11. Healthy Lifestyles, Healthy Environments

Maintaining a healthy lifestyle throughout the course of life is essential for overall wellbeing. A healthy lifestyle incorporates everything from eating a balanced diet, being physically active, avoiding unhealthy behaviors like smoking, getting preventive care and screening tests, and developing strong social support systems within families and communities. Adopting a healthy lifestyle early in life can set a person on a course toward good health for years to come.
Our environment also plays an important role in our health and well-being. There are many environmental factors that affect health, including the quality of the water we drink, the air we breathe, and the food we eat.

This section provides data on several indicators related to healthy lifestyles and environment for AI/AN in Idaho, including: weight status for both children and adults; levels of exercise; fruit and vegetable consumption; tobacco cessation; seatbelt use; asthma prevalence; and state-wide air quality; and locations of fish consumption advisories.

Most of the other indicators in this report can be seen as eventual outcomes of the issues presented in this section. Improving these measures is a crucial starting point at decreasing chronic disease and accidents.

Less than one third of Idaho AI/AN reported exercising, less than ten percent reported eating the recommended number of fruits and vegetables, and less than a third were at a healthy weight. Smoking was still more common among AI/AN than NHW with about a third of AI/AN reporting smoking currently. Of note, however, was that 33% of AI/AN males and 25% of females were former smokers who have now quit. This may be in part due to tobacco cessation counseling, as nearly 40% of Idaho Indian health clinic patients had received cessation counseling. This was better than the rest of Portland area. Air quality was good across most of Idaho; however, some parts of the Fort Hall reservation are in poor air quality areas.

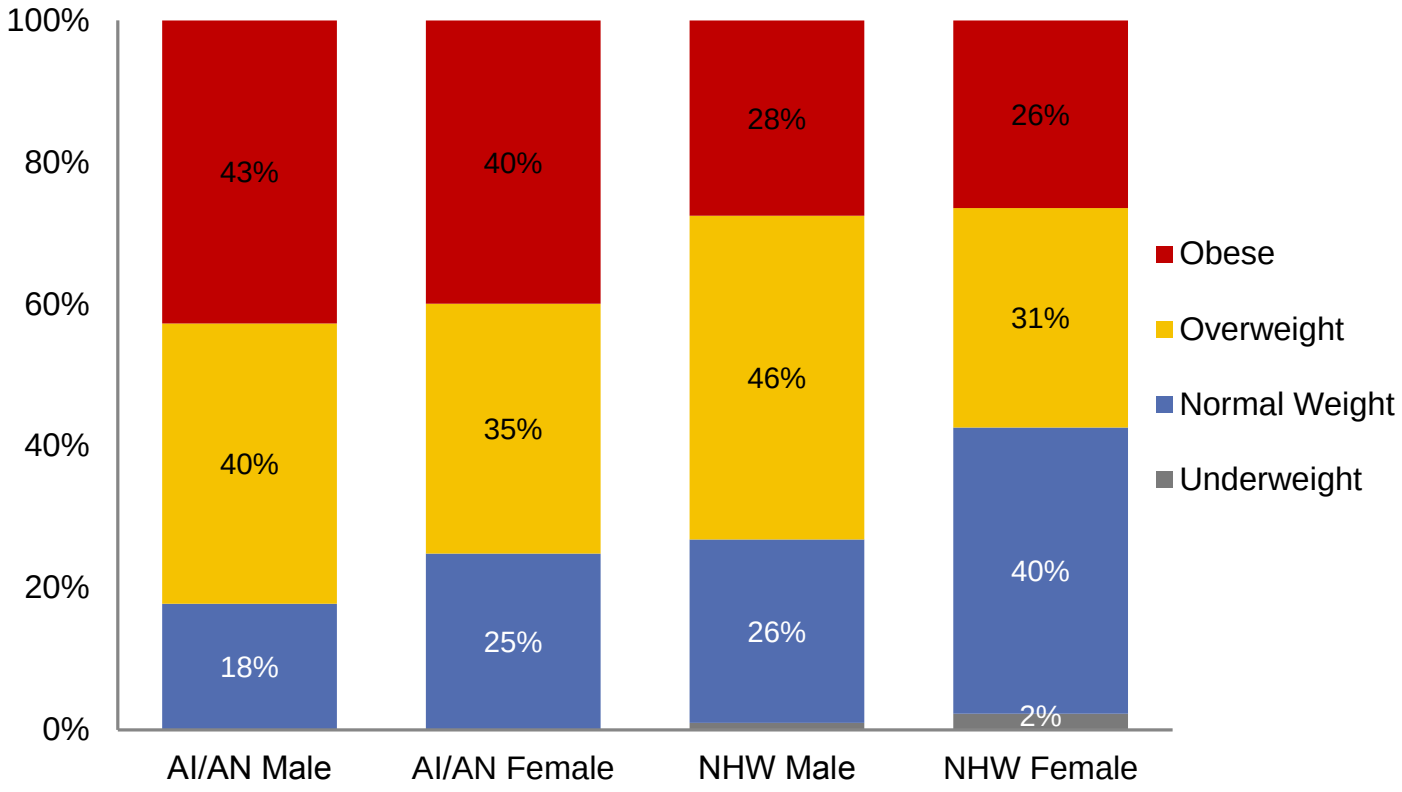
Body Mass Index (BMI)

From 2006-2012, AI/AN males and females in Idaho were more likely to be overweight or obese than their NHW counterparts in the state. Eighty percent of AI/AN males had a BMI in the overweight or obese range, compared to three quarters of NHW males. Among females, 3 out of 4 AI/AN women were overweight or obese compared to 57% of NHW women. (Figure 11.1). AI/AN females were slightly more than AI/AN males to fall in the normal weight range (25% versus 18%).

