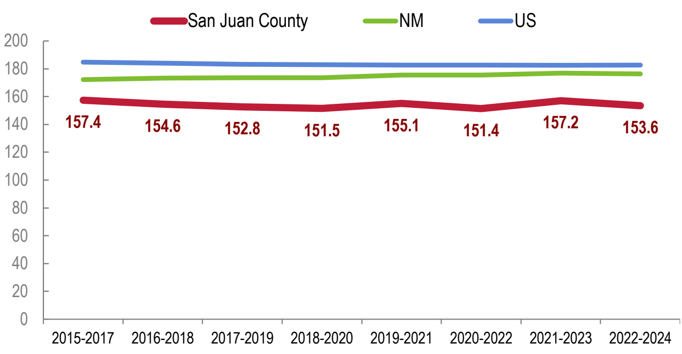
Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030

Cancer Deaths

The following chart illustrates cancer mortality (all types).

Cancer Mortality Trends
(Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Female breast cancer is the leading cause of cancer deaths.

Cancer Death Rates by Site
(2022-2024 Annual Average Deaths per 100,000 Population)

	San Juan County	New Mexico	US
ALL CANCERS	**153.6**	176.4	182.6
Female Breast Cancer	**25.6**	27.5	25.1
Prostate Cancer	**24.6**	24.1	20.4
Lung Cancer	**23.8**	27.6	38.9
Colorectal Cancer	**17.7**	17.0	16.4

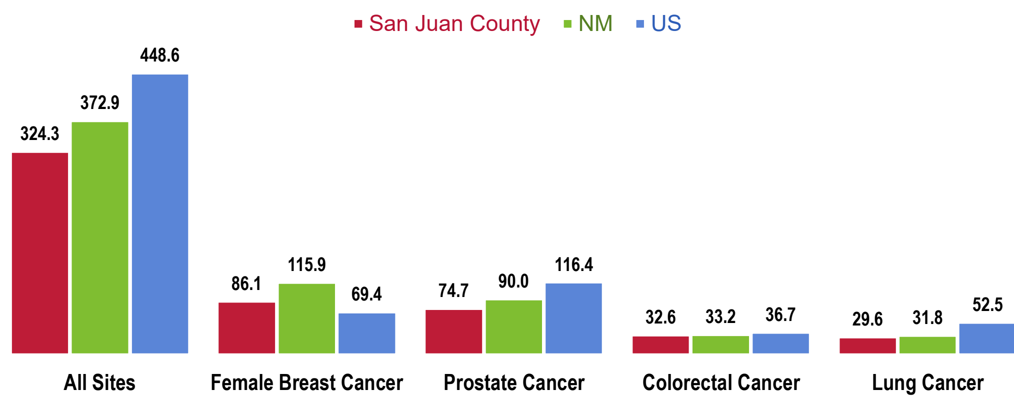
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. It is usually expressed as cases per 100,000 population per year.

Cancer Incidence Rates by Site
(2018-2022)

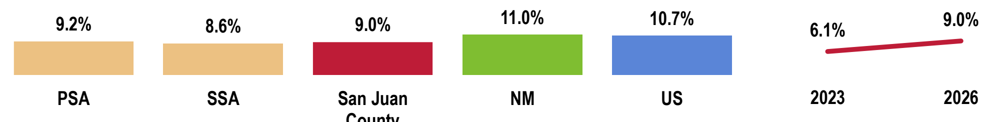


Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Prevalence of Cancer

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with cancer?"



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cancer Screenings

Cancer screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 40 to 74 years (Grade B recommendation). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women 75 years or older.

CERVICAL CANCER

The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years (Grade A recommendation). The USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with hrHPV testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing) in women age 40 to 65 years (Grade A recommendation). The USPSTF recommends against screening for cervical cancer in women younger than 21 years (Grade D recommendation). The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer (Grade D recommendation). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion or cervical cancer (Grade D recommendation).

COLORECTAL CANCER

The USPSTF recommends screening for colorectal cancer in all adults age 50 to 75 years (Grade A recommendation). The USPSTF recommends screening for colorectal cancer in adults age 45 to 49 years (Grade B recommendation). The USPSTF recommends that clinicians selectively offer screening for colorectal cancer in adults age 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences (Grade C recommendation).

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Breast Cancer Screening

PRC SURVEY ▶ **"A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"**

Breast cancer screening is calculated here among women age 40 to 74 who indicate mammography within the past two years.

Cervical Cancer Screening

PRC SURVEY ▶ **"A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"**

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 65.

Colorectal Cancer Screening

PRC SURVEY ▶ "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

PRC SURVEY ▶ "Have you ever had any other kind of test for colorectal cancer, such as a virtual colonoscopy, CT colonography, blood stool test, FIT DNA, or a Cologuard test?"

PRC SURVEY ▶ "Which of these did you have most recently?"

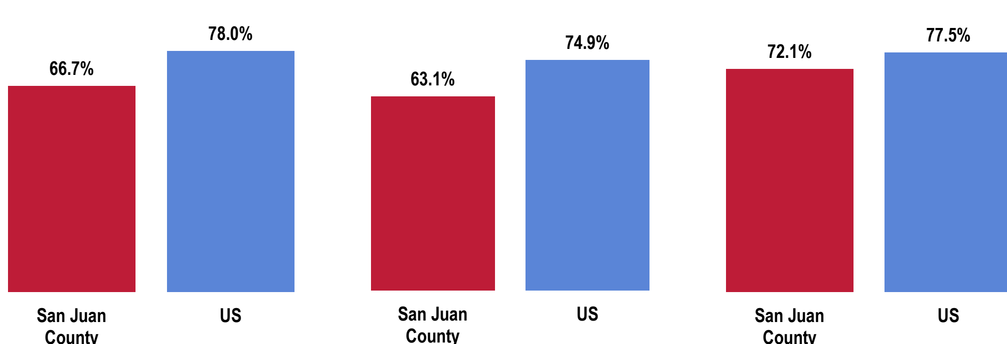
PRC SURVEY ▶ "About how long ago did you have this test?"

"Appropriate colorectal cancer screening" reflects individuals age 45 to 75 who received any of the following: colonoscopy/sigmoidoscopy in the past 10 years; CT colonography/virtual colonoscopy in the past five years; FIT DNA in the past three years; or fecal occult blood testing/FIT (non-DNA) in the past year.

Breast Cancer Screening
(Women 40-74)
Healthy People 2030 = 80.3% or Higher

Cervical Cancer Screening
(Women 21-65)
Healthy People 2030 = 79.2% or Higher

Colorectal Cancer Screening
(All Adults 45-75)
Healthy People 2030 = 72.8% or Higher



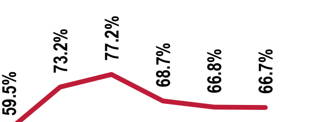
San Juan County | US | San Juan County | US | San Juan County | US

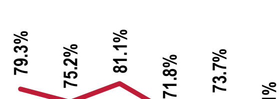
Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Items 101-103]
• 2026 PRC National Health Survey, PRC, Inc.
• US Department of Health and Human Services. Healthy People 2030.
Notes: • Each indicator is shown among the gender and/or age group specified.

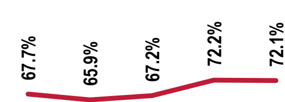
Breast Cancer Screening
(Women 40-74)
Healthy People 2030 = 80.3% or Higher

Cervical Cancer Screening
(Women 21-65)
Healthy People 2030 = 79.2% or Higher

Colorectal Cancer Screening
(All Adults 45-75)
Healthy People 2030 = 72.8% or Higher





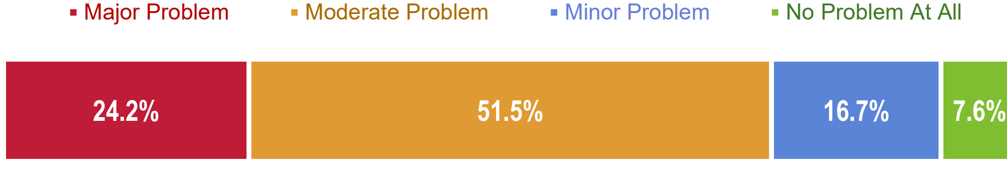


Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Items 101-103]
• US Department of Health and Human Services. Healthy People 2030.
Notes: • Each indicator is shown among the gender and/or age group specified.
• Note that trend data for breast cancer screening reflect the age group (50 to 74) of the previous recommendation.
• Note that trend data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:

Perceptions of Cancer as a Problem in the Community
(Key Informants; San Juan County, 2026)



Sources: ● 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> We see a high number of cancer patients, and it affects all ages. — Health Care Provider
>
> Working in the hospital, I see a lot of patients with cancer diagnoses. And there is only one oncology center here with what seems like limited resources. Possible causes I believe could be prevalence of alcohol, smoking, marijuana, recreational drugs, water supply, food sources environmental. — Health Care Provider
>
> We have high cancer rates. — Health Care Provider
>
> High rates. Poor access and follow up. — Physician

Access to Care/Services

> People are having to go to UNM or Mayo or other places to receive care. This puts a burden on the individual and family's costs for treatment, hotels, food, transportation, etc. — Community Leader
>
> Access to care can be weeks or more. Care options, especially surgical, are limited depending on the cancer, as might be expected for a rural setting. However, referral destinations in state are inundated and overburdened. — Physician
>
> Not accessible, only a few oncologists available for cancer treatment. — Health Care Provider

Environmental Contributors

> People are exposed to carcinogens in plastic containers, food sources, additives, pesticides and herbicides in food, water and air, even clothing with chemicals. I have noticed people are using walkers, canes and appear unhealthy, even people younger than 50 years of age. — Community Leader
>
> One concern in the Farmington area, based on environmental reports. Chemical contaminants in the local rivers. Health care access barriers: poverty, high number of citizens on welfare, generational lack of education, long distances to specialists, delayed diagnosis and treatment due to government shutdowns and lack of physicians due to state malpractice laws. — Community Leader

Leading Cause of Death

> For a community of this size, I know of a very large number of people who have, have had, or died as a result of cancer. It seems to be a high proportion of the population. Many people travel to Houston, Mayo Scottsdale and other major medical centers for treatment, which points back to access. — Community Leader

Government/Policy

> Everyone is getting cancer. It's terrifying the way the government and industries have poisoned us. — Community Leader

Lack of Providers

> Lack of oncologists and local resources/cutting edge care for various cancer types. — Physician

Respiratory Disease

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

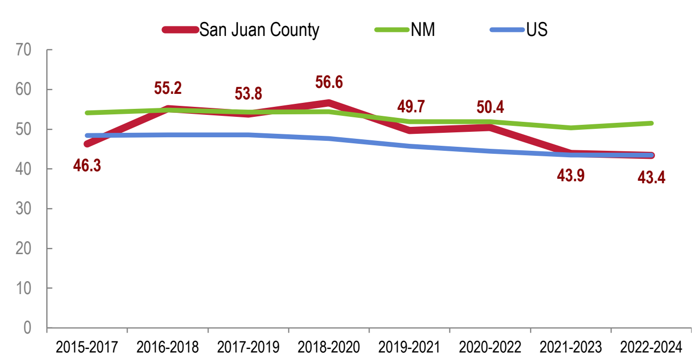
– Healthy People 2030

Respiratory Disease Deaths

Lung Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for lung disease is illustrated in the chart that follows.

Lung Disease Mortality Trends
(Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Pneumonia/Influenza Deaths

Pneumonia and influenza mortality is illustrated here.

Pneumonia/Influenza Mortality Trends
(Annual Average Deaths per 100,000 Population)

San Juan County | NM | US

30
25
20
15
10
5
0

	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023	2022-2024
San Juan County	12.7	14.8	16.7	14.8	15.0	19.0	24.3	22.4

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

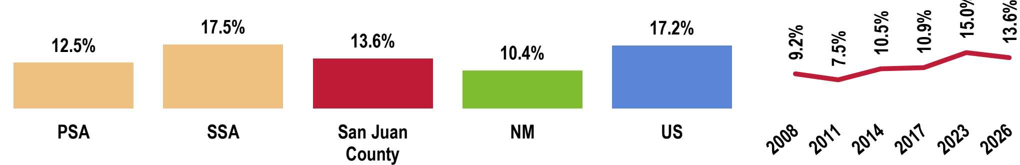
Prevalence of Respiratory Disease

Asthma

PRC SURVEY ▶ "Do you currently have asthma?"

Prevalence of Asthma

San Juan County



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 25]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
● 2026 PRC National Health Survey, PRC, Inc.

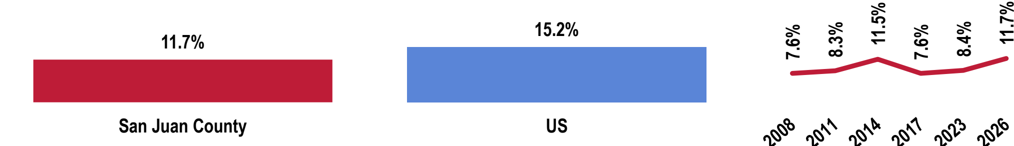
Notes: ● Asked of all respondents.

For households with more than one child under the age of 18, questions were asked about the child with the most recent birthday. This random-selection process allows for the best representation of children by age and gender.

PRC SURVEY ▶ [Among parents of children age 0-17] **"Has a doctor, nurse, or other health professional ever told you that this child had asthma?"**

Prevalence of Asthma in Children
(Children 0-17)

San Juan County



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 93]
- 2026 PRC National Health Survey, PRC, Inc.

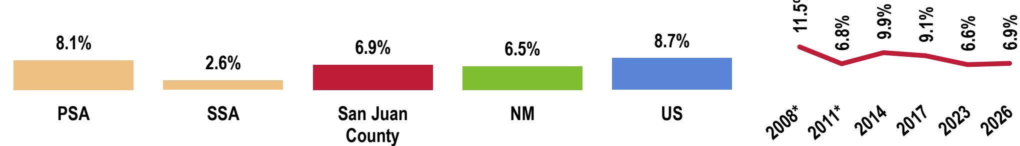
Notes:
- Asked of all respondents with children age 0 to 17 in the household.

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including chronic bronchitis or emphysema?"

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)

San Juan County

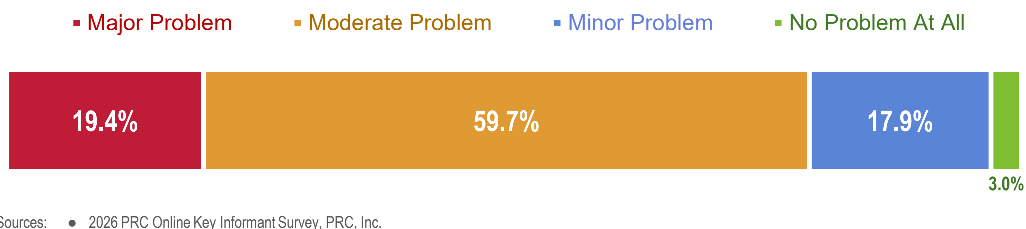


Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and emphysema.
- *In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Lack of Providers

> Not enough providers. SJRMC has one pulmonologist that sees patients only Friday; appointments are months to make. — Community Leader
>
> Not enough pulmonologists. — Health Care Provider

Obesity

> Overweight and underactive patients. Asthma is a big problem in children with limited resources for pulmonology. — Health Care Provider

Tobacco Use

> Smoking, high level of occupational exposure. Recently recruited two pulmonary physicians, but prior there was very limited pulmonary care in the community. — Physician

Environmental Contributors

> Environmental. — Health Care Provider

Work Related

> Occupational hazards. — Physician

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

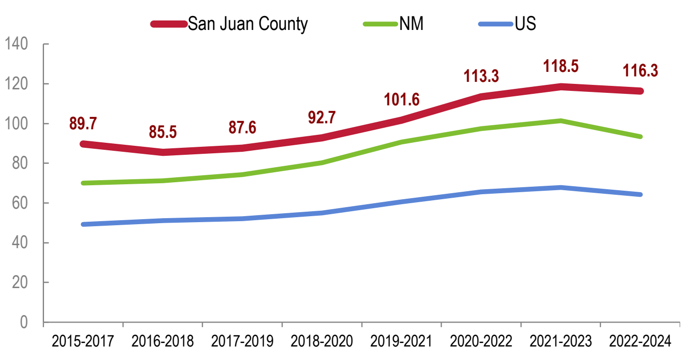
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030

Unintentional Injury Deaths

The following chart outlines mortality rates for unintentional injury in the area.

