AN ASSESSMENT OF THE HEALTH STATUS OF MINORITY POPULATIONS IN WYOMING

Prepared for:
Wyoming Minority Health Program,
Maternal & Child Health Section of the Wyoming Department of Health
by the Wyoming Primary Care Association
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Executive Summary

In an ideal world, there would be no differences in health status among racial and ethnic groups. That is not the case in Wyoming, as it is not the case throughout the nation. While numerous government programs have developed goals to eliminate the disparities, they continue to exist.

This report provides a unique view of the health status of minority populations in Wyoming. Never before has so much information about minority health, from numerous sources, been assimilated into one document. Gathering the data was a challenge. For example, it was discovered that some government programs do not record the race of their clients. Also, Wyoming's small population sometimes results in very few incidents of a disease. In such cases, the small numbers raised reliability concerns. This forced decisions about whether to include the data and how to present them.

These limitations notwithstanding, this report offers an excellent 'big picture' view of health status and health disparities in the state. Information is presented for more than 30 health status indicators in the following areas: 1) mortality; 2) maternal and child; 3) behavioral risk factors; and 4) morbidity (incidence). Also included are data relating to access to health care. When available, national rates are provided for comparison.

The data clearly reveal a health status disparity among the racial and ethnic groups. Overall, the best health status is among Asian/Pacific Islanders. The worst health status is among American Indians. The disparities revealed by some of the American Indian data are unsettling. Compared to other racial and ethnic groups, American Indians have worse rates of overall mortality, Years of Potential Life Lost (YPLL), infant mortality, suicide, unintentional injury mortality, motor vehicle accident mortality, lung cancer mortality, heart disease mortality, diabetes mortality, liver disease mortality, birth rates for 15 to 19 year olds, births to unmarried mothers, prenatal care, adult cigarette use, adult binge drinking, adults who are overweight, prevalence of tuberculosis, and incidence of chlamydia and gonorrhea. Other troubling concerns for all minority groups include the relatively high percentages of uninsured persons and higher than average prevalence of poverty.

This report is largely a needs assessment. It identifies problems, but does not outline solutions in any substantial detail. As such, it is only the first step in a process that must include numerous steps. It is hoped that the data in the report will: 1) encourage more in-depth examination of problems and possible solutions; 2) provide a basis for obtaining new funds to resolve the problems; and 3) encourage health and social services program managers to re-direct existing resources as appropriate.

Introduction

In September 2000, the Office of Minority Health, United States Department of Health and Human Services, awarded a grant to the Minority Health Program in the Wyoming Department of Health for the purpose of conducting a statewide minority health assessment. The Minority Health Program subsequently contracted with the Wyoming Primary Care Association (WPCA) to complete many of the components of the assessment.

The assessment examined the following characteristics of minority populations in the state: 1) demographics; 2) mortality rates; 3) behavioral risk factors; 4) morbidity rates; and 5) health services utilization rates. In addition, a series of community meetings and a written survey were utilized to inform the public and to gather input.

The racial composition of the Wyoming population is described throughout this report utilizing traditional categories established by the United States Census Bureau. These include: non-Hispanic white; African American; American Indian/Alaskan Native; Asian/Pacific Islander; Hispanic; and others. The "others" category includes all other races and/or persons of mixed race. Throughout the assessment, data for non-Hispanic whites are listed separate from Hispanics.