Data Source: 2006 – 2012 CDC BRFSS

Data Notes: The BRFSS prevalence estimates (shown as a percentage) are weighted to make the survey responses representative of the Idaho population. The sample sizes presented below the figures are the unweighted number of people who answered this question for the indicated years.

Figure 11.1: Body mass index (BMI) by race and sex, Idaho, 2006-2012.



BMI categories (in kg/m²): Underweight: <18.5; Normal Weight: 18.5 – 24.9; Overweight: 25.0 – 29.9; Obese: >30.0

Sample sizes (n): AI/AN males=185; AI/AN females=289; NHW males=3,773; NHW females=5,090.

Childhood Weight Control

Children with a BMI that is at or above the 95th percentile for their age group are considered obese. The U.S.goal is for no more than 9.6% of children ages 2-5 to be considered obese (Healthy People 2020).

IHS tracks the percentage of AI/AN children (ages 2-5) with a BMI in the 95th percentile range. In 2013, the IHS goal for childhood obesity was 24%. Having a lower score means better performance (i.e., fewer overweight children) for this measure.

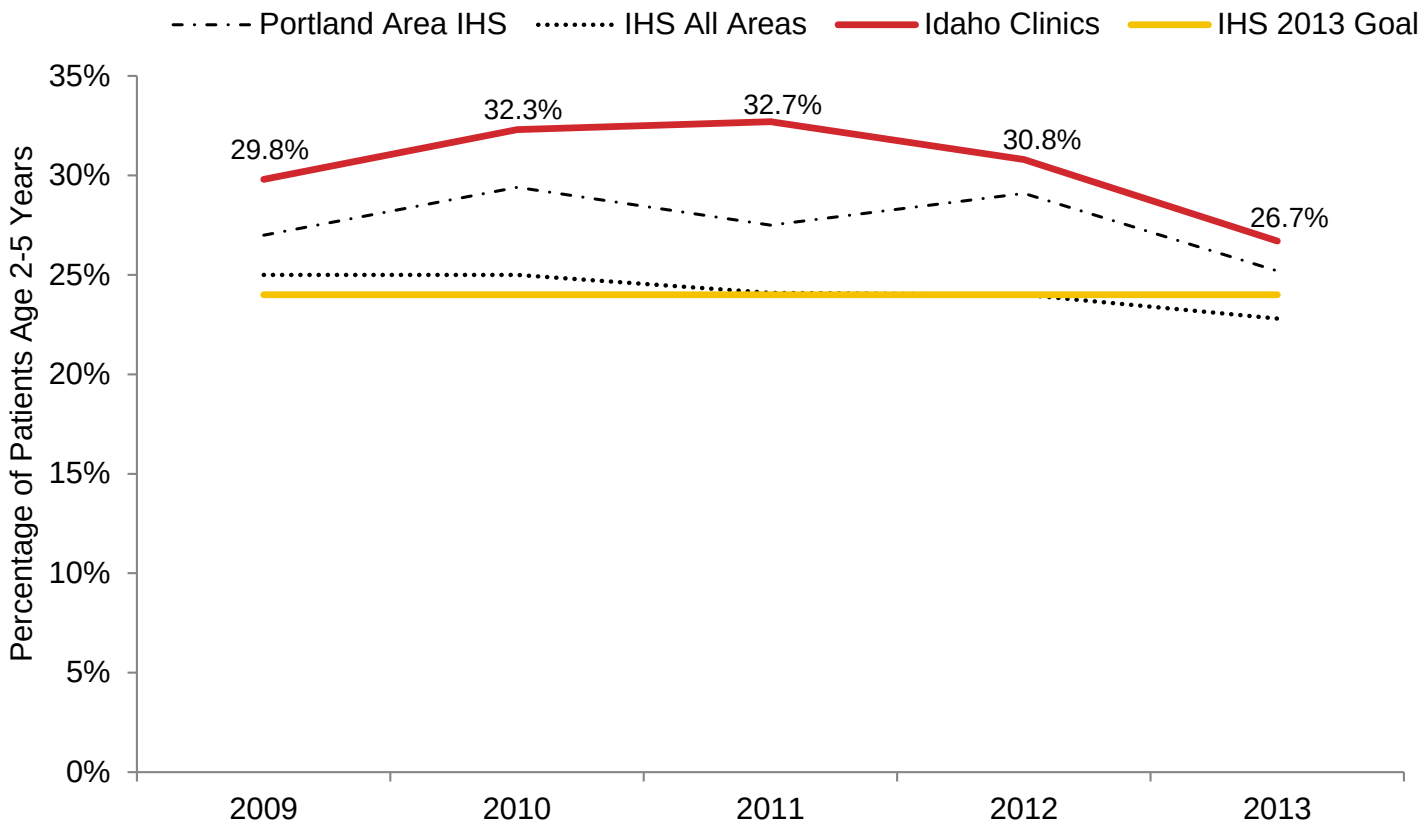
The percentage of IHS AI/AN children with an overweight BMI has decreased at the national IHS level since 2009 (Figure 11.2). In 2013, the national IHS average for this measure was 22.8%, meaning there were fewer obese children than the 2013 goal of 24%. The prevalence of childhood obesity for Idaho clinics and the Portland Area IHS has fluctuated since 2009, and has not shown a consistent upward or downward trend. In 2013, 26.7% of children seen at Idaho clinics were obese, which was slightly more than the goal of IHS 2013 goal of 24%.

Data Source: Portland Area Indian Health Service.

Data Notes: Data labels only shown for Idaho clinics.

Idaho clinics include non-urban federal and tribal Indian health facilities in Idaho. Portland Area IHS clinics include non-urban federal and tribal Indian health facilities in Idaho, Oregon, and Washington.