Unintentional Injury Mortality Trends
(Annual Average Deaths per 100,000 Population)



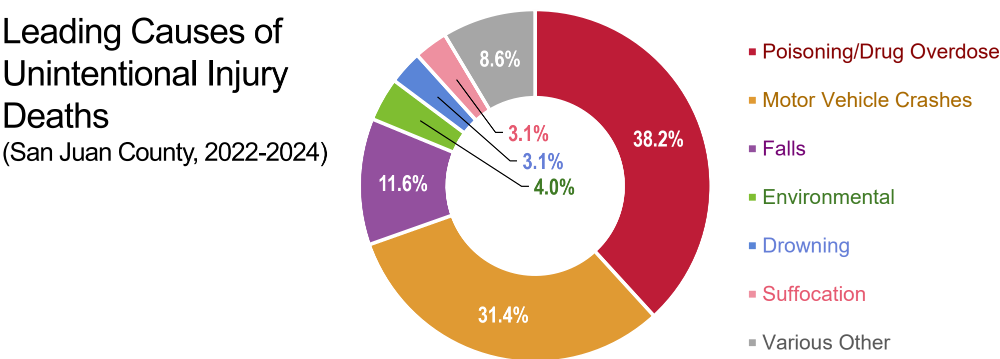
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

RELATED ISSUE
For more information about unintentional drug-induced deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.

The following outlines leading causes of accidental death in the area.

Leading Causes of Unintentional Injury Deaths
(San Juan County, 2022-2024)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

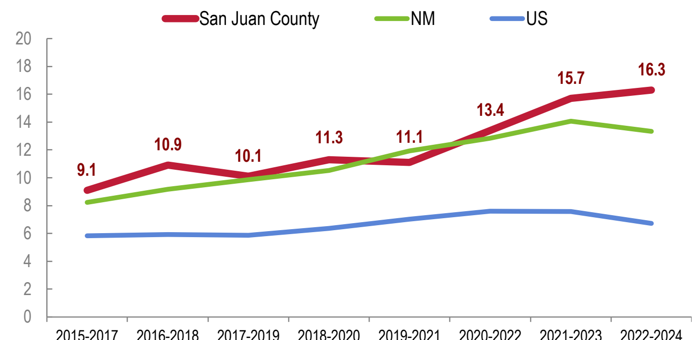
Intentional Injury

Homicide

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Mortality attributed to homicide is shown in the following chart.

Homicide Mortality Trends
(Annual Average Deaths per 100,000 Population)

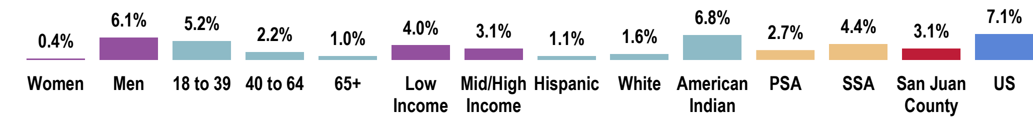


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population.

Violence

PRC SURVEY ▶ "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past five years?"

Victim of a Violent Crime in the Past Five Years
(San Juan County, 2026)



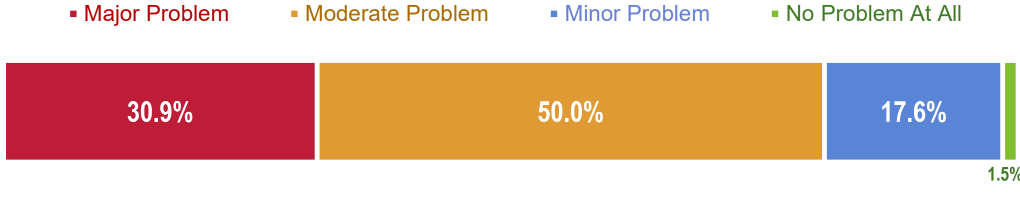
Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 32]
• 2026 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury & Violence as a Problem in the Community
(Key Informants; San Juan County, 2026)

▪ Major Problem ▪ Moderate Problem ▪ Minor Problem ▪ No Problem At All



Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Alcohol/Drug Use

> Alcohol usage, one of the leading substance abuses in our county. — Public Health Representative
>
> Lots of drug- and alcohol-related violence and injury seen in the hospital daily. — Physician
>
> Domestic violence connected to substance abuse, rural roads that are not well lit can lead to injury and violence. I don't think Farmington is any more or less dangerous than other communities, but I do feel that people can feel frustrated here with some of the closures the large employers in the energy sector. I feel Farmington is a safe community, but San Juan County is a very large county with much of the population earning below the national average or at the poverty level. This can lead to dangerous choices. There is also a lack of mental health professionals and providers that could help people process and work through some of the issues they are facing. — Community Leader

Domestic/Family Violence

> Domestic abuse is a major cause of emergency room visits and resultant injuries here. — Physician
>
> Lots of violence seen in emergency department. Domestic violence. — Physician
>
> Very high rate of domestic violence in the community with limited access. — Health Care Provider
>
> Domestic violence associated with substance abuse and socioeconomic challenges. — Community Leader

Incidence/Prevalence

> I see a lot of patients come in that have been assaulted. — Health Care Provider
>
> Because injuries are main reason for emergency department visits. — Physician
>
> 2023 CHNA identified this as a high and among the county's leading cause of death. Many residents are injured by preventable injuries including accidents, violence, and substance related events. This includes multiple MVCs, especially along 550 towards Durango. Alcohol-related accidents and crashes. The state should implement a 'do not sell alcohol' on drivers licenses. Aztec is also a hub for drugs. Domestic violence is high along with child abuse. — Health Care Provider

Unhoused Populations

> I see the most injury and violence among our street population, and it is also fueled by substance abuse. Furthermore, we continue to see problems with domestic violence. — Community Leader
>
> In my opinion, we have a quite large homeless population that are seen wondering throughout town, with many older buildings that are abandoned and broken into. Working in the hospital, I see a lot of patients come through with gunshot wounds, stabbings, and hit and run accidents. Seems like there are a lot of homeless that come to the hospital after being hit by vehicles, but I have also seen and heard of a lot of homeless that will lay down in the middle of a roadway or walk in the roadways punching and swinging at vehicles. — Health Care Provider

Income/Poverty

> Driven by high rates of poverty, substance abuse, a sharp rise in violent juvenile crime, including armed robberies and car theft. Domestic and sexual violence, high rates of suicide and high number of DWI repeat offenders. According to law enforcement, challenges with legal limitations on juvenile discipline. San Juan County ranks seventh for domestic violence: death by unintentional injury. — Community Leader

Law Enforcement

> Domestic violence resourses are slim to none. — Health Care Provider

Diabetes

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it’s the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don’t know they have it.

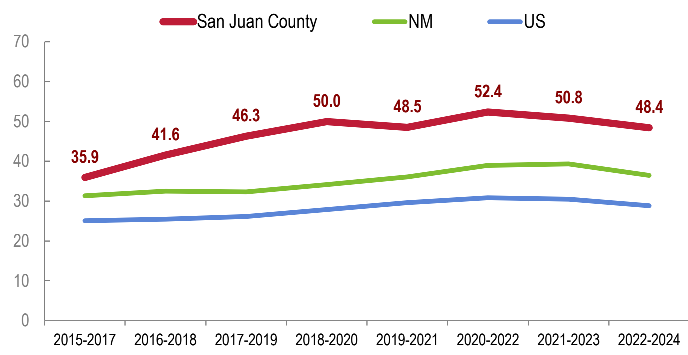
Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don’t have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030

Diabetes Deaths

Diabetes mortality for the area is shown in the following chart.

Diabetes Mortality Trends
(Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population.

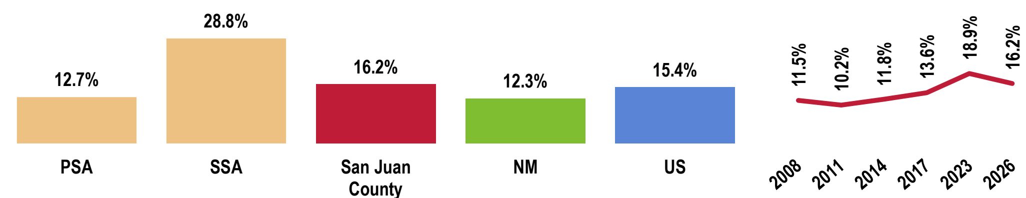
Prevalence of Diabetes

PRC SURVEY ▶ "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

PRC SURVEY ▶ "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

Prevalence of Diabetes

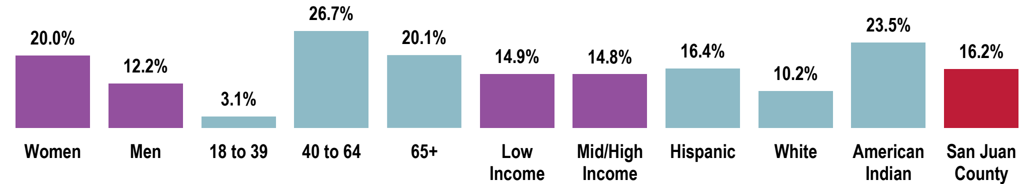
Another 16.3% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 104]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(San Juan County, 2026)



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 104]

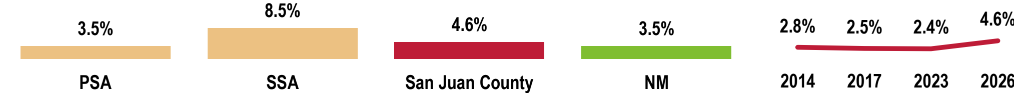
Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Kidney Disease

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with kidney disease?"

Prevalence of Kidney Disease

Healthy People 2030 = 11.4% or Lower



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 303]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.

Prevalence of Kidney Disease

(San Juan County, 2026)

Healthy People 2030 = 11.4% or Lower

Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 303]
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:

Sources: ● 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

Accessing education, medications that cost too much, affording food. — Health Care Provider

Education about diet and lifestyle is lacking. — Physician

Education, health literacy, advanced management, frequency of follow up. — Health Care Provider

Low health literacy and poor prescribing habits by many health care professionals. — Physician

The biggest problem that I think is that there are not enough education programs around teaching correct eating habits and exercise. There are no exercise programs that are affordable to help people with weight loss and diabetes prevention. — Public Health Representative

Adequate professional help in, first of all, understanding diabetes. Diabetes is a terrible disease affecting 80% of our population. Diet and exercise are a big part of it; however, understanding the consequences of not addressing issues from the early stages of the disease is critical. Giving the patient the tools to visually see what is happening to their body with high sugar levels would drastically help in combating diabetes. Insulin pumps, blood sugar sensors are the most effective way for patients to see and get the picture of how to control blood sugar levels. — Community Leader

Management and access to education, because the Navajo population has a significant amount of people living on the reservation. They do not have access to healthy food choices. — Health Care Provider

Very limited access to diabetic education, both initial and follow up education. Individuals living with advanced diabetes have to overcome an enormous learning curve to achieve adequate glycemic control. — Health Care Provider

Proper education about diabetes management and care. — Physician

Understanding what it means, the consequences of diabetes, the importance of managing it, the role of foods. Everything related to diabetes. — Health Care Provider

Education of severity of health issue/consequences if untreated or ignored. Effective treatment programs and motivation of individuals to make life changes to correct. — Community Leader

Access to Care/Services

Difficulty with close outpatient follow up regarding people with poorly controlled diabetes. — Physician

No availability for access to endocrinologist. Limited obesity management that does not focus on surgical management. — Health Care Provider

The education and resources are there. I feel the problem is many of those who struggle with diabetes might also struggle with accessing resources online. If classes are held in person, then they struggle with transportation or child care or time off from work to take the classes. Healthy food options are available in our community but are often more expensive than more processed or unhealthy food options. With so many of the dollar store businesses opening up, they are often the place where some shop for food, and the choices provided are limited in terms of fresh fruits or vegetables. — Community Leader

No endocrinology service. This is a major problem. — Health Care Provider

Access to an endocrinologist. — Physician

Access to providers. — Health Care Provider

Access to primary care that are willing to manage complicated diabetic patients and endocrinology. — Health Care Provider

Access to doctor and prescription costs. — Community Leader

Comprehensive wraparound services that address psychosocial and lifestyle modifications to support disease management. — Public Health Representative

Incidence/Prevalence

There are too many people with diabetes, mainly from being overweight. — Community Leader

High number of patients, poor control and poor access. — Health Care Provider

Diabetes. — Community Leader

About 70% of my patients suffer from some form of diabetes. — Physician

Disease Management

Blood sugar control/compliance, end stage renal failure/dialysis. — Community Leader

Lack of desire to control early signs and symptoms of type 2 diabetes. There are resources available to help educate that group of patients, but they seem to not understand the severity or gravity of the situation long term. — Community Leader

Glycemic control, multi organ dysfunction related to chronic poor glycemic control, noncompliance. — Physician

Nutrition

Diet, education and access. — Health Care Provider

Nutrition, health literacy, physical activity. — Health Care Provider

I suspect diet and lifestyle modification difficulties. — Health Care Provider

Lack of Providers

Lack of PCPs. — Health Care Provider

No endocrinologist or people to manage pumps. — Physician

Social Drivers of Health

I believe diabetes is the single largest underlying health problem in our community that is entirely by social determinants of health and further exacerbated by discontinuity of care across our systems and counties. While we have a suboptimal, informal diabetes education program and a formal outpatient one, we are overall failing our entire population in management of diabetes across systems. Appropriate medication management, attention to management and education are the biggest management fails. As a result, we have a huge burden of ESRD, neuropathy complicated by diabetic foot ulcers and loss of limbs, acute MIs, strokes, severe PAD, and more. We need a more insensitive inpatient and outpatient management strategy to address diabetes in our community. — Physician

Genetics

My impression is that diabetes in our community is mostly due to genetics and poverty. Minimizing the genetic link takes education and an ability to afford quality foods, i.e. not highly processed, not fast foods, not chemically laden foods. Education again is impacted by access. — Community Leader

Income/Poverty

People in our community who are very low income, struggle with SMI or SUD, or are living on the streets, have a hard time managing diabetes. Insulin can be tricky to manage when you do not have access to shelter or a fridge. Furthermore, some of the other health conditions, such as alcohol abuse, contribute to the onset of the disease. — Community Leader

Vulnerable Populations

Our population is ethnically more prone to diabetes. Our communities don't offer a good variety of healthy food choices to combat this issue. — Community Leader

Diagnosis/Treatment

Basic treatment is lacking, a lot of diabetes goes uncontrolled until late-stage complications such as kidney disease/retinopathy, etc. We do not have any endocrinology services in the region. — Physician

Follow-Up/Support

Access to frequent follow up to manage diabetes. Poor understanding of nutrition or poor/limited food choices. — Health Care Provider

Impact on Quality of Life

> Once you begin dialysis, it takes its toll on the human body. — Community Leader

Affordable Medications/Supplies

> Affordability to medication and education on prevention and management. — Health Care Provider

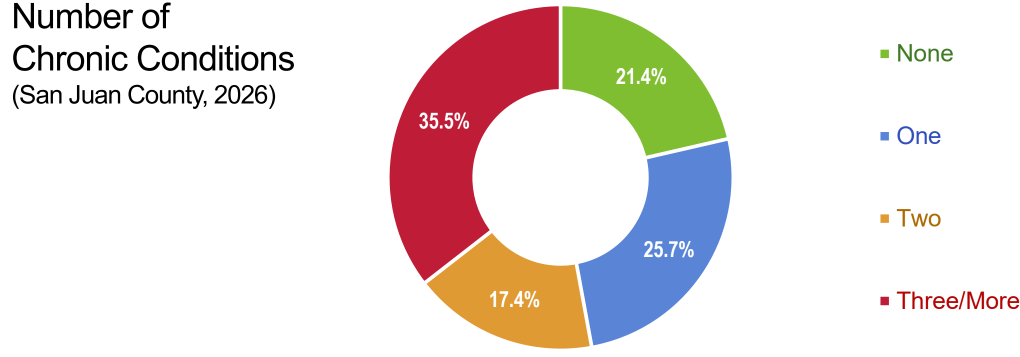
Disabling Conditions

Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

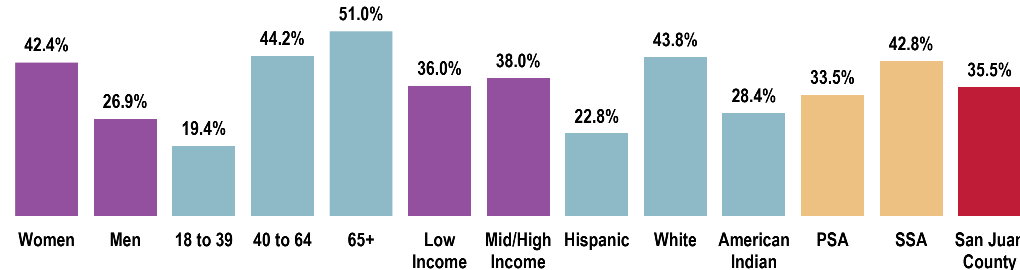
- Asthma
- Cancer
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Stroke

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 105]
Notes: • Asked of all respondents.
• In this case, chronic conditions include asthma, cancer, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

Have Three or More Chronic Conditions
(San Juan County, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 105]
Notes: • Asked of all respondents.
• In this case, chronic conditions include asthma, cancer, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

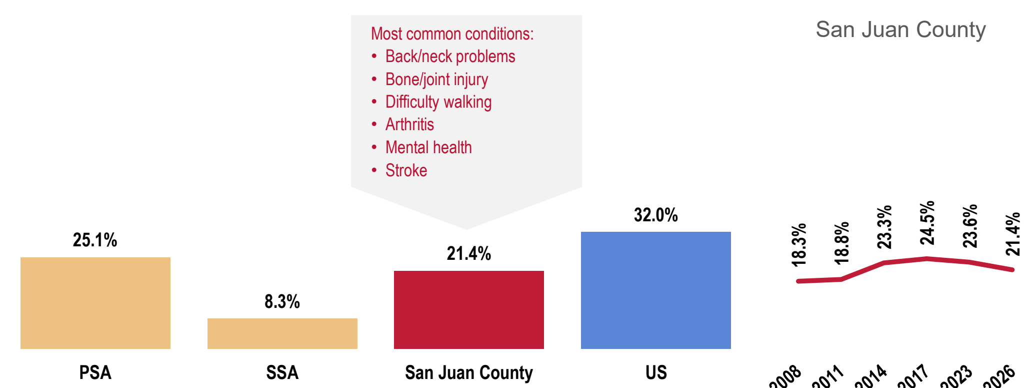
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030

PRC SURVEY ▶ **"Are you limited in any way in any activities because of physical, mental, or emotional problems?"**

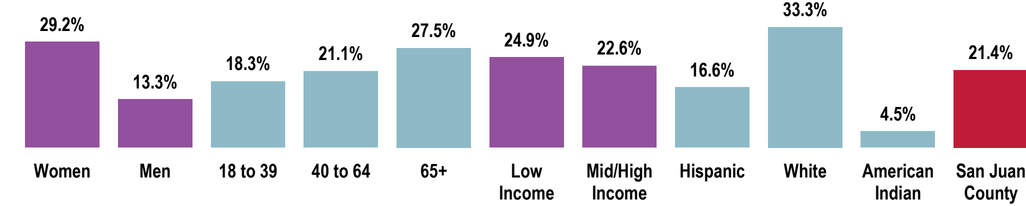
PRC SURVEY ▶ [Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**

Limited in Activities in Some Way
Due to a Physical, Mental, or Emotional Problem



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 83-84]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem
(San Juan County, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: • Asked of all respondents.