Minority Health Committee members guiding the project include: Gabriel Barajas, Co-Chairperson, Division of Disability Determination; Julie Lehman, Co-Chairperson, Wyoming Health Council; Loretta Alcarez, NOWCAP; Terry Beartusk, Thunderchild Treatment Center; Floyd Esquibel, Legislative Representative; Jose' Flores; Terrance Foley, Maternal and Child Health, Wyoming Department of Health; David Franke, Wyoming Health Council; Menlo Futa, Behavioral Risk Factor Surveillance Survey (BRFSS), Wyoming Department of Health; Renee Gamino; Wyoming Primary Care Association; Paul Hanway, Northern Arapaho Tribal Health; Sandra St. Clair, Lander Valley Hospital; Darwin St. Clair, Indian Health Service; Mary Hutchings, Western Wyoming Family Planning; Dolores Jimerson, Mental Health Division, Wyoming Department of Health; Frankie Jones, African American Wellness Project; Wenlin Liu, Economic Analysis Division, Wyoming Department of Administration and Information; Gary Maier, Community Services Block Grant, Wyoming Department of Health; Kaye McCary, Migrant Education, Wyoming Department of Education; Ron Mitchell, U.S. Social Security Administration; Mary Rose Morris, Wyoming Art Council; Beverly Morrow, Wyoming Primary Care Association; Frances Noseep, Eagle's Wings; Lorenzo Olivas, Office of Minority Health, U.S. Department of Health and Human Services; Gabrielle Powell, Eagle's Wings; Dennis Royal; Casper-Natrona County Human Services Commission; Bea Salazar, Four Directions Consulting; Don Sanders, Urban Native American Project; Betty Sones, Minority Health, Wyoming Department of Health; Peggy Staley, Wyoming Department of Family Services; Tahir Suleyman, SE Wyoming Mental Health Center; Clarence Thomas, Tribal Health; Douglas Thiede, Office of Rural Health, Wyoming Department of Health.

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Goals/Objectives

A number of national health initiatives, including Healthy People 2010, have identified disparities among racial and ethnic populations throughout the United States. Depending on the initiative, various goals have been set to reduce or eliminate these disparities in the future.

The mission of the Office of Minority Health (OMH), within the United States Department of Health and Human Services (DHHS), is to improve the health of racial and ethnic populations through the development of effective health policies and programs that help to eliminate disparities in health. Recently OMH established a goal of eliminating health disparities in six areas by 2010. The six focus areas are: infant mortality; cancer screening and management; cardiovascular disease; diabetes; HIV Infection/AIDS; and immunizations.

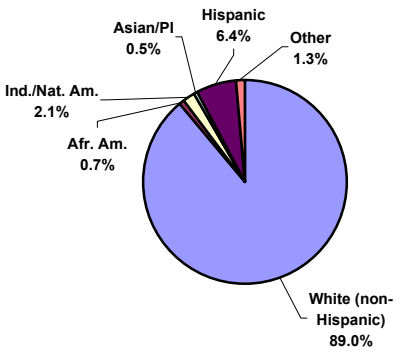
This report, which is largely funded by OMH, includes data for these six areas as well as numerous other areas. It is hoped that the data will point the way to strategies that can be utilized to reduce existing disparities. According to DHHS, "Eliminating racial and ethnic disparities in health will require enhanced efforts at preventing disease, promoting health and delivering appropriate care. This will necessitate improved collection and use of standardized data to correctly identify all high risk populations and monitor the effectiveness of health interventions targeting these groups. Research dedicated to a better understanding of the relationships between health status and different racial and ethnic minority backgrounds will help us acquire new insights into eliminating the disparities and developing new ways to apply our existing knowledge toward this goal. Improving access to quality health care and the delivery of preventive and treatment services will require working more closely with communities to identify culturally-sensitive implementation strategies."

Demographic and Socioeconomic Indicators

Compared to many states, Wyoming is not very racially diverse. In 2000, the composition of the state's population was: 88.9% non-Hispanic white; 6.4% Hispanic; 0.7% African American; 2.1% Native American; 0.5% Asian/Pacific Islander; and 1.3% other (Figure 1). During the same year, the composition of the United States population was 69.1% non-Hispanic white; 12.5% Hispanic; 12.1% African American; 0.7% Native American; 3.7% Asian/Pacific Islander; and 1.9% other.

Overall, minorities accounted for 11.1% of the Wyoming population in 2000. This is a slight increase compared to 1990 (Table 1). In 1990, 9.0% of the population was a racial or ethnic minority.