Figure 11.2: Percentage of IHS patients ages 2-5 considered obese (with BMI ≥ 95 percentile), 2009-2013.



Exercise

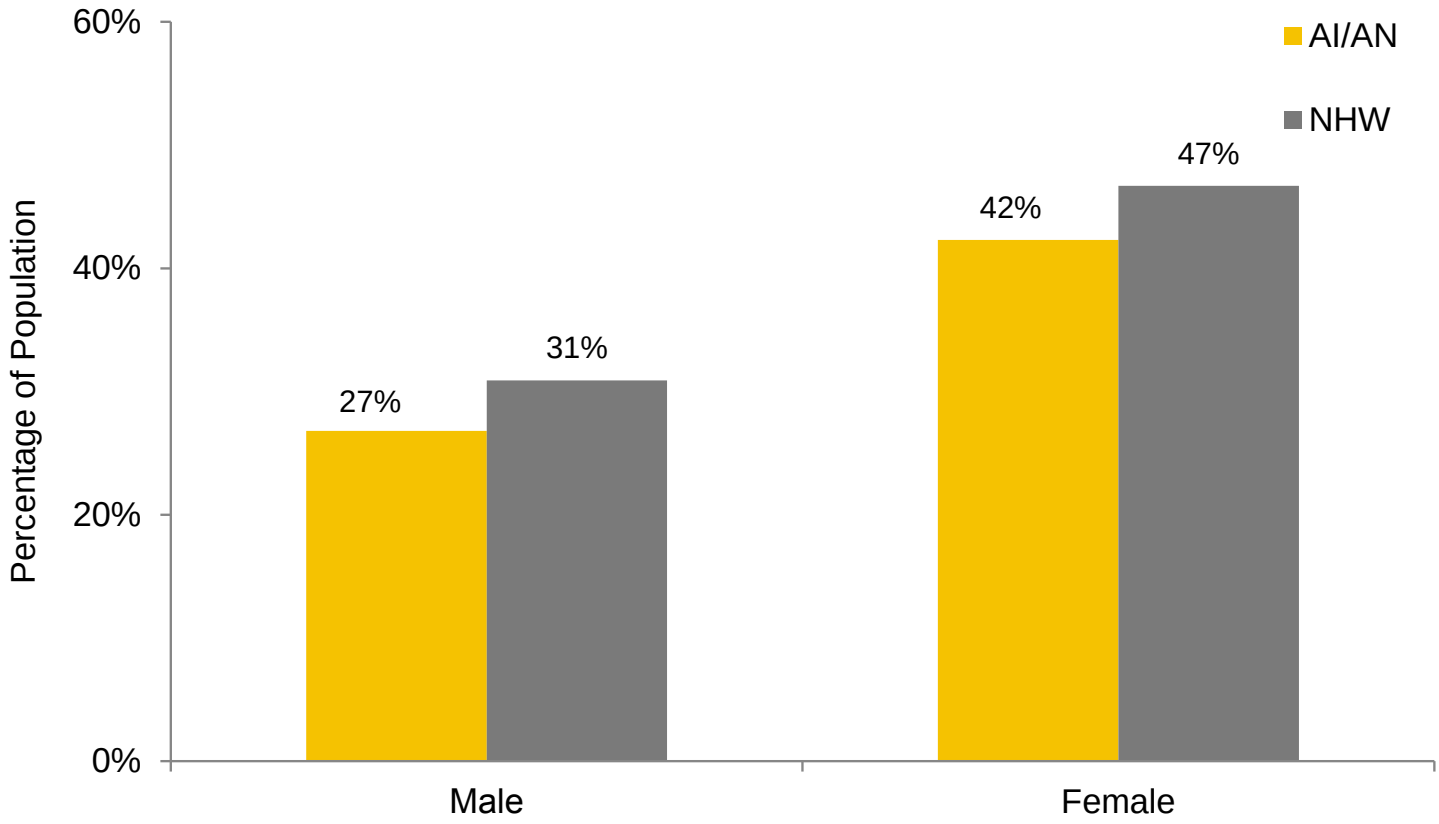
Exercise and physical activity was defined as any exercise in the past month. Females of both races were more likely than males to have exercised, and there was not much difference between AI/AN and NHW.

Less than half of AI/AN women and less than one third of AI/AN men reported participating in any exercise in the past month.

Data Source: 2006 – 2012 CDC BRFSS

Data Notes: The BRFSS prevalence estimates (shown as a percentage) are weighted to make the survey responses representative of the Idaho population. The sample sizes presented below the figures are the unweighted number of people who answered this question for the indicated years.

Figure 11.3: Percentage of population who exercised in the past month, by race and sex, Idaho, 2006-2012.



Sample sizes (n): AI/AN males=521; AI/AN females=865; NHW males=36,250; NHW females=56,138.