Alzheimer’s Disease

ABOUT DEMENTIA

Alzheimer’s disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

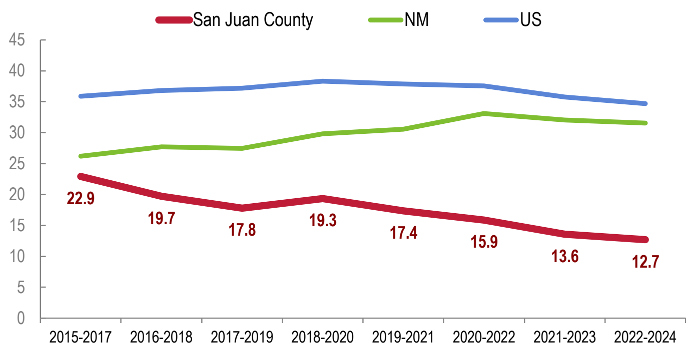
While there’s no cure for Alzheimer’s disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030

Alzheimer’s Disease Deaths

Alzheimer’s disease mortality is outlined in the following chart.

Alzheimer's Disease Mortality Trends
(Annual Average Deaths per 100,000 Population)



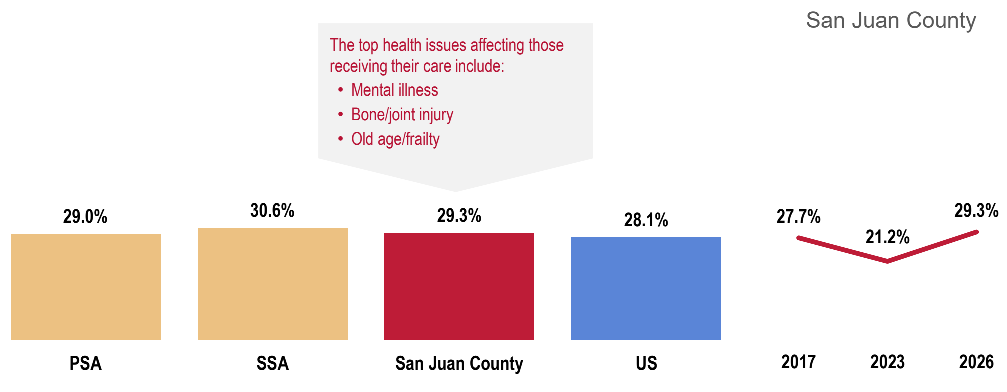
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Caregiving

PRC SURVEY ▶ "People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

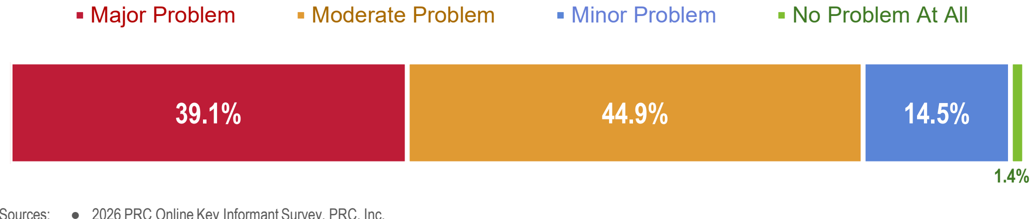
PRC SURVEY ▶ [Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 85-86]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Disabling Conditions

The following chart outlines key informants' perceptions of the severity of *Disabling Conditions* as a problem in the community:



Sources: ● 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> This is based on the patient population I have seen. — Physician
>
> Because there are a lot of people with these conditions in the community that I encounter. — Physician
>
> Many individuals suffer from disabling conditions in the community. Some of these conditions arose from other conditions (victim of a violent crime or diabetes, etc.), and others simply lack resources. Individuals with dementia often cannot access long-term care unless they are Medicaid patients. — Community Leader
>
> Dementia, child and adolescent behavioral issues, CKD on dialysis, ETOH and meth addiction, psychological trauma. Minimal child psychiatry services, addiction services. — Health Care Provider

> Chronic pain and dementia are both issues in the community. There is not great outpatient services for medications related to chronic pain, ex. physicians who are comfortable with this, and not enough neurology/access. Especially for Geri-psych. — Physician
>
> I see too many individuals using wheelchairs provided while shopping and using canes or walkers. There are many handicapped parking spaces, but I wonder when these vehicles are huge trucks, SUVs and loaded with hay and other merchandise. Do drivers use grandparents and parents' disability parking cards? — Community Leader

Access to Care/Services

> I don't know of any service that treats chronic pain or dementia specifically. And there is only one ENT physician here. — Health Care Provider
>
> Limited access to pain management care. — Health Care Provider
>
> Helping families who are caring for dementia patients. They have limited resources to help them care for their needs. Assistant living facilities available. Cost of these facilities. — Health Care Provider
>
> Lack of access to neurologists. — Health Care Provider

Lack of Providers

> Lack of providers, lack of supporting facilities. — Health Care Provider
>
> Scarcity of specialty specific providers and resources. — Physician
>
> Limited specialist. — Community Leader

Awareness/Education

> Difficult to identify and access resources, especially for those with newly diagnosed disabling conditions. — Health Care Provider
>
> Lack of resources, unable to access care. — Physician
>
> Health literacy, lack of access to resources for food, living, utilities, and transportation. — Health Care Provider

Narcotic Use

> So many people suffer from chronic pain that is due to arthritis, or sport injuries, or an accident suffered in early years. Chronic pain leads to narcotic abuse and eventually people becoming so dependent that they become homeless. Loss of hearing is a big concern because treatment is so expensive, the average set of hearing aids cost $5,000. people cannot afford the treatment and communicating becomes more and more difficult. — Community Leader

Transportation

> Often due to transportation, cost, lack of insurance, and the rural nature of the population served, there is a large number of individuals with disabling conditions. There is significant stigma for many community members accessing care and providers delivering care are not always invested in the community. They come from other areas, are not culturally sensitive, and don't have an understanding of the population. — Community Leader

BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social drivers of health is critical for reducing these disparities.

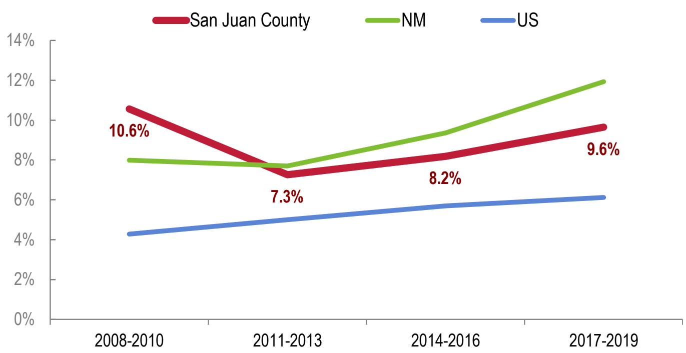
– Healthy People 2030

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health.

This indicator reports the percentage of women who did not receive timely prenatal care. This indicator can signify a lack of access to preventive care, a lack of health knowledge, or other barriers to services.

Trends in Lack of Prenatal Care in the First Six Months of Pregnancy
(Percentage of Live Births)



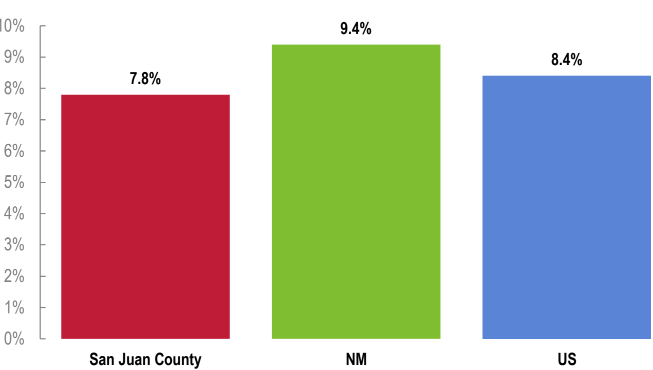
Sources: • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).
Notes: • This indicator reports the percentage of women who do not obtain prenatal care during their first six months of pregnancy, if at all.

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

Low-Weight Births
(Percent of Live Births, 2017-2023)



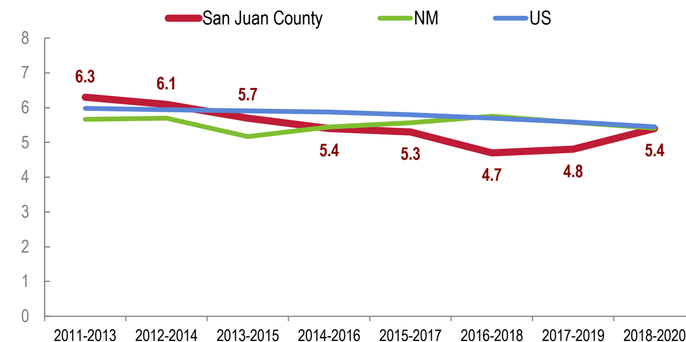
Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of total births that are low birthweight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health.

Infant Mortality Trends
(Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2030 = 5.0 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2026.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Rates are three-year averages of deaths of children under one year old per 1,000 live births.

Family Planning

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030

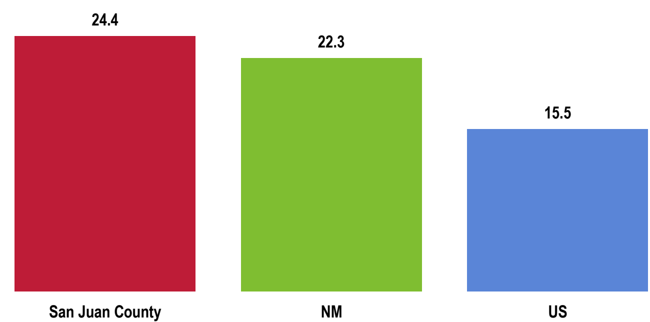
Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior.

Teen Birth Rate

(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2017-2023)

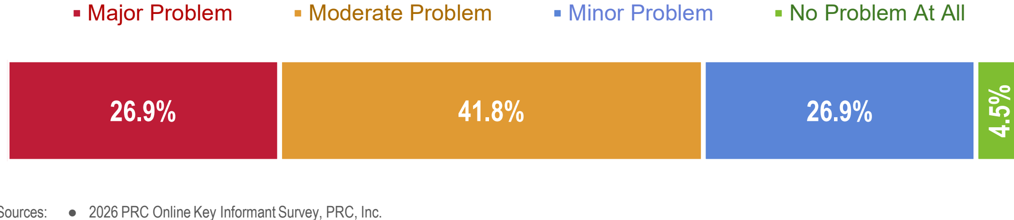


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15-19 per 1,000 female population age 15-19.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health & Family Planning* as a problem in the community:



Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Limited resources/access. — Community Leader
>
> Maternal health services in New Mexico are shrinking, risks are growing. Women living in rural parts of New Mexico have limited OB/GYN care. Three counties statewide are considered OB deserts. Even some urban and suburban communities like Farmington are struggling with insufficient health care. — Community Leader
>
> Accessibility to primary care and coverage for the hospital. — Health Care Provider
>
> I have seen a few family planning buildings around town but I honestly don't know if they are even open, facilities look old, rundown, and sometimes vacant. — Health Care Provider
>
> High risk on, lack of access to care, teenage births. — Physician
>
> Access, health care literacy issues. — Health Care Provider
>
> Lack of access to care, low health literacy. — Physician
>
> Lack of prenatal care. — Health Care Provider

Income/Poverty

> Many low-income individuals cannot afford to take care of their children. Unplanned pregnancies or adolescent pregnancies are very prevalent in this population. When a mother who is not resourced has a child, this impacts the health of the mother and the infant. — Community Leader
>
> There is a high San Juan County resident poverty level, which reduces the ability to afford contraception, transportation, and preventive reproductive care. Economic hardship is higher than the U.S. average and creates obstacles to consistent access. Lack of health insurance coverage, which directly affects access to family planning and preventive services. Individuals without insurance have fewer visits for contraception counseling and reproductive health screenings. Access to primary care services. — Health Care Provider
>
> People who don't plan on having a child seem to abuse children through poverty, neglect, lack of discipline and parenting skills. Childhood trauma affects a child's learning, socialization and future. Parents don't make enough money so one parent can remain at home and care for a child with love, nurturing, good nutrition, sound parenting skills and TLC. — Community Leader

Lifestyle

> I believe that teaching children the proper diet for a healthy lifestyle is very important. — Community Leader

Family Planning

> Not enough family planning, excessive births per family. — Physician

Lack of Providers

> Many more patients than available providers. — Physician

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

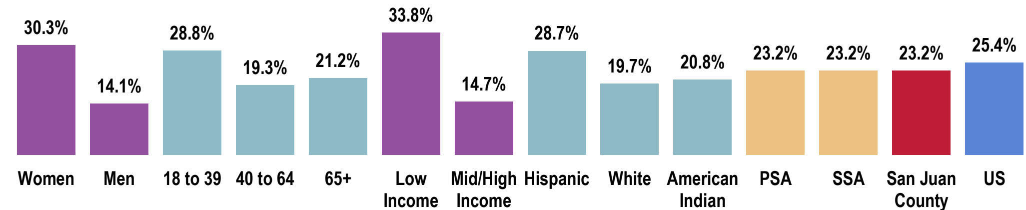
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030

Access to Fresh Produce

PRC SURVEY ▶ "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(San Juan County, 2026)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 63]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Physical Activity

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

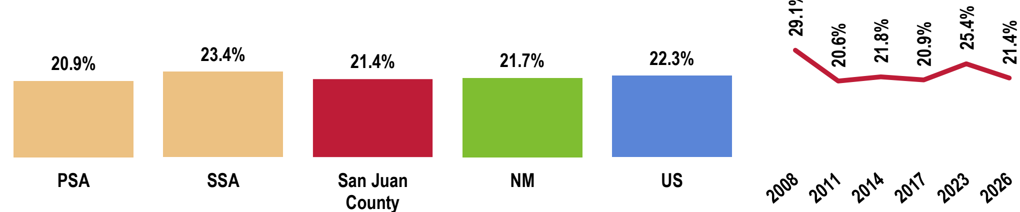
– Healthy People 2030

Leisure-Time Physical Activity

PRC SURVEY ▶ "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 66]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

For adults, "meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activities:

- **Aerobic Activity** — For substantial health benefits, adults should do at least 150 minutes (2 hours and 30 minutes) to 300 minutes (5 hours) a week of moderate-intensity, or 75 minutes (1 hour and 15 minutes) to 150 minutes (2 hours and 30 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity. Preferably, aerobic activity should be spread throughout the week.

  Additional health benefits are gained by engaging in physical activity beyond the equivalent of 300 minutes (5 hours) of moderate-intensity physical activity a week.
- **Strengthening Activity** — Adults should also do muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on 2 or more days a week, as these activities provide additional health benefits.