Figure 1: Composition of the Wyoming Population in 2000



While the racial and ethnic percentages are small, it should be noted that they represent 54,983 individuals (Table 1). These individuals are not evenly distributed among the counties (Table 2). The county with the largest minority population is Fremont. It is home to the Wind River Indian Reservation, comprised of the Eastern Shoshone and Northern Arapaho Tribes. The county with the smallest minority population is Crook. Overall, Fremont, Carbon and Laramie counties are the most racially diverse (see map).

Table 1: Wyoming Minority Populations in 1990 & 2000

Race/Ethnic Group	1990	2000	Change
Non-Hispanic White	412,711	438,799	+6.3%
Hispanic	25,751	31,669	+23.0%
African American	3,426	3,504	+2.3%
Native American	8,857	10,238	+15.6%
Asian/P.I.	2,622	2,934	+11.9%
Other	221	6,638	*
Total	**453,588**	**493,782**	**+8.9%**
Total Minority	**40,877**	**54,983**	**+34.5%**

*Multiple race individuals included in 'other' group for 1st time in 2000, resulting in large percentage increase.

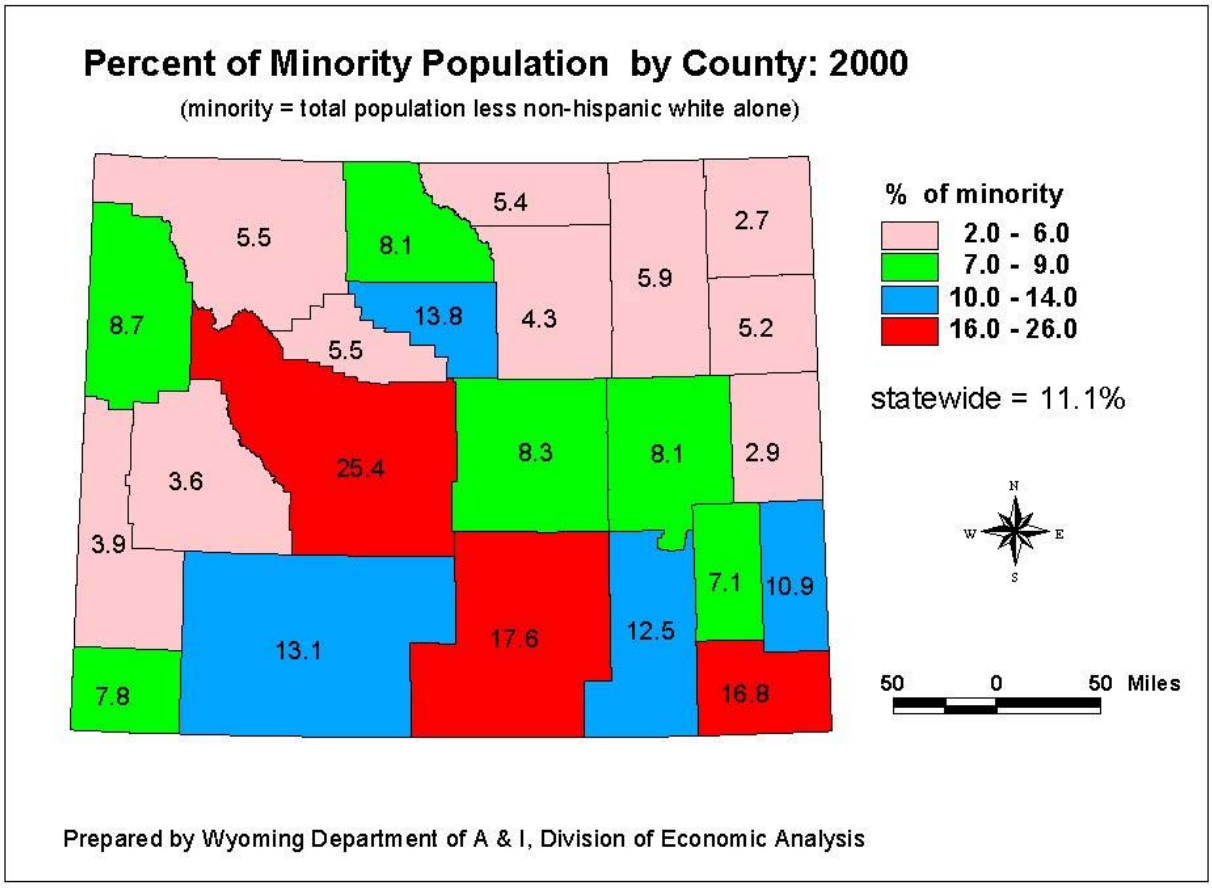


Table 2: Wyoming Minority Populations in 2000 by County (U.S. Census Bureau)								
County	**Total Population**	**Hispanic**	**African American**	**American Indian**	**Asian/ Pacific Islander**	**Other**	**Total Minority**	**% Minority**
Albany	32,014	2,397	322	264	552	476	4,011	12.5%
Big Horn	11,461	707	9	76	29	113	934	8.1%
Campbell	33,698	1,191	47	280	128	351	1,997	5.9%
Carbon	15,639	2,163	103	178	111	194	2,747	17.6%
Converse	12,052	660	18	95	34	173	980	8.1%
Crook	5,887	54	3	57	4	40	158	2.7%