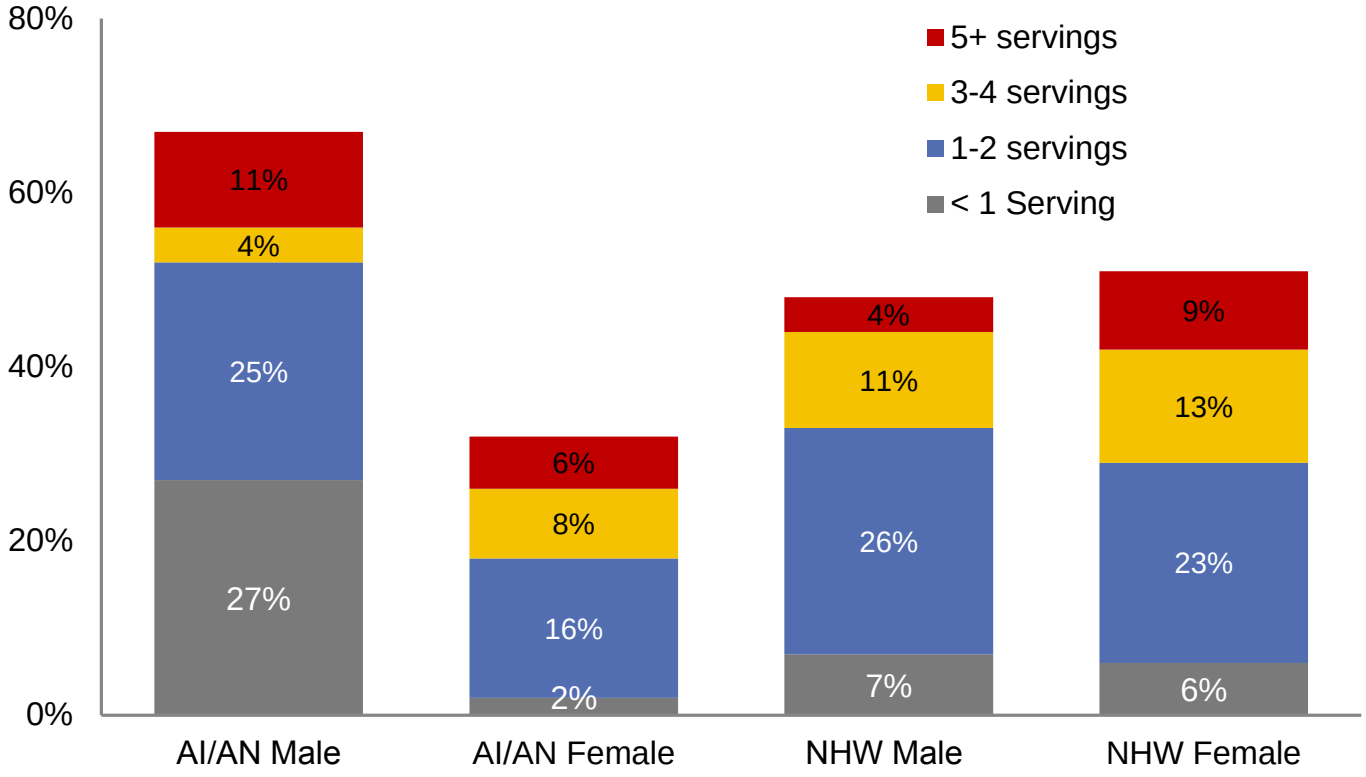
Fruit and Vegetable Consumption

Self-reported fruit and vegetable consumption is shown in Figure 11.4. Only 15% of AI/AN males and 14% of AI/AN females reported eating at least 3 to 5 servings of fruit and vegetables on an average day, which was similar to the NHW results. The proportion who reported eating fewer than one serving on average was very low for AI/AN females (2%), in fact lower than NHW. However, almost one third of AI/AN males reported eating fewer than one serving of fruits and vegetables on an average day.

Data Source: 2006 – 2012 CDC BRFSS

Data Notes: The BRFSS prevalence estimates (shown as a percentage) are weighted to make the survey responses representative of the Idaho population. The sample sizes presented below the figures are the unweighted number of people who answered this question for the indicated years.

Figure 11.4: Self-Reported fruit and vegetable consumption by race and sex, Idaho 2006-2012



Sample sizes (n): AI/AN males=33; AI/AN females=47; NHW males=2,271; NHW females=3,422.