– 2018 Physical Activity Guidelines for Americans, US Department of Health and Human Services

To measure physical activity frequency, duration and intensity, respondents were asked:

PRC SURVEY ▶ **"During the past month, what type of physical activity or exercise did you spend the most time doing?"**

PRC SURVEY ▶ **"And during the past month, how many times per week or per month did you take part in this activity?"**

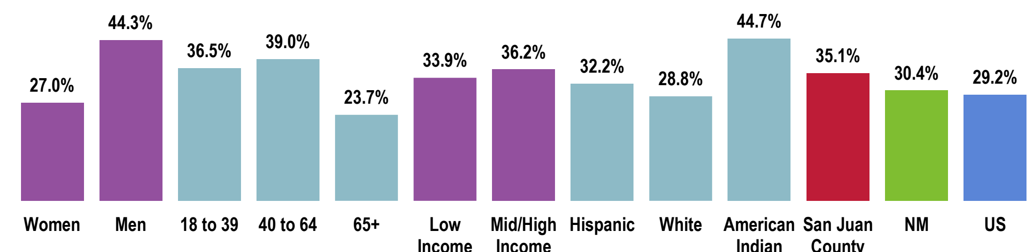
PRC SURVEY ▶ **"And when you took part in this activity, for how many minutes or hours did you usually keep at it?"**

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

PRC SURVEY ▶ **"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles?"**

Meets Physical Activity Recommendations
(San Juan County, 2026)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 109]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week (or an equivalent combination of moderate and vigorous-intensity activity) *and* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

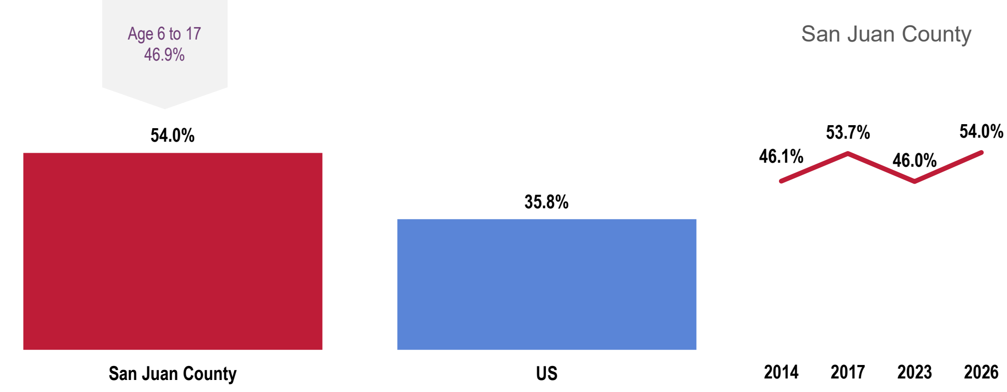
CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents age 6 through 17 years should do 60 minutes (one hour) or more of moderate-to-vigorous physical activity daily.

– 2018 Physical Activity Guidelines for Americans, US Department of Health and Human Services

PRC SURVEY ▶ [Among parents of children age 2-17] **"During the past seven days, on how many days was this child physically active for a total of at least 60 minutes per day?"**

Child Is Physically Active for One or More Hours per Day
(Children 2-17)



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 95]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

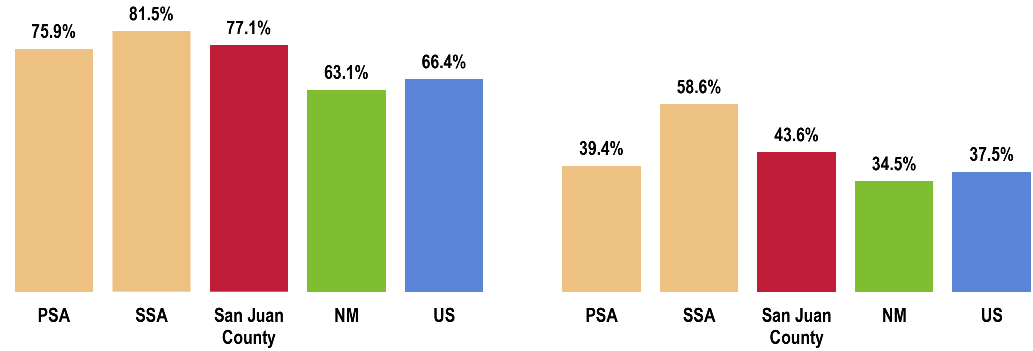
PRC SURVEY ▶ **“About how much do you weigh without shoes?”**

PRC SURVEY ▶ **“About how tall are you without shoes?”**

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight
(Overweight and Obese)

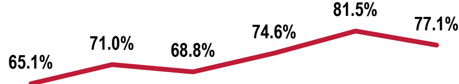
Prevalence of Obesity
Healthy People 2030 = 36.0% or Lower



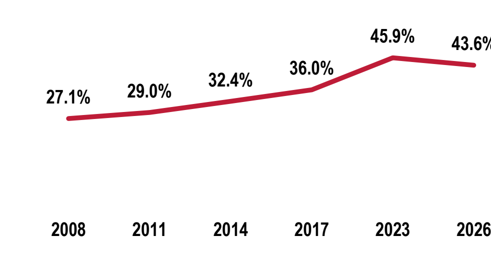
Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 111]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Total Overweight [Overweight and Obese]
(San Juan County)



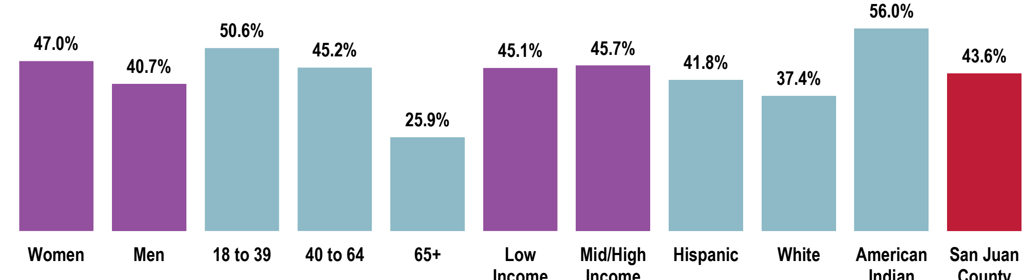
Prevalence of Obesity
(San Juan County)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 111]
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity
(San Juan County, 2026)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 111]
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

– Centers for Disease Control and Prevention

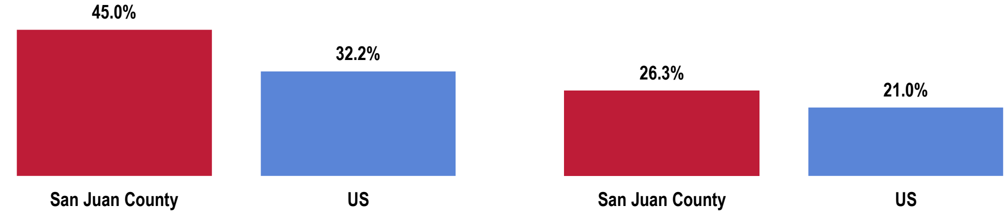
The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

PRC SURVEY ▶ [Among parents of children age 5-17] **"How much does this child weigh without shoes?"**

PRC SURVEY ▶ [Among parents of children age 5-17] **"About how tall is this child?"**

Prevalence of Overweight in Children
(Children 5-17)

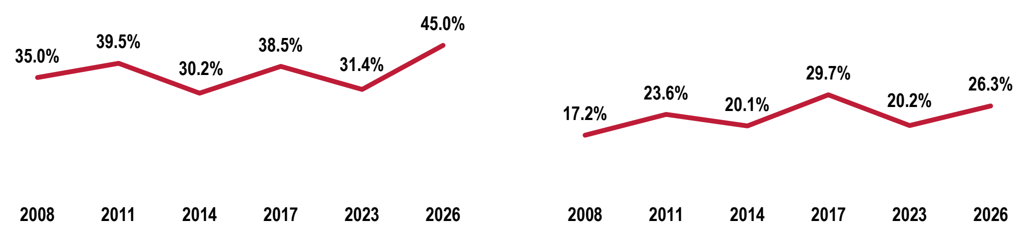
Prevalence of Obesity in Children
(Children 5-17)
Healthy People 2030 = 15.5% or Lower



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 112]
● 2026 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030.
Notes: ● Asked of all respondents with children age 5-17 at home.
● Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Prevalence of Overweight in Children
(Children 5-17; San Juan County)

Prevalence of Obesity in Children
(Children 5-17; San Juan County)
Healthy People 2030 = 15.5% or Lower

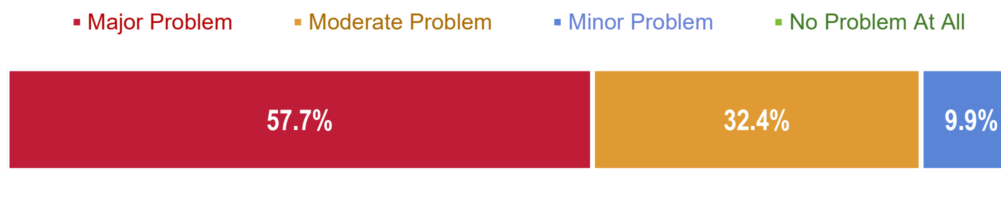


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 112]
● US Department of Health and Human Services. Healthy People 2030.
Notes: ● Asked of all respondents with children age 5-17 at home.
● Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Key Informants; San Juan County, 2026)



Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Health literacy, programs to support making changes, school education. — Health Care Provider
>
> Lack of education and poverty. — Community Leader
>
> Access to nutritional education is limited. Access to physical activity is great is this community. Weight management resides with PCPs and a few private facilities. — Physician
>
> Education of the value of regular physical activity, indoor and outdoor. Need to limit time spent on social media and fixation on mobile devices. Expand physical activity program requirements in schools. — Community Leader
>
> Poor health literacy. — Physician
>
> People are not aware of the importance of nutritious food. We have too many fast-food restaurants, which contribute to unhealthy habits, and poor nutrition. — Physician
>
> Understanding the consequences of extra weight and the motivation to change the situation. — Health Care Provider
>
> Patients have been taught through advertising that highly processed foods are both nutritious and delicious. Patients are overeating foods which are high in caloric value and low in nutrition. Food assistance programs have historically allowed the purchase of these same foods and made it near impossible to feed a family of 4 raw and nutritious foods. — Community Leader

Obesity

> Prominent obesity crisis in the community, food insecurity, poverty. — Health Care Provider
>
> High rate of obesity. Generational changes in physical activity. — Physician
>
> Too many fat people eating too much and exercising none. — Community Leader
>
> Obesity as a cause of many other health conditions. — Physician
>
> Obesity is a major problem here. — Physician
>
> Looking at the people in the public, there is a lot of obesity in children, young adults, teens and elders. Relying on fast food instead of home-cooked meals is a problem for weight gain. Kids don't play outside for fear of abductions, molesters or lack of safety. Obesity is acceptable and people don't mind how they look and dress. — Community Leader
>
> High obesity and chronic disease rates. In Farmington, 26% of adults are classified as obese, with a 12% diabetes rate. Childhood obesity: roughly 28% of third graders in SJC are obese. Between kindergarten and third grade, obesity rates increase. American Indian children in the region have the highest obesity prevalence, nearly 47% of American Indian third-graders in New Mexico overweight or obese in 2022. Chronic diseases: obesity contributes to high rate of diabetes, heart disease, and hypertension. — Community Leader

Access to Affordable Healthy Food

> Funds to purchase healthy food. — Health Care Provider
>
> Lack of healthy food offerings, plenty of fast food options. — Community Leader

> Our community lacks healthy eating options. Mostly fast food chains. Our groceries have to travel far to get here, therefore they lack freshness. — Physician
>
> Lack of affordable healthy food. Sedentary lifestyle. — Health Care Provider

Access to Care/Services

> Access to providers. — Physician
>
> Lack of access to resources. — Health Care Provider
>
> Accessible resources for patients/families. Starting early in life, perhaps in schools, integrated program. — Physician

Nutrition

> Poor diet and lack of access to PCPs. — Health Care Provider
>
> Increasing number of fast food and large chain restaurants that serve highly processed foods. Lack of affordable community-based workshops on nutrition, physical activity, and healthy weight management. — Public Health Representative

Lifestyle

> Resistance from individuals to change their habits. — Health Care Provider
>
> Personal responsibility and motivation to make changes for a healthier lifestyle. — Community Leader

Built Environment

> It is hard for people to maintain good nutrition, and while our area has ample outdoor space, our community is not very walkable. If we were to bulk up walkable streets and bike lanes, we would probably have more success with physical activity. And SNAP and food bank foods should probably be a little more nutritious. — Community Leader

Genetics

> The ethnicities in San Juan County have significant predisposition for diabetes and being overweight. — Health Care Provider

Social Drivers of Health

> Social determinants of health and childhood traumas. — Physician

Substance Use

ABOUT DRUG & ALCOHOL USE

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030

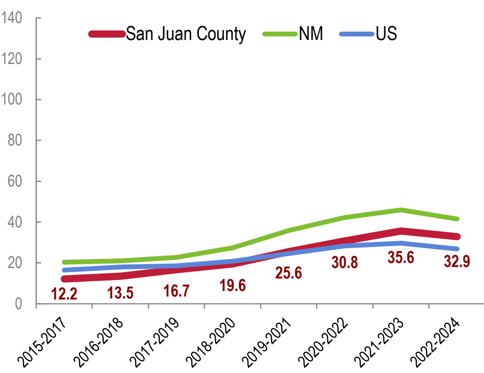
Substance-Related Deaths

The following charts outline alcohol- and drug-induced mortality in the area. Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included.

Alcohol-Induced Mortality
(Annual Average Deaths per 100,000 Population)

140
120
100
80
60
40
20
0
San Juan County
NM
US
48.4
52.4
59.9
73.4
84.3
96.0
85.1
79.6
2015-2017
2016-2018
2017-2019
2018-2020
2019-2021
2020-2022
2021-2023
2022-2024

Unintentional Drug-Induced Mortality
(Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Excessive Drinking

PRC SURVEY ▶ "During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

PRC SURVEY ▶ "On the day(s) when you drank, about how many drinks did you have on average?"

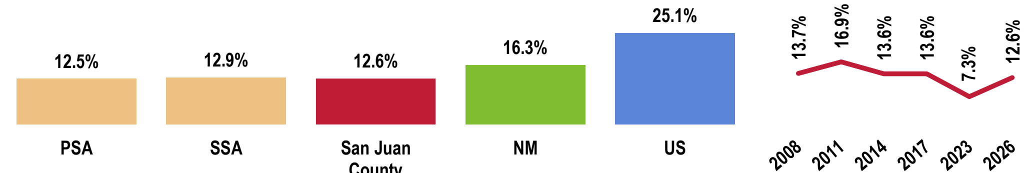
PRC SURVEY ▶ "Considering all types of alcoholic beverages, how many times during the past 30 days did you have five (if male)**/four** (if female) **or more drinks on an occasion?"**

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKING ▶ men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ▶ men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

Engage in Excessive Drinking

San Juan County



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 113]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drug Use

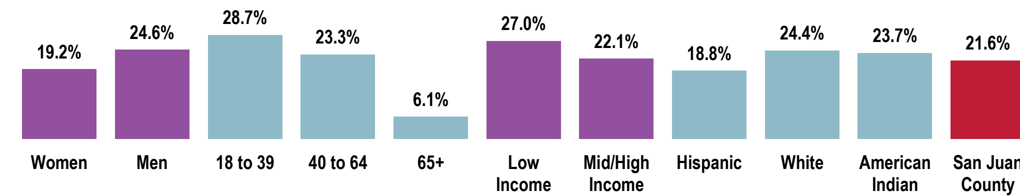
Marijuana/THC Use

PRC SURVEY ▶ "During the past 12 months, have you used marijuana or products containing THC in any form? This includes use of traditional marijuana, hashish, edibles, and concentrates like hash oil, wax, or shatter. It does not include use of CBD oils."

Used Marijuana/THC in the Past Year

Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 35]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes traditional marijuana, hashish, edibles, and concentrates like hash oil, wax, or shatter (does not include CBD oils).

Used Marijuana/THC in the Past Year
(San Juan County, 2026)



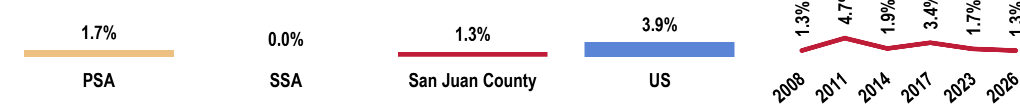
Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 35]
Notes: ● Asked of all respondents.
● Includes traditional marijuana, hashish, edibles, and concentrates like hash oil, wax, or shatter (does not include CBD oils).