Fremont	35,804	1,566	43	6,743	108	651	9,111	25.4%
Goshen	12,538	1,107	25	93	40	101	1,366	10.9%
Hot Springs	4,882	116	17	73	10	52	268	5.5%
Johnson	7,075	148	5	42	4	105	304	4.3%
Laramie	81,607	8,897	2,015	553	816	1,425	13,706	16.8%
Lincoln	14,573	315	14	67	39	136	571	3.9%
Natrona	66,533	3,257	473	575	289	916	5,510	8.3%
Niobrara	2,407	36	3	11	2	18	70	2.9%
Park	25,786	959	19	104	123	225	1,430	5.5%
Platte	8,807	465	3	37	11	110	626	7.1%
Sheridan	26,560	646	44	306	134	308	1,438	5.4%
Sublette	5,920	112	12	27	16	44	211	3.6%
Sweetwater	37,613	3,545	270	290	248	585	4,938	13.1%
Teton	18,251	1,185	25	86	103	184	1,583	8.7%
Uinta	19,742	1,055	18	161	62	236	1,532	7.8%
Washakie	8,289	951	8	37	4	93	1,146	13.8%
Weston	6,644	137	8	83	14	104	346	5.2%
Wyoming	**493,782**	**31,669**	**3,504**	**10,238**	**2,934**	**6,638**	**54,983**	**11.1%**
Percentage	**100%**	**6.4%**	**.7%**	**2.1%**	**.5%**	**1.4%**	**11.1%**	**11.1%**

The median age for all groups in Wyoming in 2000 was 36.2 years. However, for some minority groups it was much lower (see chart on next page). It was lowest for Hispanics at 24.8 years, followed closely by American Indians and African Americans at 26.0 years and 26.2 years respectively. Overall, 26% of the state's population is under 18 years of age. By comparison, 36% of all minority populations are under age 18 (Table 3). More specifically the following percentages of the minority populations are under 18: Hispanics, 37%; African Americans, 28%; American Indian, 36%; and Asian/P.I., 22%. For more detailed age composition, see: http://eadiv.state.wy.us/demog_data/pop2000/State_ASR.htm.