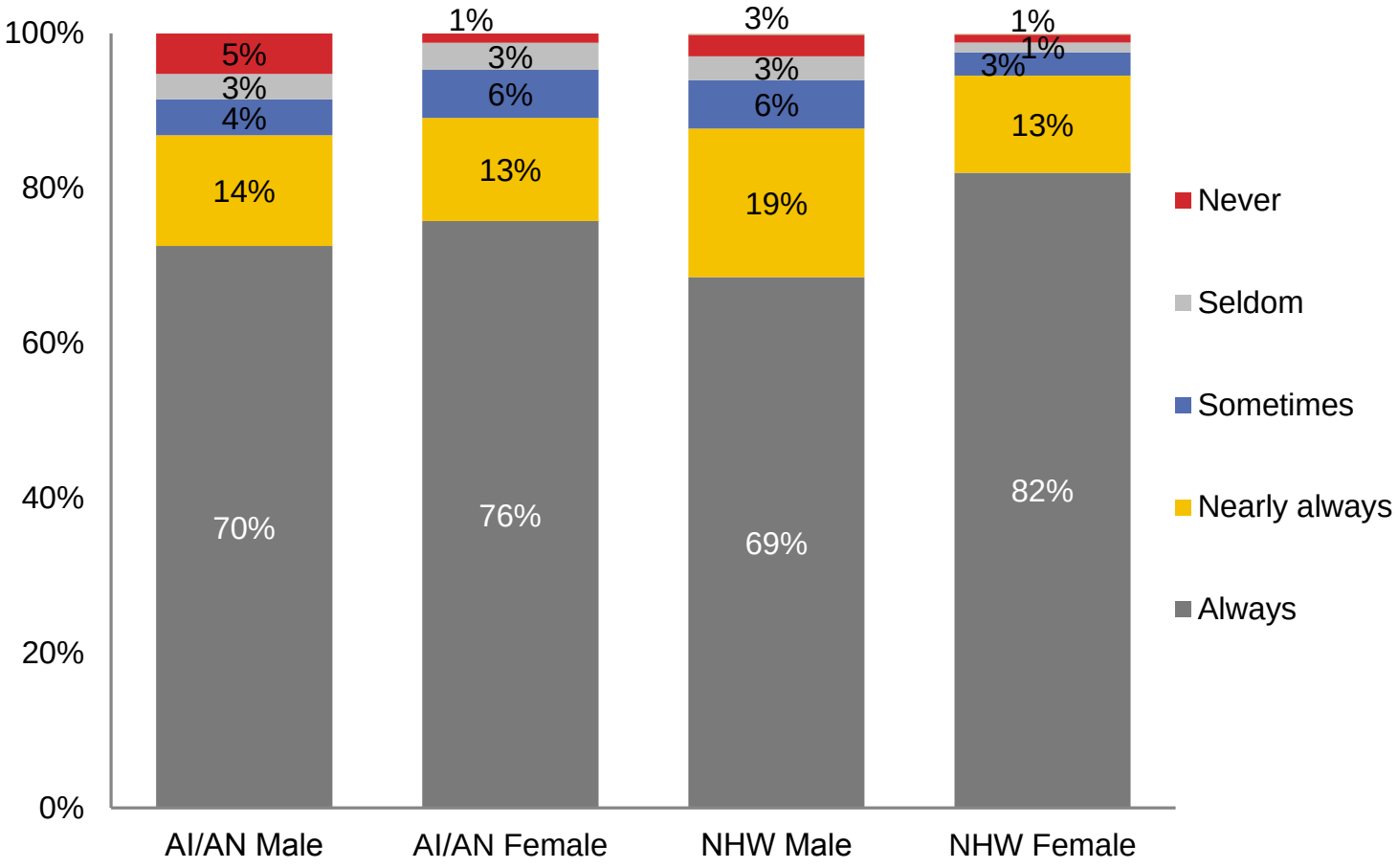
Seatbelt Use

Among AI/AN and NHW in Idaho, women were more likely than men to report always wearing a seatbelt (Figure 11.5). The majority (82%) of NHW women always wore seatbelts, while 76% of AI/AN women always wore seatbelts. Eight percent of AI/AN men and six percent of NHW men reported that they seldom or never wore seatbelts. It should be noted that some of these data were collected prior to states implementing seatbelt ticketing laws.

Data Source: 2006 – 2012 CDC BRFSS

Data Notes: The BRFSS prevalence estimates (shown as a percentage) are weighted to make the survey responses representative of the Idaho population. The sample sizes presented below the figures are the unweighted number of people who answered this question for the indicated years.

Figure 11.5: Self-reported seatbelt use by race and sex, Idaho, 2006-2012.



Sample sizes (n): AI/AN males=375; AI/AN females=660; NHW males=27,452; NHW females=42,555.

Smoking Status

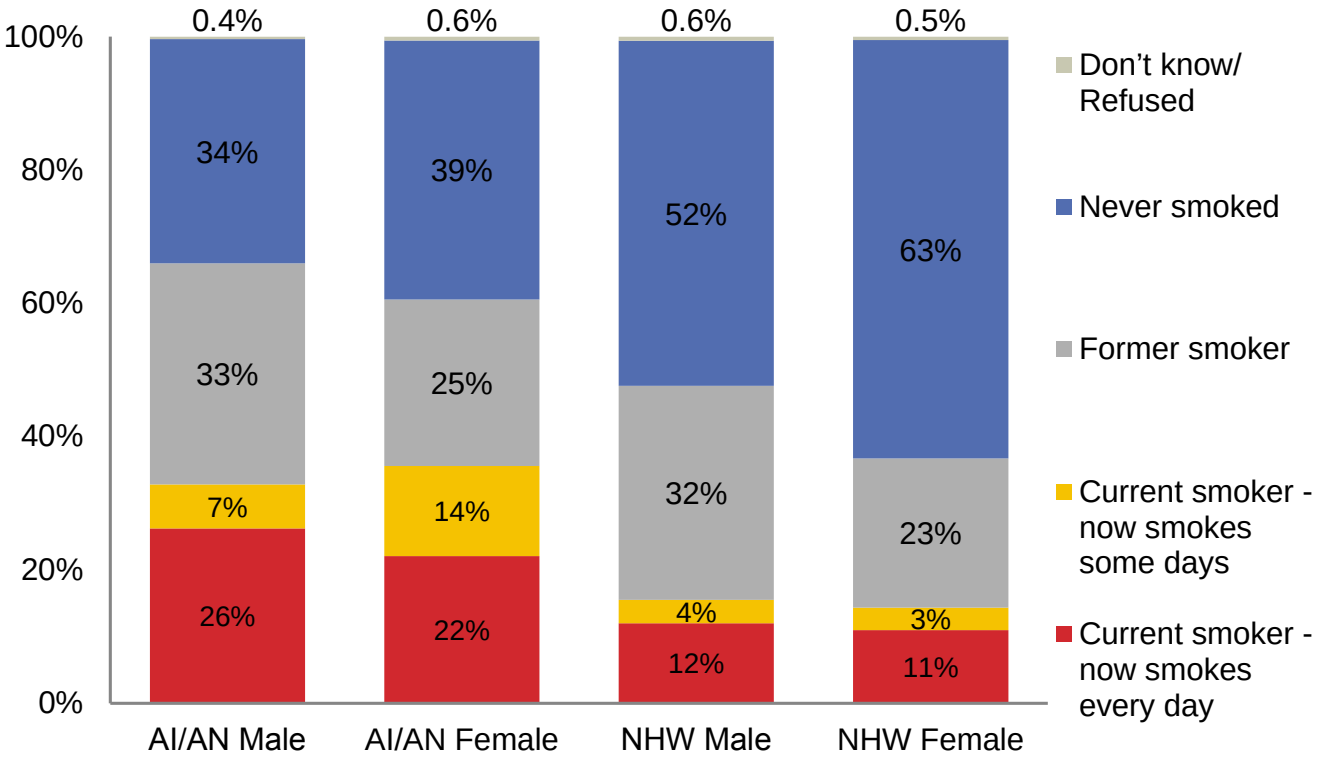
AI/AN males and females in Idaho were more likely to report being current smokers than NHW in the state. From 2006-2012, about one in four AI/AN males reported smoking every day while 8% reported smoking some days (Figure 11.6). AI/AN females were less likely to be current smokers than AI/AN males; however, one in five still reported smoking every day and an additional 14% on some days.