Illicit Drug Use

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

PRC SURVEY ▶ "During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Illicit Drug Use in the Past Month

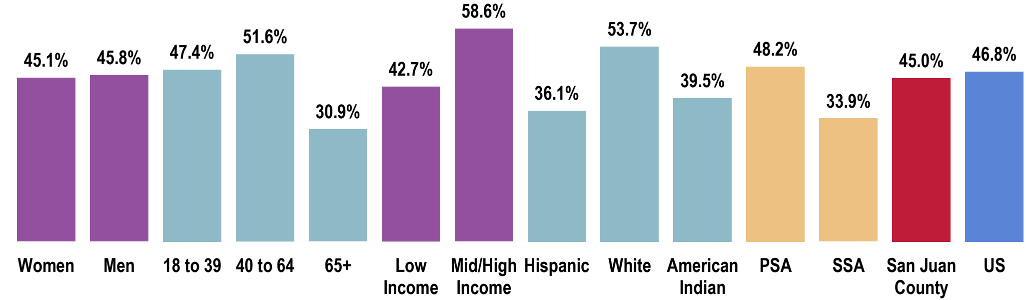


Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 39]
• 2026 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Personal Impact From Substance Use

PRC SURVEY ▶ "To what degree has your life been negatively affected by your own or someone else's substance use issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

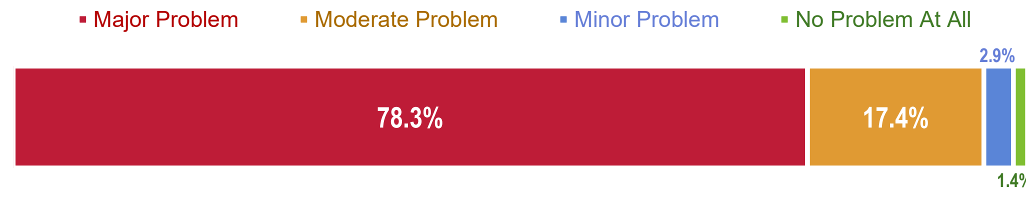
Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)
(San Juan County, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 41]
• 2026 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes response of "a great deal," "somewhat," or "a little."

Key Informant Input: Substance Use

The following chart outlines key informants' perceptions of the severity of *Substance Use* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> I understand centers prioritize court-ordered patients, and thus it is often full to walk-ins. We have some good options. I believe, however, most patients with alcohol use disorder have such severe underlying trauma and mental health disorders. Until these are addressed, it will be difficult to attain sobriety. To that end, there needs to be a seamless flow from street to hospital to doctor's office to intensive outpatient program with psychiatric support to inpatient and across the system. — Physician
>
> Lack of rehab and resources to pay for it. — Health Care Provider
>
> Limited treatment beds, providers, community programs, wraparound services. — Health Care Provider
>
> Access, knowing resources, psychologists. — Physician
>
> Limited options for treatment/services. — Health Care Provider
>
> Availability of clinics/providers. — Physician
>
> Program availability. — Physician
>
> Mental health access. — Physician
>
> Reputable treatment centers. — Health Care Provider
>
> Specialist availability when patients are ready to make a change. It can take months to get into a substance abuse program. — Health Care Provider
>
> Very few resources to address this problem, mostly left to the primary care providers. I always felt very inadequate to address acute problems, mostly relied on the emergency room, which is very inefficient. — Community Leader
>
> Not enough outpatient or inpatient treatment facilities. — Physician
>
> Limited resources and doctors. — Health Care Provider
>
> Immediate access to treatment services, sufficient beds and funding, relapses. — Community Leader

Diagnosis/Treatment

> Realistic expectations in regard to outcomes, transport, having these services be interwoven with mental health treatment. — Physician
>
> Quality of treatment, lack of qualified personnel, funding. — Community Leader
>
> Treatment and rehabilitation. — Health Care Provider

Incidence/Prevalence

> They keep using. — Physician
>
> Drugs and alcohol abuse is something I am not too aware, but I see street people who appear to be in need of treatment. — Community Leader
>
> Treatment centers are available in our community, but it seems we still face the same problems with people continuing to use and abuse substances. DUI laws seem lax, and there is no law against being intoxicated in public spaces. — Community Leader

Disease Management

> We have the services and resources. People need to face their addictions and seek help. — Community Leader
>
> Patient desire to access treatment. Transportation and low socioeconomic status add to this. — Physician

Law Enforcement

> Mandatory requirement to participate in programs when law enforcement and/or medical professionals are required to intervene. — Community Leader
>
> Law enforcement related to existing PI, drunk driving laws, etc. — Physician

Affordable Care/Services

> Cost of Inpatient treatment. — Community Leader
>
> Not enough low-cost providers. — Community Leader

Lack of Providers

> Lack of providers. — Community Leader
>
> Lack of providers and facilities. — Health Care Provider

Access for Medicare/Medicaid Patients

> Again, numerous providers do not accept Medicare. Addiction knows no age limit. We have one residential treatment and detox facility. MAT providers are more prevalent, so that is great. However, the root causes of substance abuse still need to be addressed, as does intensive case management. — Community Leader

Income/Poverty

> Financial limitations. High cost of insurance, but many are uninsured due to high costs of insurance. Stigma, denial, lack of awareness, change in family status. — Community Leader

Awareness/Education

> Access to education and care. No inpatient rehab except limited through the Behavioral Health Unit. — Physician

Alcohol Use

> Alcohol usage. Emergency room full of patients that require medical care due to alcohol usage.
> — Public Health Representative

Co-Occurrences

> It leads to a variety of issues. Food insecurity, domestic violence, homelessness, crime. — Community Leader

Denial/Stigma

> Stigma, lack of providers. — Community Leader

Follow-Up/Support

> Social support. — Physician

Insurance Issues

> Insurance companies. — Physician

Tobacco Use

ABOUT TOBACCO USE

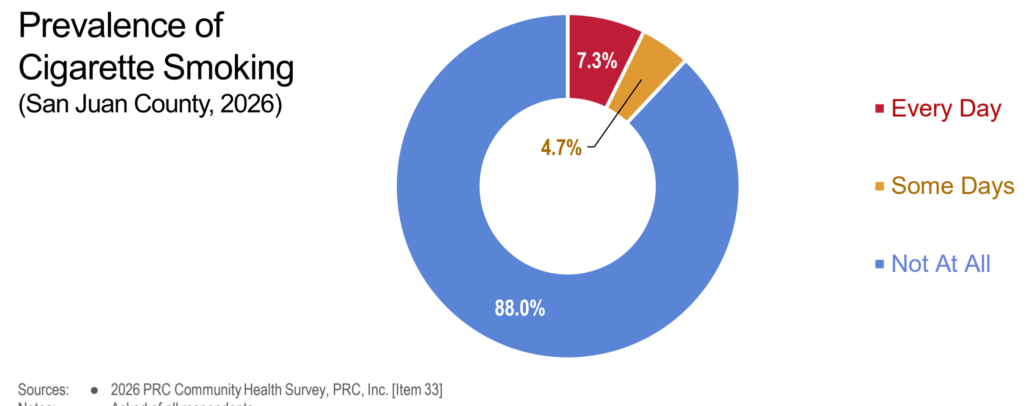
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030

Cigarette Smoking

PRC SURVEY ▶ "Do you currently smoke cigarettes every day, some days, or not at all?"

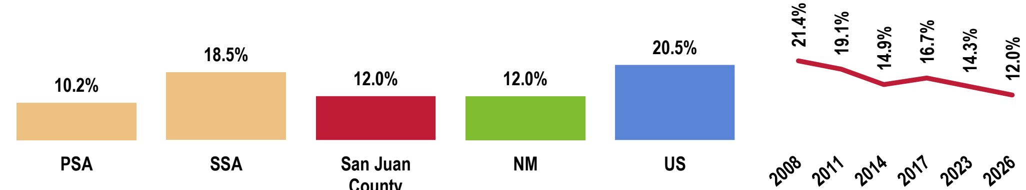


"Currently Smoke Cigarettes" includes those smoking "every day" or on "some days."

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower

San Juan County



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 33]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

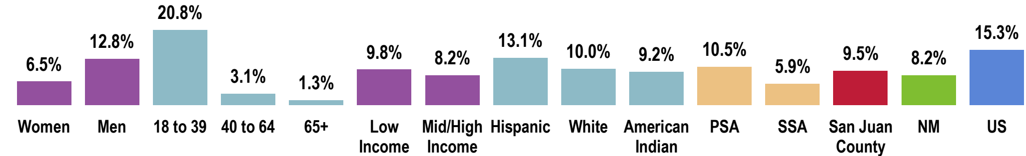
Use of Vaping Products

PRC SURVEY ▶ "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

"Currently Use Vaping Products" includes use "every day" or on "some days."

Currently Use Vaping Products

(San Juan County, 2026)

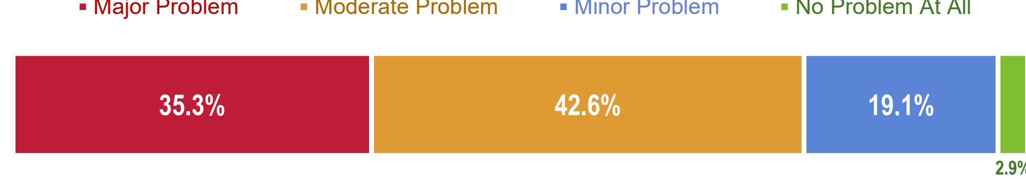


Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:



Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

High smoking prevalence (16 % of adults), high youth vaping rates, and significant preventable tobacco -related mortality. Low state funding for prevention, weak tobacco taxes, and high rates of usage among populations with lower education or income. 2,630 to 2,800 deaths annually in New Mexico. Leading cause of preventable deaths. 37% of high school students in the Southwest use e-cigarettes to consume nicotine. Marketing exposure contributes to the initiation of tobacco use. — Community Leader

I encounter a high rate of people using tobacco products. — Physician

I see lots of patients who smoke or vape, mainly self-medicating for anxiety. — Health Care Provider

A lot of my patients continue to smoke despite counseling and understanding the risks. — Physician

High rates of use and lung disease. — Physician

Use among patient population. — Health Care Provider

E-Cigarettes

Vaping. — Health Care Provider

Vaping in our kids is epidemic. — Health Care Provider

Vaping seems to be a bigger problem than traditional forms of tobacco. — Community Leader

Access to Care/Services

Access to rehab options and education. — Physician

Teen/Young Adult Usage

Likely starting at young age. — Physician

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs (sexually transmitted infections). And people who have an STI may be at higher risk of getting HIV (human immunodeficiency virus). Promoting behaviors like condom use can help prevent STIs.

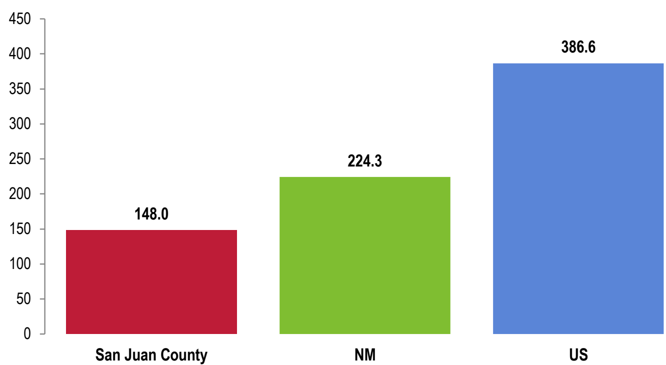
Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030

HIV

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.

HIV Prevalence
(Prevalence Rate per 100,000 Population, 2022)



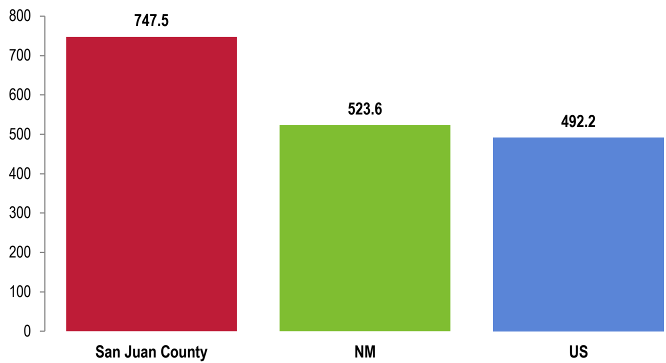
Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

Chlamydia

Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

Chlamydia Incidence
(Incidence Rate per 100,000 Population, 2023)



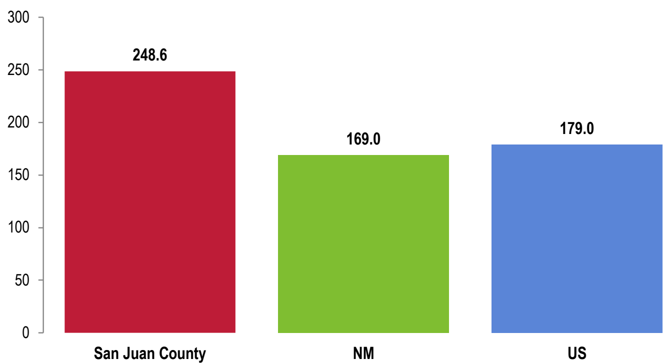
Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Gonorrhea

Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs.

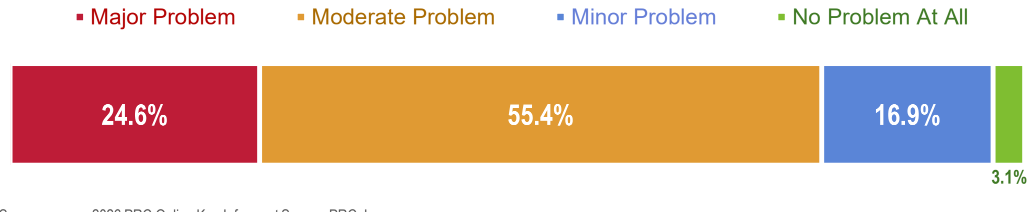
Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2023)



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Because working in education, I regularly hear that it is. — Community Leader
>
> STDs and STD-related infections are much more prevalent here, especially off the reservation, than they are elsewhere. — Physician
>
> High levels of STDs, lack of providers. — Health Care Provider
>
> Rising STI cases, particularly syphilis. — Physician
>
> High prevalence for promiscuity, homelessness, and STIs. — Health Care Provider
>
> High rates of STIs. — Physician
>
> Syphilis is high as is gonorrhea and chlamydia. — Health Care Provider

Cultural Expectations

> Our communities promote abstinence instead of safe sex. Homeless population, undiagnosed STIs. — Health Care Provider

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

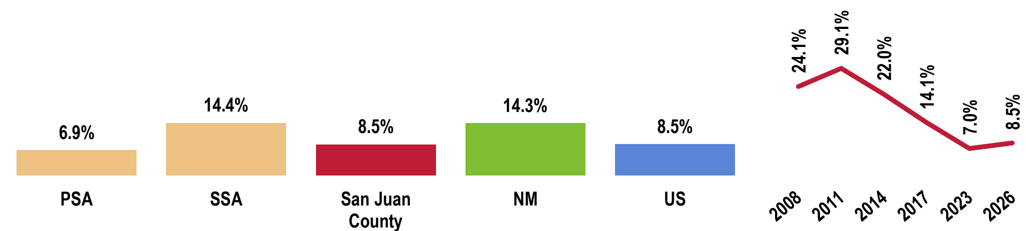
Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

PRC SURVEY ▶ "Do you have any government-assisted health care coverage, such as Medicare, Medicaid, or VA/military benefits?"

PRC SURVEY ▶ "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay for health care entirely on your own?"

Lack of Health Care Insurance Coverage
(Adults 18-64)
Healthy People 2030 = 7.6% or Lower

San Juan County



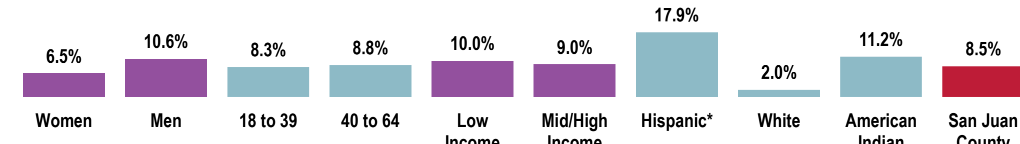
Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage

(Adults 18-64; San Juan County, 2026)

Healthy People 2030 = 7.6% or Lower



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 114]
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Reflects respondents age 18 to 64.
- *Use caution when interpreting the results, as the sample falls below n=50.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

PRC SURVEY ▶ "Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"

PRC SURVEY ▶ "Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

PRC SURVEY ▶ "Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"

PRC SURVEY ▶ "Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

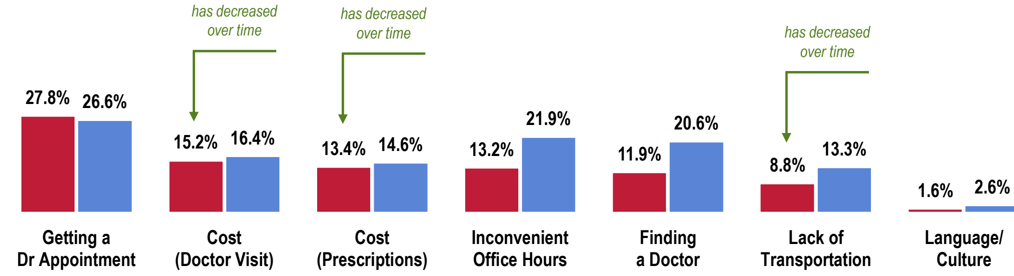
PRC SURVEY ▶ "Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

PRC SURVEY ▶ "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

PRC SURVEY ▶ "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year

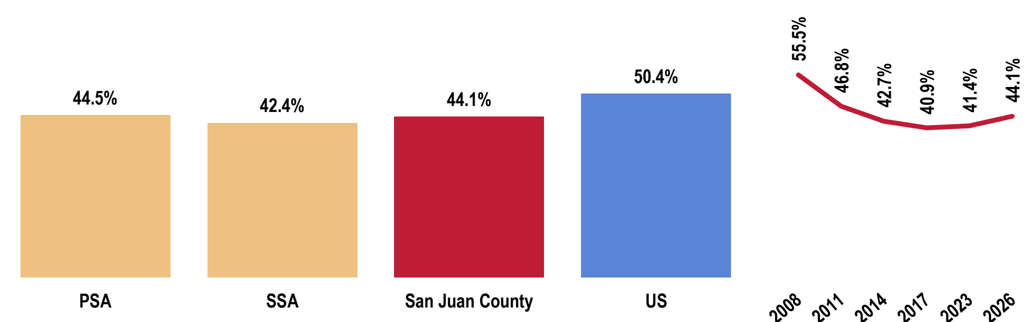


Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Items 6-12]
• 2026 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

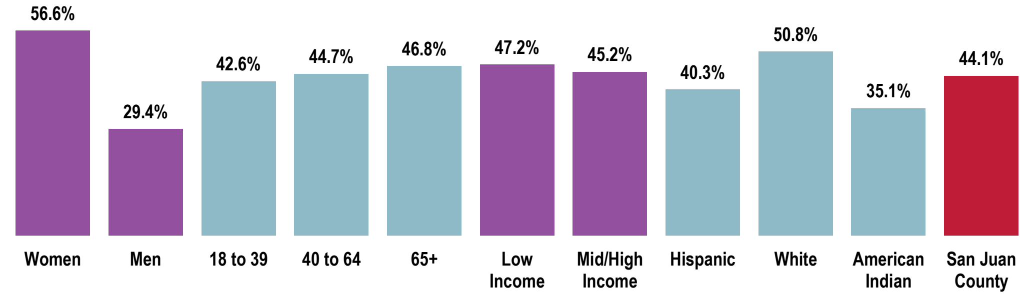
The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers), again regardless of whether they needed or sought care.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 116]
• 2026 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year (San Juan County, 2026)



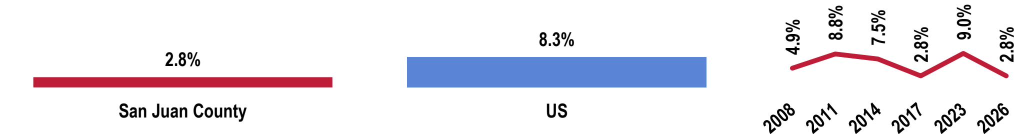
Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 116]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Accessing Health Care for Children

PRC SURVEY ▶ [Among parents of children age 0-17] **"Was there a time in the past 12 months when you needed medical care for this child but could not get it?"**

Had Trouble Obtaining Medical Care for Child in the Past Year
(Children 0-17)

San Juan County



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 91]
• 2026 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children age 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:

Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants; San Juan County, 2026)

Moderate Problem ▪ Minor Problem ▪ No Problem At All

Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Lack of Providers

> Inadequate number of health care providers in the community, long wait time for some to access services, lack of insurance. — Health Care Provider
>
> Not enough physicians, not providers, but physicians. — Health Care Provider
>
> Lack of overall health care providers in the Four Corners region is severely lacking. Patients are having to travel out of state to seek primary care providers because of the lack of PCP providers and specialists. This is a systemic problem in the entire state of New Mexico, which has been recognized by the current governor. — Community Leader
>
> People don't have a PCP, and this community's health IQ is really low. — Health Care Provider
>
> Not enough providers, not enough transportation resources. — Health Care Provider

In the current political environment due to medical malpractice, there are not enough providers. It takes months to get an appointment with a specialist. If you don't have a primary care provider, access becomes critical. The emergency room becomes the only resource available. It may be hours of wait time, or sometimes you may be told to leave because you won't be seen or to go to Durango for care. There are limited preventive health care solutions. People are waiting for a long time to address health problems. By the time that they seek care, their needs become more complex. Thus, driving up the costs of health care. — Community Leader

Lack of health care providers. Long wait times, even for chronic situations. — Community Leader

Lack of PCP. Unable to see PCP or specialist in timely fashion. — Physician

Not enough doctors and other health care professionals. — Community Leader

Lack of providers. — Health Care Provider

Locating providers who provide services. If providers are located, providing access in a timely manner. The area could really benefit from a partial hospitalization program. — Physician

Limited access to physicians. If there are not enough doctors to treat the sick, they will only get sicker. — Health Care Provider

Lack of Specialty Care

Very few physicians are available in specialty practice. Appointments are not readily available. Some are not accepting certain insurances. — Community Leader

Lack of psychiatrists to care for patients. There are multiple counselors; however, even that service is challenging to get a new patient, or a patient experiencing acute problems, into care. The main avenue is to send those patients to the ER for referral and entrance into the system. Child psych is a significant problem, and certainly any inpatient care is unavailable locally. — Community Leader

There is a lack of specialty doctors in areas such as endocrinology, diabetes, child/adolescent psych, licensed mental health therapists, rheumatology, dermatology, autistic services for children/adolescent of all ages. There are probably more specialty services that are lacking, but these are just the ones I can think of today. Access is difficult, and many services are lacking so patients must go to other cities to access services or receive timely services. — Community Leader

Lack of specialists that force people to seek care in Colorado. — Community Leader

Lack of specialty providers, long wait times to get seen, not enough primary care, need education for chronic diseases transportation to appointments. — Health Care Provider

Lack of specialists. — Physician

I believe access to specialties and availability of providers. We have to ship a lot of our patients out and have extremely long wait times for patients to get appointments. — Health Care Provider

Access to Care/Services

Lack of access to quality care. Lack of physicians, providers, RNs, and ancillary staff. — Physician

Difficulty with timely access to outpatient care. — Physician

There is a lack of accessibility to primary care and specialty providers. We need a reliable way to recruit and more importantly retain quality providers. - H Follow with certain specialties - getting an appointment in a timely fashion, being able to see a PCP when needed. I also think that education is difficult with this population, understanding when and how to use medications. Lastly, I think there needs to be more social services, more access to mental health, better services for struggling children. — Physician

Long wait times to get an appointment. Not enough doctors and few really good specialists. — Community Leader

Long wait times for appointments, doctors consistently overbooked across specialties, heavy reliance on mid-level providers, atrocious emergency room wait times, lack of subspecialty providers, egregious wait times for subspecialty referrals. — Physician

Awareness/Education

Preventing outside clinics from sharing information about local resources without marketing's approval unintentionally limits the support we can offer our patients. The purpose of providing resource information in our clinics is to improve access, reduce barriers, and connect patients with the services they need. When decisions prioritize appearance over function, we risk losing the true meaning of patient-centered care. We serve a community facing multiple socioeconomic and health challenges. Posting relevant, vetted resource information in our clinic spaces is one of the simplest and most effective ways to educate patients and link them to help. Ensuring that clinics can share appropriate, community-based resources — without unnecessary restrictions — supports health equity, strengthens trust, and aligns with our mission to care for the whole person. — Health Care Provider

Low health literacy, lack of transportation, substance/alcohol/mental health impairing ability to follow through with steps needed to access. — Physician

Insurance Issues

> Payer source. — Health Care Provider
>
> Insurance that is accepted. Timely appointments. Transportation to appointments. — Health Care Provider

Transportation

> Transportation to and from appointments, diabetes education or patients are educated but have difficulty understanding. — Health Care Provider
>
> Transportation, health literacy. — Health Care Provider

Government/Policy

> The state of New Mexico has created an unfriendly environment for physicians and all medical providers. Hopefully, some changes will be made during the 30 Legislative sessions to make New Mexico more friendly to medical providers. There is also an access problem for those who are on Medicare, and it can be very difficult to find a provider in Farmington and San Juan County. — Community Leader

Vulnerable Populations

> Inadequate care for minority groups, specifically Native American, Black, and Hispanic groups. I am very fortunate to be a White, Protestant male. — Community Leader

Diagnosis/Treatment

> Quality providers and a quality forward thinking hospital system. People not really caring about health and wellness. — Health Care Provider

Mental Health

> Mental health. We are desperate. Also, infectious disease, primary care. — Physician

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

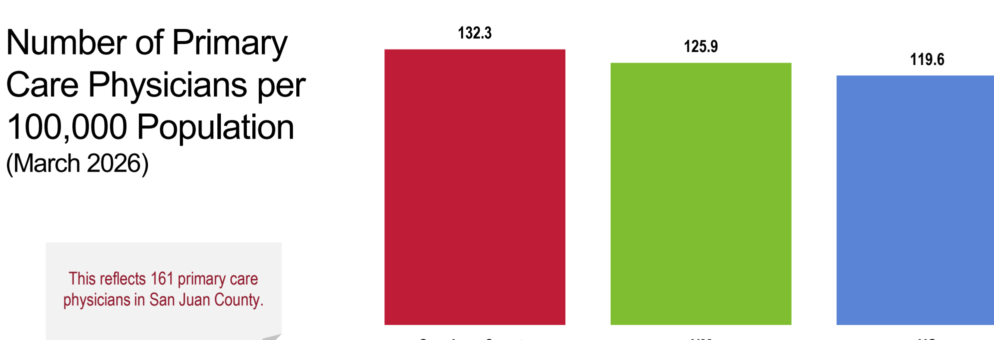
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030

Access to Primary Care

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

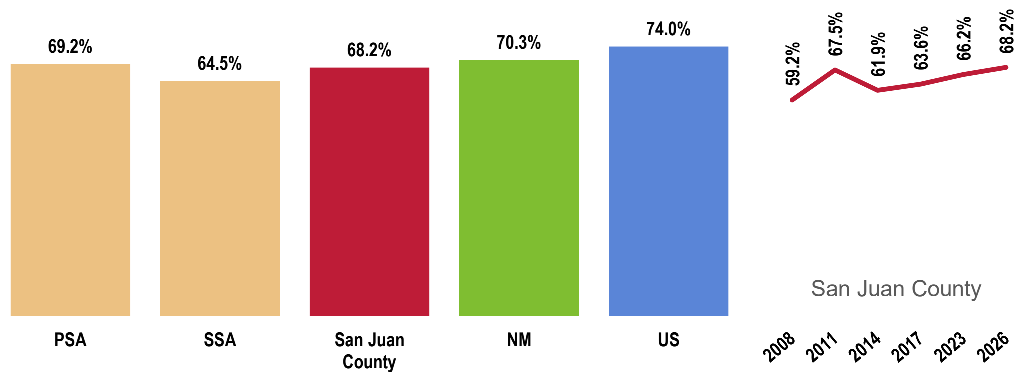


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Utilization of Primary Care Services

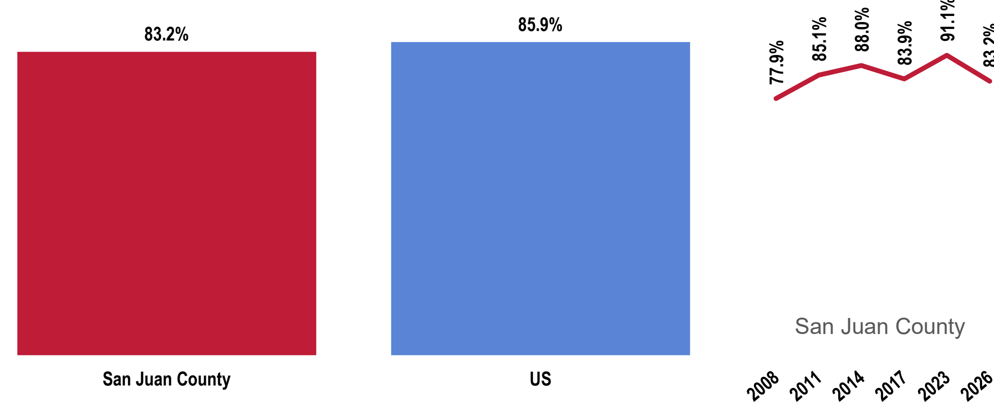
PRC SURVEY ▶ "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ▶ [Among parents of children age 0-17] **"About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"**



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 92]
- 2026 PRC National Health Survey, PRC, Inc.

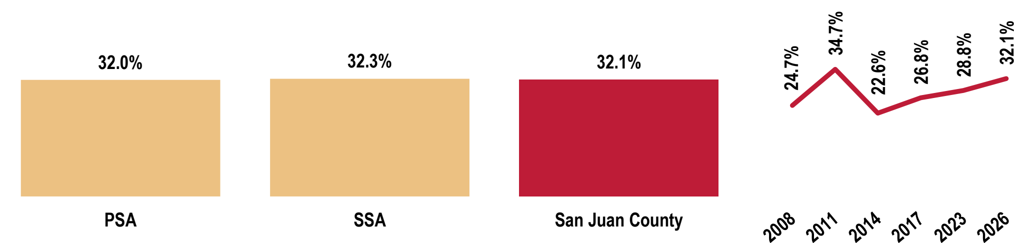
Notes:
- Asked of all respondents with children age 0 to 17 in the household.

Outmigration for Care

PRC SURVEY ▶ **"Is there any health care service for which you need to leave San Juan County because that health care service is not available locally?"**

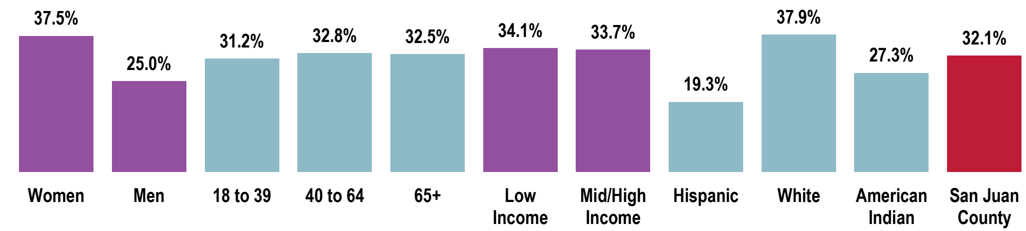
PRC SURVEY ▶ [Among those who leave the county for a health care service] **"Would you please tell me which health care service that is?"**

Outmigration for Health Care Services

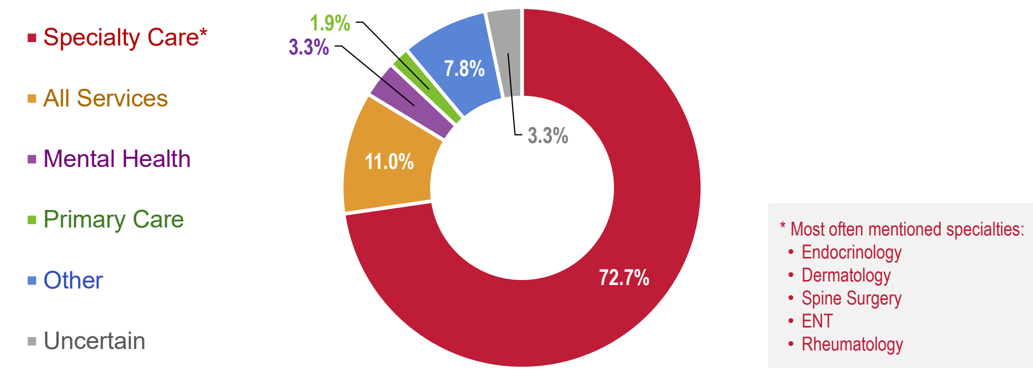


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: ● Asked of all respondents.

Outmigration for Health Care Services
(San Juan County, 2026)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: ● Asked of all respondents.



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: • Asked of those respondents who leave San Juan County for health care services not available locally.

Oral Health

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

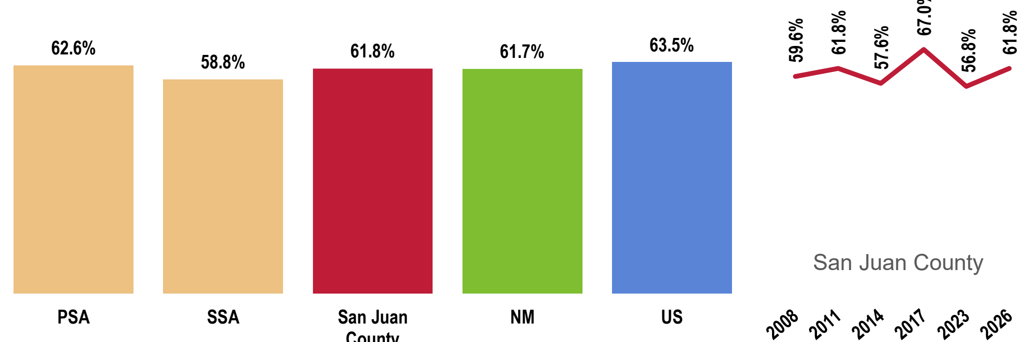
– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

PRC SURVEY ▶ "About how long has it been since you last visited a dentist or a dental clinic for any reason?"