Among NHW, about 15% were current smokers. More than half had never smoked, compared to about a third of AI/AN.

Data Source: 2006 – 2012 CDC BRFSS

Data Notes: The BRFSS prevalence estimates (shown as a percentage) are weighted to make the survey responses representative of the Idaho population. The sample sizes presented below the figures are the unweighted number of people who answered this question for the indicated years.

Figure 11.6: Smoking status by race and sex, Idaho, 2006-2012.



Sample sizes (n): AI/AN males=530; AI/AN females=875; NHW males=36,557; NHW females=56,587.

Tobacco Cessation

Tobacco use increases the risk for many diseases, including lung cancer, cardiovascular diseases, and respiratory diseases. The U.S. goal is for 80% of adult smokers to attempt to stop smoking in the past 12 months (Healthy People 2020).

IHS tracks the percentage of tobacco-using patients who have received a tobacco cessation intervention (such as tobacco cessation counseling) in the past year. The 2012 goal for this measure was 30%. IHS is using 2013 rates to establish a new baseline for this measure, and did not set a 2013 goal.

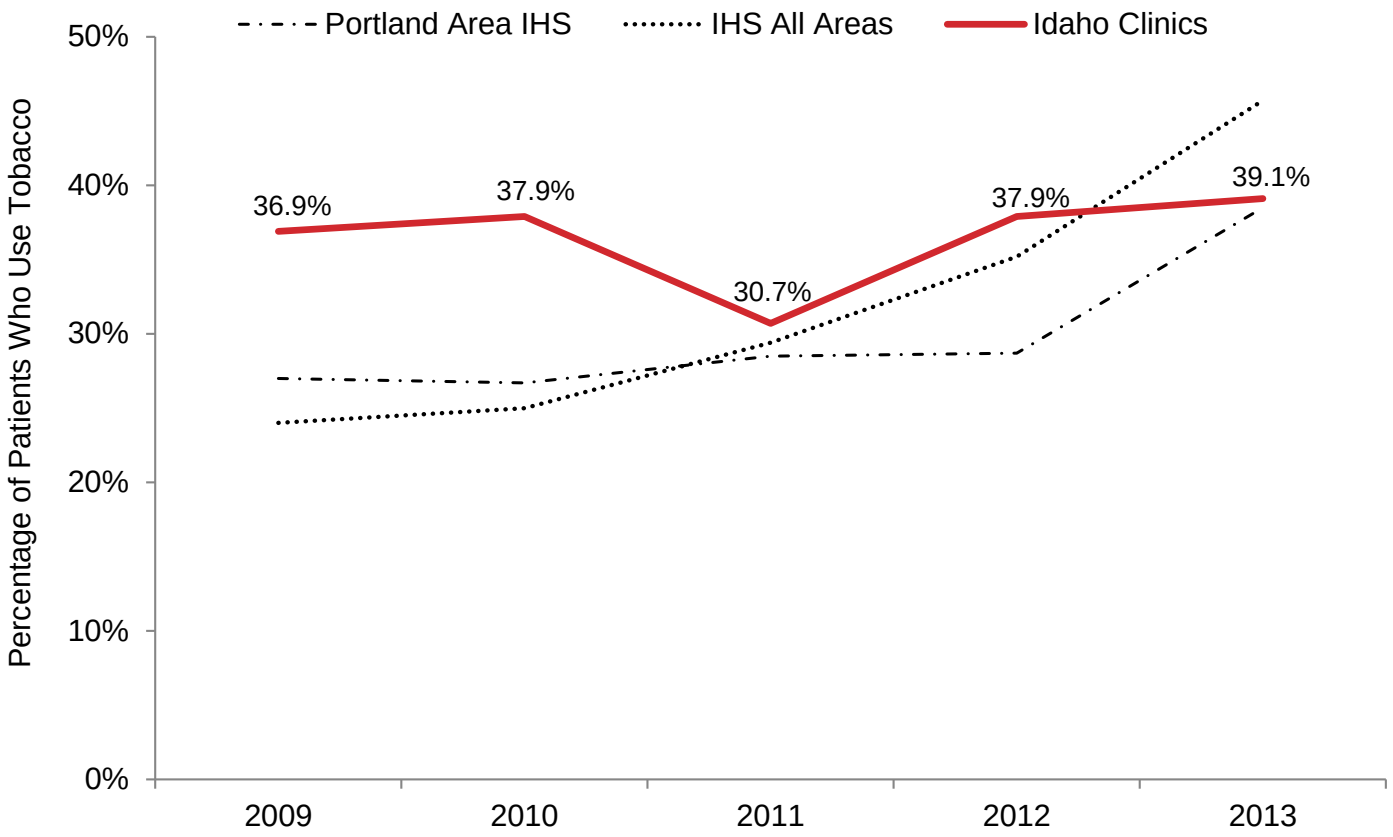
The tobacco cessation counseling rates for Idaho clinics fluctuated between 30-40% from 2009 and 2013, and exceeded the Portland Area IHS average for all years. The Portland Area and national IHS have shown an upward trend for this measure since 2009, with a sharper increase for the national IHS. In 2012, Idaho clinics and the national IHS exceeded the 2012 goal of 30%, while the Portland Area IHS fell below this goal.

Data Source: Portland Area Indian Health Service.

Data Notes: Data labels only shown for Idaho clinics.