Have Visited a Dentist or Dental Clinic Within the Past Year

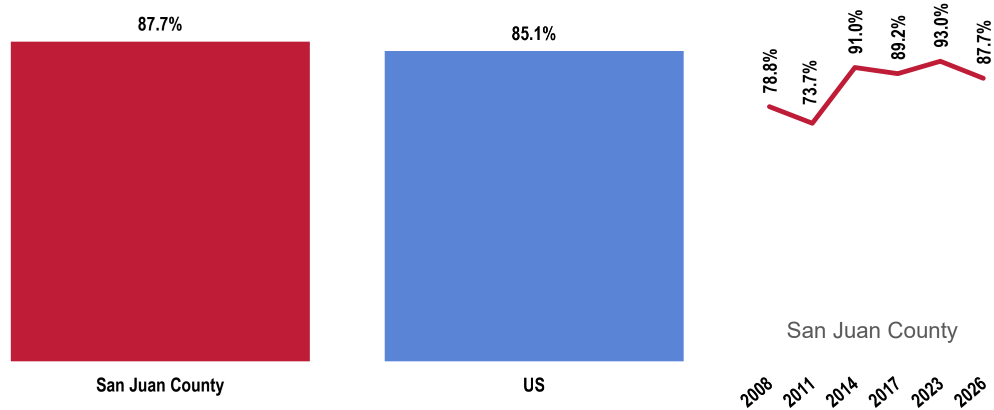
Healthy People 2030 = 45.0% or Higher



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 New Mexico data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.

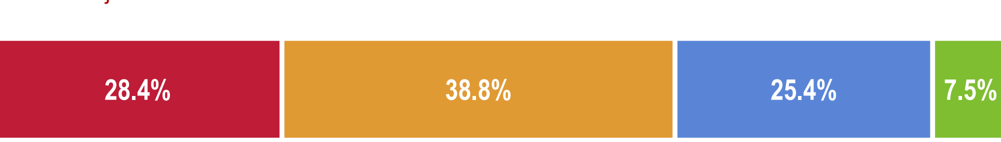
PRC SURVEY ▶ [Among parents of children age 2-17] **"About how long has it been since this child visited a dentist or dental clinic?"**



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 94]
● 2026 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030.
Notes: ● Asked of all respondents with children age 2 to 17 in the household.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:



Sources: ● 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Affordable Care/Services

> People cannot afford dental work. Dentists want payment in full up front before any services. People have missing teeth, and some even gum their food to eat. Children are exposed to sodas, sweets and tooth-damaging foods. Values differ in many households. I read your heart and oral health are related, and if you can't get dental care, you suffer. The cost is high, and people go on without getting a cap glued back on. The rich have nice teeth. — Community Leader
>
> Cost of oral care is often prohibitive. — Health Care Provider
>
> I frequently see very poor dentition in my patients with no access to dental care for financial reasons. — Physician

Access for Medicare/Medicaid Patients

> Medicare does not provide dental care. I see a lot of seniors who struggle with their oral health, and they cannot afford a dentist. — Community Leader

Insurance Issues

> Difficulty of dental offices getting patients in due to insurance, lack of availability, etc. as well as patient population/lifestyles. — Health Care Provider

Access to Care/Services

> Wait times for new or existing appointments can be up to six months. — Physician

Alcohol/Drug Use

> Meth use is high and dental health is poor. — Health Care Provider

Incidence/Prevalence

> Because I care for persons with rotten teeth on a daily basis. — Physician

Social Drivers of Health

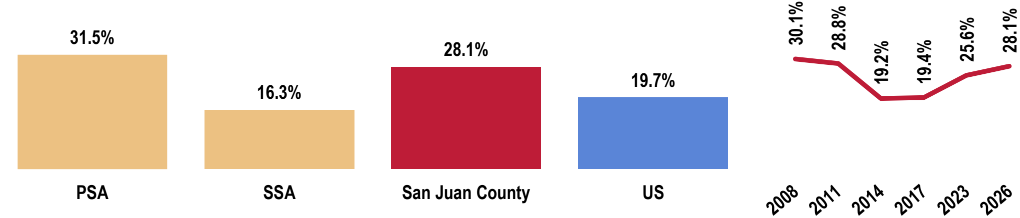
> Social determinants of health. — Physician

LOCAL RESOURCES

Perceptions of Local Health Care Services

PRC SURVEY ▶ "How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"

Perceive Local Health Care Services as "Fair/Poor"



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 4]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- AA/NA
- Addiction Care
- Cenikor
- Childhaven
- Community Health Worker
- Desert View Family Counseling
- Doctors' Offices
- Exceptional Care Hospital
- Food Bank
- Hospitals
- Indian Health Services
- Insurance
- Mercy Hospital
- Northern Navajo Medical Center
- Piñon Family Practice
- Presbyterian Health
- Presbyterian Medical Services
- San Juan Behavioral Health
- San Juan Center for Independence
- San Juan College
- San Juan Health Partners
- San Juan Regional Medical Center
- Senior Centers
- Sexual Assault Services
- Sih Hasin Street Medicine Clinic
- Social Services
- Telehealth
- Transportation
- Urgent Care
- VA Clinic

Cancer

- Cancer Center
- Doctors' Offices
- Four Corners Ambulatory Surgery Center
- Four Corners Cancer Center
- GI Center
- Mercy Medical
- New Mexico Cancer Society
- Northern Navajo Medical Center
- Otolaryngology Head and Neck Surgery
- Plastic Surgery
- Reading
- San Juan Oncology
- San Juan Regional Medical Center

Diabetes

- Bonnie Dallas Senior Center
- Department of Health
- Diabetes Education
- Diabetes Prevention Classes
- Diabetes Treatment Center
- Diabetic Dietician
- Dialysis Centers
- Doctors' Offices
- Echo Food Bank
- Faith-Based Programs
- Fitness Centers/Gyms
- Hospitals
- Indian Health Services
- National Diabetes Prevention Program
- Northern Navajo Medical Center
- Online Resources
- Presbyterian Health
- Presbyterian Medical Services
- San Juan College
- San Juan County
- San Juan Health Partners
- San Juan Medical Group
- San Juan Regional Medical Center
- School System
- Supplemental Nutrition Assistance Program
- University of New Mexico

Disabling Conditions

- Doctors' Offices
- Family Crisis Center
- Food Bank
- Hearing Aid Programs
- Home Health
- Homeless Shelter

- Indian Health Services
- Interventional Spine
- Long-Term Care Facilities That Accept Medicaid
- Nursing Facilities/Assisted Living
- Occupational/Physical Therapy Clinics
- Personal Caretakers
- Piñon Ear, Nose & Throat
- Presbyterian Medical Services
- Red Apple Transit
- Rehab Centers
- Safe Ride
- San Juan Center for Independence
- San Juan Regional Medical Center

Heart Disease & Stroke

- 911
- Doctors' Offices
- Fitness Centers/Gyms
- Heart Center
- Indian Health Services
- Inpatient Rehab
- Mercy Medical
- Mercy Regional Medical Center
- Online Resources
- Presbyterian Medical Center
- Reading
- San Juan Cardiology
- San Juan Health Partners
- San Juan Regional Medical Center
- Sycamore Center

Infant Health & Family Planning

- Childhaven
- Doctors' Offices
- Indian Health Services
- Planned Parenthood
- Presbyterian Health
- Presbyterian Medical Services
- San Juan Health Partners
- San Juan Regional Medical Center

Injury & Violence

- Alternative Sentencing Program
- Cenikor
- Childhaven
- City of Farmington
- Desert View Family Counseling
- Doctors' Offices
- Family Crisis Center
- Law Enforcement
- Mental Health Task Force
- Nonprofit Support for Victims of Domestic Violence
- Northern Navajo Medical Center
- San Juan Health Partners
- San Juan Regional Medical Center
- SANE Program

Mental Health

- 988
- Cenikor
- Community Compass
- Counseling Services
- Crisis Triage Center
- Desert Hills
- Desert View Family Counseling
- Doctors' Offices
- Hospitals
- Indian Health Services
- Inpatient Behavioral Health Unit
- Law Enforcement
- Mental Health Task Force
- National Alliance on Mental Illness
- Navigation Center
- Northern Navajo Medical Center
- Presbyterian Medical Services
- San Juan
- San Juan Behavioral Health
- San Juan County Navigation Center
- San Juan Health Partners
- San Juan Regional Medical Center
- School System
- Substance Use Counseling
- Totah

Nutrition, Physical Activity & Weight

- Active Medical Group
- Bariatric Center for Surgery
- Baristas Surgery
- Bonnie Dallas Senior Center
- Boys & Girls Club
- Catholic Charities
- Churches
- Doctors' Offices
- Echo Food Bank
- Farmers' Markets
- Fitness Centers/Gyms
- Food Bank
- Indian Health Services

- McDonald's
- Medications
- Northern Navajo Medical Center
- NutriMeals
- Online Resources
- Parks and Recreation
- PhD Nutrition
- Presbyterian Health
- Presbyterian Medical Services
- San Juan College
- San Juan Health Partners
- San Juan Metabolic and Bariatric Institute
- San Juan Regional Medical Center
- Summer Food Service Program
- Weight Loss Clinics

Oral Health

- Dental Offices
- Doctors' Offices
- Medicaid
- New Mexico Mission of Mercy
- Nizhoni Smiles
- Presbyterian Dental
- Presbyterian Medical Services
- San Juan College

Respiratory Diseases

- Doctors' Offices
- Presbyterian Medical Services
- San Juan Regional Medical Center

Sexual Health

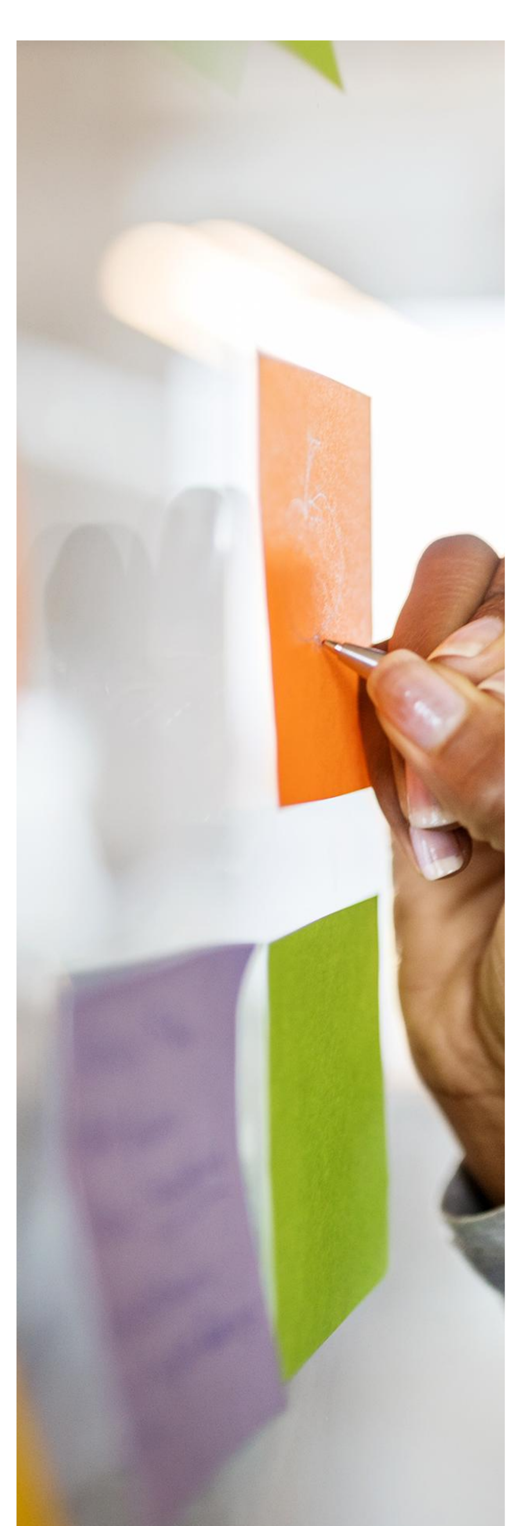
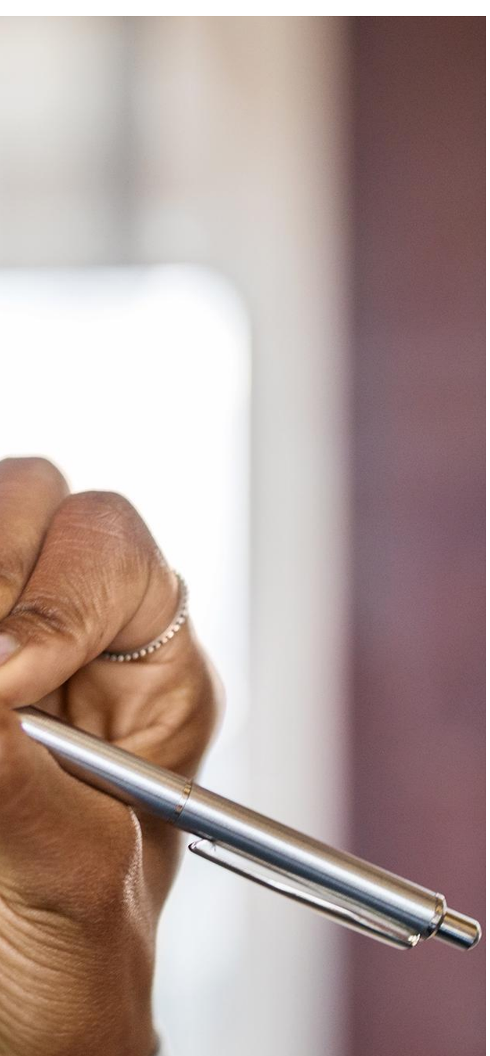
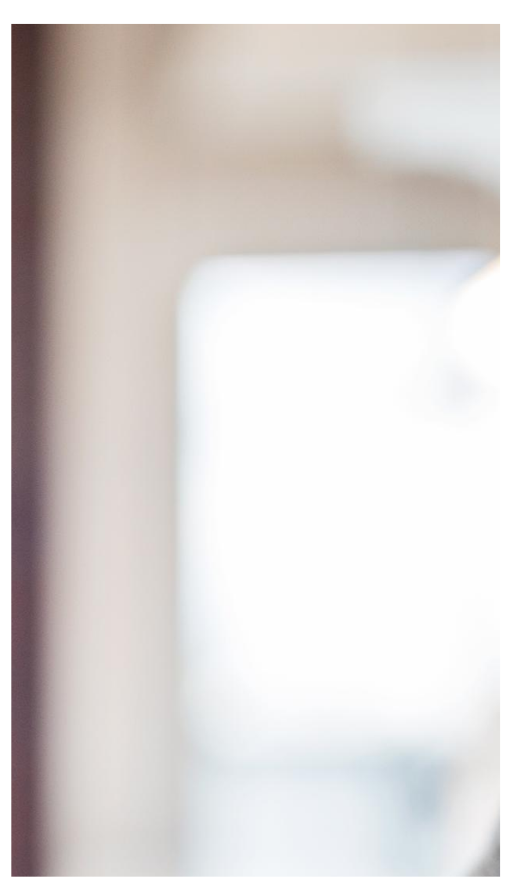
- Doctors' Offices
- Health Department
- Hospitals
- Planned Parenthood
- San Juan Regional Medical Center
- Sexual Assault Services

Substance Use

- AA/NA
- Behavioral Health
- Byron's House is Hope
- Cenikor
- Community Compass
- Community Recovery Groups
- Cottonwood
- Court-Ordered Counseling
- Desert View Family Counseling
- Doctors' Offices
- Faith-Based Programs
- Four Winds Recovery
- Hospitals
- Ideal Options
- Masada House
- Methadone Clinic
- New Mexico Treatment Center
- Presbyterian Medical Services
- San Juan County Navigation Center
- San Juan Regional Medical Center
- Sobering Center
- Substance Use Counseling
- Totah

Tobacco Use

- Cenikor
- Doctors' Offices
- National Quit Line
- Over the Counter Treatments
- San Juan College
- San Juan Regional Medical Center

APPENDIX

EVALUATION OF PAST ACTIVITIES

Implementation Plan Progress Report

Addressing Community Health Needs in Alignment with our Community Health Needs Assessment (CHNA)

San Juan Regional Medical Center remains committed to advancing health equity, improving access to care, and addressing the most pressing health challenges facing our region. This report provides a comprehensive summary of the progress made through strategic initiatives identified in our **Implementation Plan**, developed in response to the priorities outlined in our **Community Health Needs Assessment (CHNA)**.

Each executive summary included below highlights measurable actions taken between **July 1, 2023, through December 31, 2025**, and demonstrates how we are living our mission:
Better is our mission—improving lives through personalized health and care.

Access to Care

- Establishment of the Primary Care Residency Program

Executive Summary
In alignment with San Juan Regional Medical Center's strategic goal to improve access to care and address provider shortages in rural and underserved areas, the organization has taken a major step forward with the establishment of an Internal Medicine Primary Care Residency Program. This program is a long-term investment in the development, recruitment, and retention of skilled physicians who are committed to serving our region. Through collaboration with the New Mexico Primary Care Training Consortium, the residency program reflects our commitment to clinical excellence and the advancement of community health.

Summary of Action Plan Results
San Juan Regional Medical Center has successfully initiated the creation of an **Internal Medicine Primary Care Residency Program**, aimed at strengthening access to care for medically complex patients and supporting a sustainable healthcare workforce for our community.

Key achievements include:

- **Program Launch and Development:**
  - The residency program is currently **on track for full implementation**, offering structured training opportunities to new medical graduates.
  - Curriculum design is aligned with both **clinical excellence** and **community health priorities**.
- **Strategic Collaboration:**
  - Developed in partnership with the **New Mexico Primary Care Training Consortium**, which serves as the sponsoring Graduate Medical Education (GME) institution.
- **Impact on Community Health:**
  - Supports the **long-term retention** of internal medicine physicians in the region.
  - Enhances capacity to care for **medical complex and underserved** patient populations.

- Reinforces San Juan Regional Medical Center's **mission of personalized health and care** through a focus on high-quality, patient-centered education and service.

This initiative marks a significant milestone in building a more resilient and capable local healthcare system designed to meet present and future needs.

- Ongoing coordination to help meet the needs of those being discharged from the hospital or Emergency Department who do not have a primary care provider and directing them to services at the San Juan Health Partners Family Medicine Farmington location to establish a primary care provider.

Executive Summary
San Juan Regional Medical Center implemented a coordinated initiative to address the needs of patients discharged from the hospital or Emergency Department who lacked an established primary care provider. This effort, led in collaboration with San Juan Health Partners Family Medicine Farmington, focused on connecting these patients with appropriate primary care services to ensure continuity of care and improve long-term health outcomes. The initiative has demonstrated meaningful results in patient outreach and coordination.

Summary of Action Plan Results
As part of the ongoing coordination effort, a total of **832 patients** discharged from the Urgent Care, Emergency Department, or hospital between **July 1, 2023, and the present** were identified as not having a primary care provider. These patients were directed to **San Juan Health Partners Family Medicine Farmington** to establish a primary care relationship. This action plan has significantly contributed to closing gaps in care and fostering access to essential primary health services within our community.

- Continuing the role of community health worker positions at the family medicine clinics.

Executive Summary
As part of San Juan Regional Medical Center's commitment to addressing social determinants of health and improving access to care, the organization expanded its original initiative to maintain community health worker positions in Family Medicine clinics. This initiative evolved into a broader, integrated support model that now includes both community health workers and licensed clinical social workers across multiple service lines. The strategic expansion has enhanced patient support, care coordination, and access to behavioral health and social services throughout the care continuum.

Summary of Action Plan Results
The original plan to continue community health worker (CHW) positions at Family Medicine clinics was successfully implemented and significantly expanded. Community health and licensed clinical social work services now support the following areas:

- **Community Health Worker and Social Work Coverage:**
    - **Full-Time CHW Positions (3 total):**
        - One position covers Aztec, Family Medicine Farmington, and Internal Medicine.
        - One position supports Urgent Care, Wound Treatment Center, and the Metabolic and Bariatric Institute.
        - One position is dedicated to Pediatrics and two OB/GYN clinics.
- **Licensed Clinical Social Worker Expansion:**
    - A **dedicated LCSW** provides both group and individual therapy within **Pediatrics**. This position was hired and onboarded on November 20, 203, and

currently maintains an average caseload of 60 to 70 active patients receiving individual therapy.

A **global LCSW** supports **all other clinics**, ensuring comprehensive coverage across specialties. This role was hired and onboarded on September 30, 2024.

While **Behavioral Health** does not currently have a dedicated CHW or LCSW, plans are underway to extend support to that area. Finalization of this expansion is anticipated by June 30, 2206.

- Recruit and retain medical providers to serve our community.

Executive Summary
To address healthcare access and service demands across our region, San Juan Regional Medical Center prioritized the recruitment and retention of high-quality medical providers as a key component of its strategic plan. From July 1, 2023, through December 31, 2025, significant progress has been made in building a stable, skilled provider workforce. This effort ensures continuity of care, enhances specialty services, and strengthens our ability to meet the growing and complex healthcare needs of our community. The recruitment effort reflects our ongoing commitment to personalized health and care by expanding provider coverage across a broad range of medical specialties.

Summary of Action Plan Results
As part of our focused strategy to recruit and retain providers, **69 medical providers**—including **physicians and advanced practice providers**—have joined **San Juan Regional Medical Center** as **W2 employees** (PRN, half-time, and full-time) and **remain actively employed**.

These hires span a wide range of specialties, supporting comprehensive care delivery across the organization:

- **Hospital-Based Specialties:**
    - Anesthesia: 8
    - Emergency Medicine: 7
    - Hospitalist: 12
    - Critical Care – Intensivist: 2
    - Radiation Oncology: 3
    - Neurosurgery: 1
- **Outpatient and Specialty Services:**
    - Family Medicine: 8
    - Internal Medicine – Outpatient: 1
    - Psychiatry: 4
    - Pediatrics: 5
    - Gastroenterology: 5
    - General Surgery: 2
    - Cardiology – Electrophysiology – Pulmonology 2
    - Pain Management – Interventional Spine: 2
    - Neurology: 1

- Physiatry: 1
- Urgent Care: 2
- Urology: 1
- Wound Treatment: 1
- OBGYN - 1

This milestone supports our broader mission by enhancing access, reducing care gaps, and ensuring high-quality medical services are consistently available to our community.

- Utilize telemedicine to expand healthcare services provided in the Four Corners region.

Executive Summary
San Juan Regional Medical Center continues to leverage telemedicine as a vital tool to expand healthcare access and address specialist shortages throughout the Four Corners region. By strategically deploying telehealth services across multiple departments, the organization is reducing geographic barriers to care, improving timely access to specialty expertise, and supporting high-quality treatment for patients of all ages. This initiative aligns with our commitment to innovation, equity, and meeting patients where they are—especially in rural and underserved communities.

Summary of Action Plan Results
In response to evolving healthcare needs and the importance of increasing access to specialty services, San Juan Regional Medical Center has **reprioritized and expanded the use of telemedicine** across several service lines.

Key achievements include:

- **Behavioral Health:**
  - Sustained telemedicine access for **children and adolescents** through remote behavioral health providers.
  - **Upgraded equipment** in the Behavioral Health clinic to improve **connectivity and patient experience** during virtual visits.
- **Pediatrics:**
  - Actively exploring models to connect pediatric patients with **specialists via telemedicine**, enabling clinic-based visits without the need for travel.
- **Hospital-Based Telehealth Services:**
  - Implementing 24/7/365 **EEG interpretation services** for both **pediatric and adult** patients using telemedicine.
  - Sustained a **neurosurgery and neurology consultation service** via telehealth for the Emergency Department when in-house neurosurgical coverage is unavailable.
  - **In progress:** Development of a **hospital-based infectious disease consult service** using telemedicine.

These initiatives reflect a targeted strategy to **expand telehealth access in niche, hard-to-cover specialties**, ensuring patients receive timely, expert care regardless of location. The approach strengthens our capacity to deliver on our mission of personalized health and care while supporting operational resilience across the healthcare continuum.

- Continue participation in the 340-B program.

Executive Summary
San Juan Regional Medical Center remains committed to leveraging the 340B Drug Pricing Program as a vital resource to improve access to care and support vulnerable populations. By maintaining full compliance with federal regulations and implementing strong oversight measures, the organization ensures the integrity of its 340B operations while strategically reinvesting savings to address key community health priorities. Participation in the program is essential to sustaining medication access, enhancing outpatient services, and supporting the broader mission to improve lives through personalized health and care—particularly for underserved patients in the Four Corners region.

Summary of Action Plan Results
San Juan Regional Medical Center continues active and compliant participation in the **340B Drug Pricing Program**, resulting in significant reinvestment into community health and patient care:

- **Program Compliance and Oversight:**
    - Maintains full compliance with all **federal 340B requirements**.
    - Implements **rigorous internal controls and monitoring** to ensure appropriate use of program savings.
- **Community Reinvestment:**
    - 340B savings are used to support priorities identified in the **Community Health Needs Assessment (CHNA)**, including:
        - Improved access to medications
        - Enhanced outpatient services
        - Support for underserved and vulnerable populations
- **Financial Impact:**
    - From **July 2023 to present**, the hospital has realized **$5,075,305.98 in drug cost savings**, which have been **reinvested into hospital services**.
    - Through an **expanded contract pharmacy network**, patients have received **$12,200,067.14 worth of medications** while paying **$1,596,950.92 in copays**—making high-cost therapies accessible at a significantly reduced out-of-pocket expense.
- **Disproportionate Share Hospital Status:**
    - As a designated **Disproportionate Share Hospital (DSH)** through HRSA, San Juan Regional Medical Center is empowered to provide **advanced medication therapies** locally reducing the need for patients to travel outside the region for treatment.

These outcomes underscore the critical role of the 340B Program in ensuring equitable access to care and demonstrate our continued commitment to delivering high-quality, affordable services to those who need them most.

Executive Summary: Bariatric and Metabolic Institute – Expanding Local Access to Specialized Obesity Care

Reporting Period: July 1, 2023 – December 31, 2025

To address the rising prevalence of obesity and related chronic conditions in our region,

San Juan Regional Medical Center launched the **Bariatric and Metabolic Institute**, offering both **medical and surgical weight loss options** tailored to individual needs. This program is designed to support **long-term health improvement** and empower community members to make sustainable lifestyle changes without needing to leave the Four Corners region for specialized care.

Key components of the program include:

- **Personalized nutrition counseling** from a dedicated registered dietitian.
- **Surgical weight loss procedures** for eligible patients.
- **Medical weight management strategies** for those seeking non-surgical interventions.

By providing evidence-based, comprehensive treatment options locally, this initiative removes a significant access barrier and responds directly to a critical community health need. It reflects our commitment to proactive, preventive care that supports healthier lives through **ongoing support and long-term success**.

This effort is a direct reflection of our mission:
Better is our mission—improving lives through personalized health and care.

Executive Summary: Community Van Transportation Program – Breaking Down Barriers to Access

Reporting Period: July 1, 2023 – December 31, 2025
San Juan Regional Medical Center continues to address a key social determinant of health—**transportation access**—through our **Free Community Van Transportation Program**, which remains the only such service in the Four Corners region.

During the reporting period, the program achieved the following impact:

- **26,935 miles traveled.**
- **878 unique individuals transported.**
- **806 medical appointments facilitated.**

Serving patients within a 20-mile radius of Farmington, this essential service reaches those who often face the greatest obstacles to care, including elderly individuals, those with disabilities, and residents with limited income. By eliminating transportation as a barrier, the program helps ensure **continuity of care**, reduces missed appointments, and contributes to better health outcomes across the region.

This initiative exemplifies San Juan Regional Medical Center's dedication to **health equity, community well-being, and personalized support**, advancing our mission in tangible, life-improving ways.

Executive Summary: Support for the San Juan County Mental Wellness Resource Center
Reporting Period: November 1, 2020 – February 2, 2025
In alignment with our commitment to holistic health and care, San Juan Regional Medical Center has played a foundational role in the development and success of the **San Juan County Mental Wellness Resource Center**. Recognizing the growing need for accessible mental health support in our region, we proudly provided **2,828 square feet of dedicated space** to house this essential community resource.

Since its inception on **November 1, 2020**, the Mental Wellness Resource Center has served as a safe and welcoming environment where individuals and families can connect with mental health services, educational resources, and guidance. San Juan Regional Medical Center's early and

continued support was instrumental in **launching and sustaining this program**, helping to bridge the gap between community members in need and the services available to them. Over the past five years, this center has become a vital access point for those seeking mental health assistance, reinforcing our commitment to addressing not just physical, but also emotional and psychological well-being. By helping establish and maintain this center, we have strengthened the local behavioral health network and promoted resilience and recovery in our community.

Our support of the Mental Wellness Resource Center reflects San Juan Regional Medical Center's enduring mission to improve lives through personalized, compassionate, and comprehensive care—ensuring that every member of our community has the opportunity to thrive.

Diabetes

- Expanding the pool of diabetes educators
- Assessment of diabetes education materials for both hospitalized and non-hospitalized patients
- Continue group classes, individual assessments, and education on diabetes
- Complete analysis for re-establishment of the National Diabetes Prevention program

Executive Summary
San Juan Regional Medical Center remains focused on expanding and enhancing diabetes education and prevention services as part of its commitment to managing chronic disease and improving community health outcomes. Recognizing the rising prevalence of diabetes in our region, efforts have centered on increasing access to certified diabetes education, tailoring educational materials, and evaluating the re-establishment of the National Diabetes Prevention Program (NDPP). These services not only support patients with diabetes but also empower community members with the knowledge and resources to prevent its onset. By investing in targeted education and care, the organization continues to advance its mission of better health through personalized support and evidence-based practices.

Summary of Action Plan Results
San Juan Regional Medical Center has implemented the following diabetes-related initiatives to improve care access, education, and prevention:

- **Expansion of Diabetes Education Resources:**
    - The department currently operates with **one Certified Diabetes Care and**
    - **Education Specialist (CDCES)** working 60 hours per pay period, supported by a **part-time Administrative Assistant**.
    - There is an identified need for an additional **Registered Dietitian** to align with **ADA Standards of Care**, which recommend collaborative care between a CDCES and dietitian for newly diagnosed patients.
- **Assessment of Educational Materials:**
    - All **outpatient diabetes education** patients receive **personalized education materials** tailored to their specific needs.
    - The department has evaluated and continues to refine materials for **both hospitalized and non-hospitalized patients**.
- **Ongoing Education Offerings:**
    - The team continues to provide a combination of **group classes and individual assessments**.

- Between **July 2024 and December 2025**, a total of **254 individual patients** received diabetes education.
- Additionally, **55 community members** participated in group education events.
- **Total individuals served: 309.**

- **National Diabetes Prevention Program (NDPP):**
  - The NDPP is a **yearlong program** requiring two trained lifestyle coaches.
  - Re-establishment is currently on hold due to staffing limitations; one team member would need to **recertify,** and a **second trained coach** is needed to resume the program.
- **Related Initiative – Metabolic and Bariatric Institute:**
  - In response to obesity-related health concerns, the **Bariatric and Metabolic Institute** now provides **local medical and surgical weight loss options**.
  - Patients receive individualized care, including **dietitian support**, eliminating the need to travel for specialized services.

These efforts reflect a strong, patient-centered approach to diabetes management and prevention and highlight the hospital's ongoing response to a critical community health need.

Cancer

- Expansion of services: Stereotactic body radiotherapy (SBRT) and Stereotactic radiosurgery (SRS)
- Prostate Specific Antigens or PSMA expansion
- Physician Recruitment in Radiation Oncology
- Selective internal radiation therapy (y-90 therapy) of liver tumors

Executive Summary: Expansion of Radiation Oncology Services
San Juan Regional Medical Center has made substantial strides in expanding and enhancing cancer care services for our region, reinforcing our commitment to delivering advanced, patient-centered treatment close to home. A key milestone in this effort was the **successful recruitment of a full-time Radiation Oncologist, Dr. Brian Fuller, who joined the organization on November 2, 2023.** Dr. Fuller brings deep expertise and continuity of care to our Radiation Oncology team. His full-time presence ensures consistent treatment planning, direct patient interaction, and high-quality oversight of complex cases. In addition, a PRN Radiation Oncologist is on staff to provide seamless coverage when Dr. Fuller is unavailable, ensuring there is no interruption in care.

Key Service Expansions Include:

- **Stereotactic Body Radiotherapy (SBRT):**
SBRT was launched for prostate cancer patients in January 2025, following the successful implementation for breast cancer patients in October 2024. With the recent acquisition of the Alta Device and scheduled training in June 2025, SBRT capabilities will expand to include lung and abdominal cancers.
- **Stereotactic Radiosurgery (SRS):**
In place since early 2024, SRS offers non-invasive, high-precision treatment for brain cancers, improving outcomes while minimizing side effects.

- **Prostate Cancer Services – Hormone Therapy Expansion:**
  Hormone injections (Eligard) are now administered regularly in our clinic, with an average of 5 to 8 injections monthly, enhancing localized care for prostate cancer patients.

- **Patient Volume Growth:**
  Dr. Fuller has seen a total of **615 patients** since joining the team:
  - Nov. 2 – Dec. 31, 2023: 33 patients
  - Jan. 1 – Dec. 31, 2024: 301 patients
  - Jan. 1 – Dec. 31, 2025: 479 patients

- **Prone Breast Treatment:**

  We can treat certain breast cancers with the patient in the prone position. This is done so we can spare the lung and heart, which leads to fewer side-effects and better overall outcomes.

Additionally, selective internal radiation therapy (Y-90 therapy) for liver tumors continues to grow and is expanding Interventional Radiology (IR) services at SJRMC, offering patients access to specialized treatment without needing to leave the region. In parallel, our newly launched Cardiac PET-CT program provides advanced imaging for the assessment of heart disease, helping physicians diagnose and tailor treatment plans with precision. This state-of-the-art technology allows patients to receive expert cardiac care close to home, reducing the need for travel while supporting earlier and more accurate interventions.

Together, these developments represent a significant step forward in meeting the complex needs of both cancer and cardiac patients in the Four Corners region, improving outcomes, reducing travel burdens, and reinforcing our mission:
Better is our mission—improving lives through personalized health and care.