Idaho clinics include non-urban federal and tribal Indian health facilities in Idaho. Portland Area IHS clinics include non-urban federal and tribal Indian health facilities in Idaho, Oregon, and Washington.

Figure 11.7: Tobacco cessation counseling rates for IHS patients, 2009-2013.



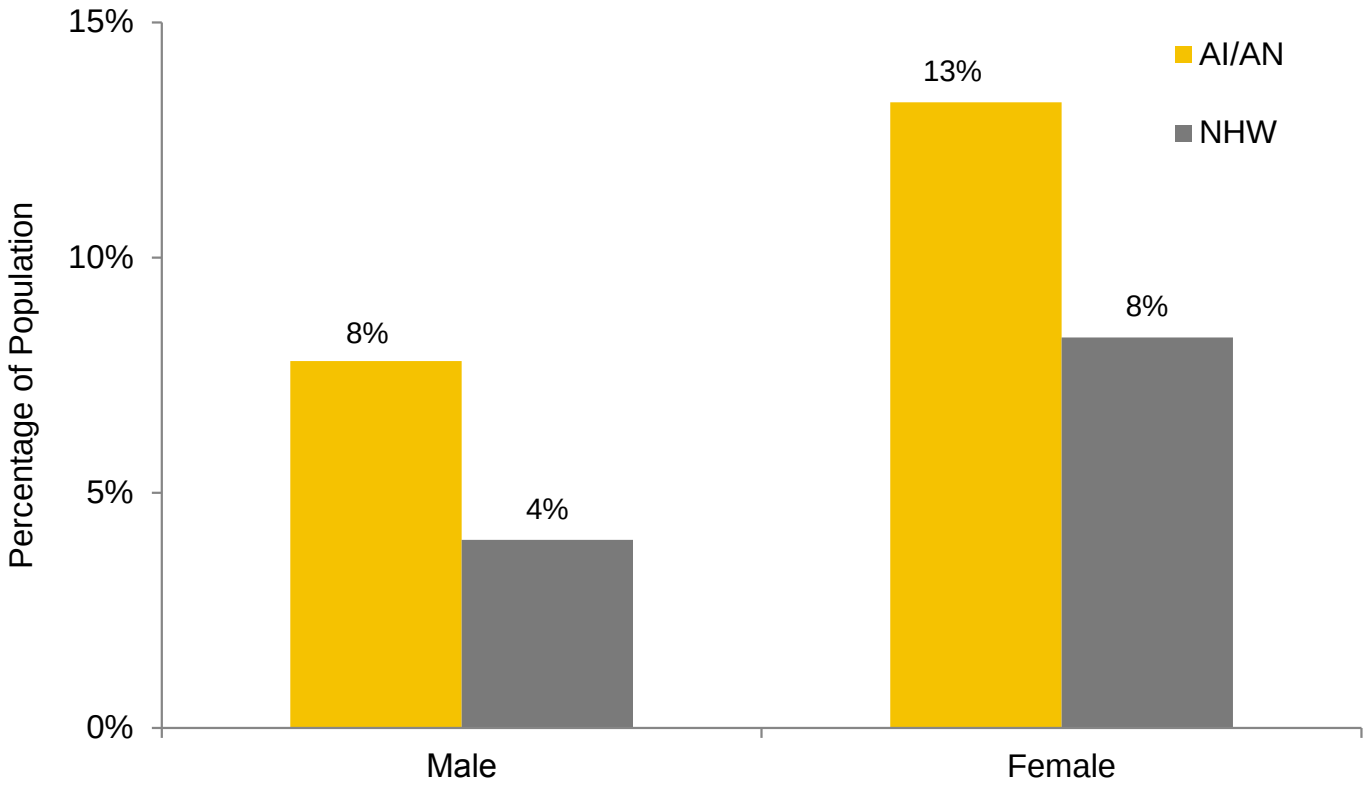
Asthma Prevalence

Compared to their NHW counterparts in the state, more AI/AN males and females in Idaho reported having experienced asthma during their lifetime (Figure 11.8). Thirteen percent of AI/AN females reported having asthma during their lifetime. This was much higher when compared to AI/AN males (8%), NHW males (4%), and NHW females (8%).

Data Source: 2006 – 2012 CDC BRFSS

Data Notes: The BRFSS prevalence estimates (shown as a percentage) are weighted to make the survey responses representative of the Idaho population. The sample sizes presented below the figures are the unweighted number of people who answered this question for the indicated years.

Figure 11.8: Lifetime asthma prevalence by race and sex, Idaho, 2006-2012.



Sample sizes (n): AI/AN males=185; AI/AN females=313; NHW males=13,758; NHW females=20,918.

Environmental Health

Air Quality

The U.S. Environmental Protection Agency (EPA) has national air quality standards for six key air pollutants: ozone, sulfur dioxide, carbon monoxide, particulate matter (PM-2.5 and PM-10), lead, and nitrogen dioxide[1]. Non-attainment areas are geographic areas where air pollution levels are consistently higher than these national standards. The EPA requires local and state governments to take actions to reduce air pollution in non-attainment areas. If a non-attainment area meets and maintains air quality standards, it can be re-designated as a maintenance area.

Idaho has three non-attainment areas in the state (Figure 11.9): Fort Hall (PM-10), Cache Valley (PM-2.5), and Pinehurst (PM-10). PM 2.5 are small particles that are generated from smoke (especially from wood-burning stoves), vehicle exhaust, and industrial processes. PM-10 are larger particles (such as dust) that become airborne due to wind and human activities. Exposure to PM-2.5 and PM-10 in the air can increase risks for respiratory illnesses, cardiovascular disease, and premature death.

Idaho has three air quality maintenance areas: Portneuf Valley (PM-10), Sandpoint (PM-10), and Northern Ada County (CO and PM-10). These areas currently meet air quality standards, but exceeded them in the past.

1. http://www.epa.gov/air/criteria.html

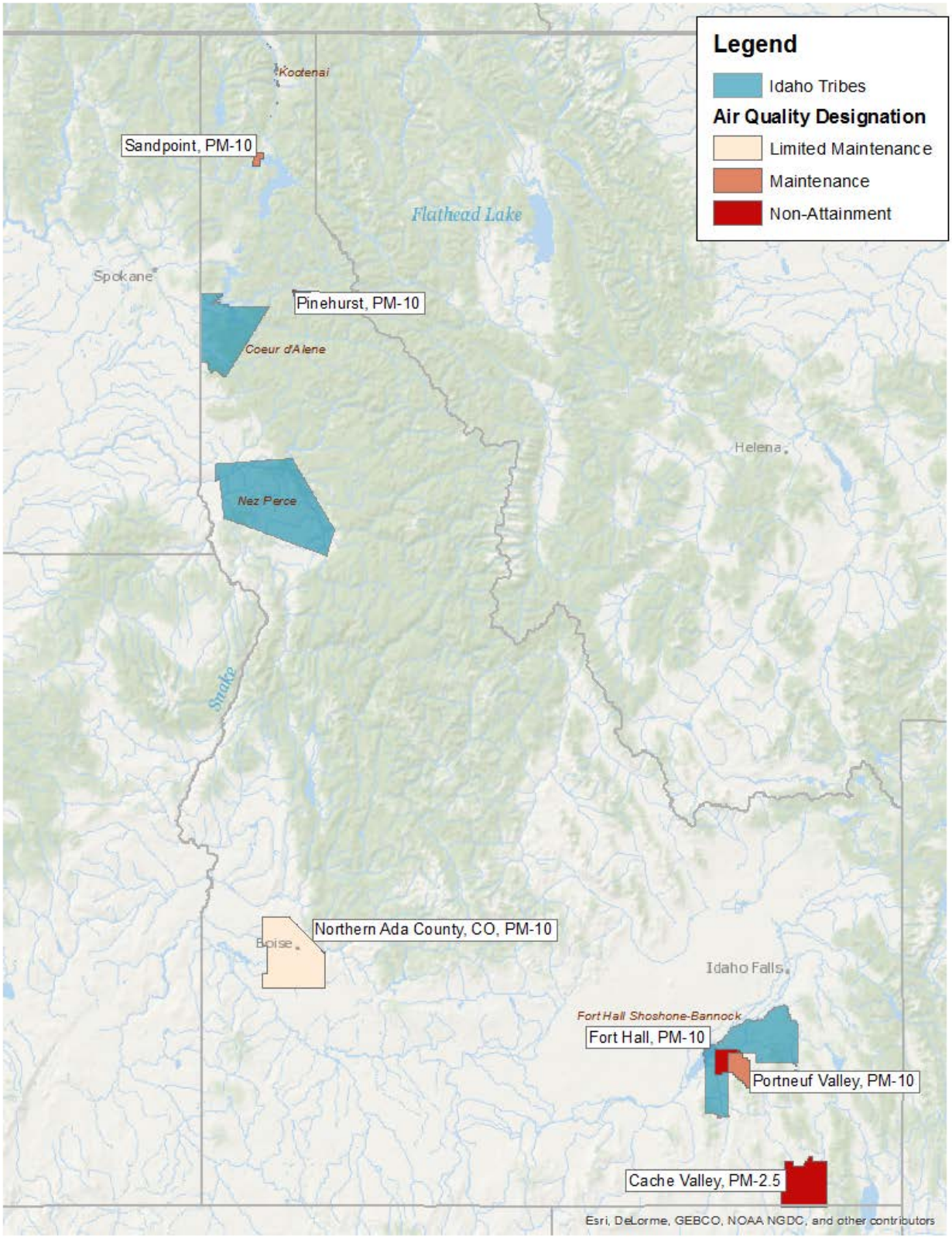
2. http://www.ecy.wa.gov/programs/air/sips/designations/pm_tacoma.htm

Data Source: Idaho Department of Environmental Quality Air Quality Website: http://www.deq.idaho.gov/air-quality

GIS Layers: http://cloud.insideidaho.org/

Data Notes: The air quality information presented in this report is current as of August 2014. For up-to-date information on air quality in Idaho, visit: http://www.deq.idaho.gov/air-quality

Figure 11.9: Air quality non-attainment and maintenance areas in Idaho.



Program Spotlight: Comprehensive Cancer Tribal BRFSS Project

AI/AN are a diverse population representing hundreds of tribes with a variety of cultural beliefs and customs. Disease incidence rates and risk factors within the AI/AN population also vary by region. However, there is little tribe-specific information on the factors that could increase (or decrease) health risks; these factors include tobacco use, obesity, physical activity, diet, and getting screened for cancer. While states collect information on health behaviors and risk factors through the Behavioral Risk Factor Surveillance System (BRFSS), AI/AN populations are not well-represented in state-level BRFSS data.

NPAIHB's Comprehensive Cancer Tribal BRFSS Project is one of seven tribal sites that receive funding for comprehensive cancer control activities through the National Comprehensive Cancer Control Program (NCCCP). The Project is working with other NCCCP tribal programs to improve cancer and other health risk factor surveillance by conducting BRFSS-type health surveys within tribal communities or working with states to obtain a more representative sample of AI/AN through the traditional BRFSS. These activities will provide local-level data on risk factors and build tribes' capacity to implement health surveys within their communities.

The Comprehensive Cancer Tribal BRFSS Project is funded through the Centers of Disease Control and Prevention through a contract with the Indian Health Service.

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http://www.npaihb.org/epicenter/project/comprehensive_cancer_tribal_brfss_project