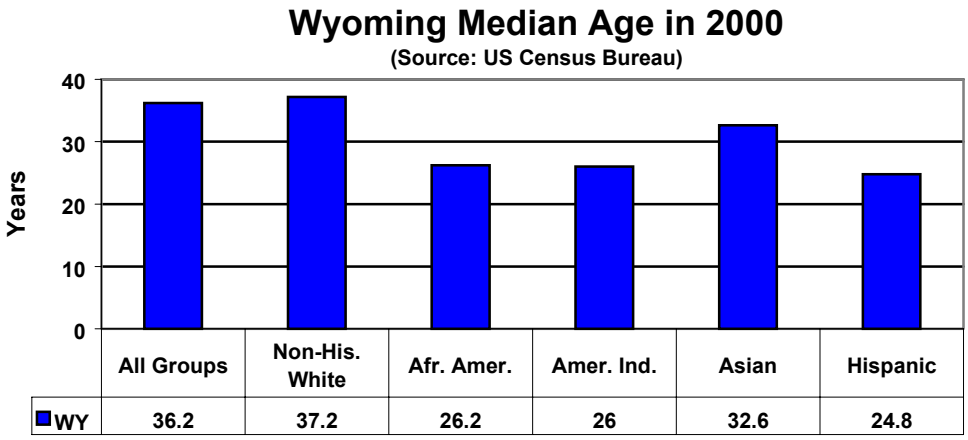


Table 3: Age Structure of Minority Populations in Wyoming in 2000

Age	Non-Hispanic White		Hispanic		African American		American Indian		Asian/PI		Total	
	<18	≥18	<18	≥18	<18	≥18	<18	≥18	<18	≥18	<18	≥18
Albany	4,801	23,202	700	1,697	72	250	49	215	94	458	5,894	26,120
Big Horn	2,895	7,632	317	390	9	3	26	50	9	20	3,287	8,174
Campbell	9,662	22,039	483	708	22	25	98	182	41	87	10,456	23,242
Carbon	2,962	9,930	656	1,507	15	88	46	132	30	81	3,772	11,867
Converse	3,043	8,029	267	393	11	7	23	72	10	24	3,430	8,622
Crook	1,514	4,215	25	29	1	2	21	36	2	2	1,581	4,306
Fremont	6,180	20,513	636	930	9	34	2,728	4,015	20	88	9,827	25,977
Goshen	2,511	8,661	429	678	9	16	39	54	12	28	3,034	9,504
Hot Sprgs.	983	3,631	42	74	8	9	25	48	2	8	1,076	3,806
Johnson	1,588	5,183	70	78	0	5	15	27	1	3	1,712	5,363
Laramie	16,306	51,595	3,203	5,694	526	1,489	143	410	176	640	21,023	60,584
Lincoln	4,273	9,729	130	185	6	8	17	50	9	30	4,502	10,071
Natrona	15,257	45,766	1,275	1,982	161	312	170	405	70	219	17,300	49,233
Niobrara	525	1,812	13	23	0	3	1	10	1	1	544	1,863
Park	5,801	18,555	345	614	7	12	26	78	34	89	6,302	19,484
Platte	2,000	6,181	183	282	1	2	5	32	3	8	2,233	6,574
Sheridan	5,887	19,237	269	377	13	31	96	210	37	97	6,412	20,148
Sublette	1,445	4,264	52	60	3	9	8	19	4	12	1,526	4,394
Sweetwater	9,086	23,589	1,335	2,210	89	181	88	202	28	220	10,869	26,744
Teton	3,210	13,458	333	852	5	20	11	75	14	89	3,632	14,619
Uinta	5,969	12,241	452	603	9	9	51	110	23	39	6,605	13,137
Washakie	1,797	5,346	391	560	4	4	12	25	27	40	2,208	6,031
Weston	1,482	4,816	52	85	4	4	22	61	3	11	1,598	5,046
Wyoming	109,175	329,624	11,658	20,011	981	2,523	3,720	6,518	640	2,294	128,873	364,909
Percent	25%	75%	37%	63%	28%	72%	36%	64%	22%	78%	26%	74%

Source: U.S. Census Bureau

The average annual family median income in Wyoming from 1997 to 1999 was $30,256 for all races (Table 4). The highest median income was among non-Hispanic Whites ($31,000) and the lowest was among American Indians ($11,920). During the same time period, 15% of Wyoming residents had incomes below 100% Federal Poverty Level (FPL). Poverty rates were much higher among American Indians (57.8%).

Enrollment in means tested economic assistance programs provides another indicator of economic status (Table 5). In December 2000, Wyoming residents were enrolled in public assistance programs at the following rates: Temporary Assistance to Needy Families (0.6% of the population); Food Stamps (6.7% of the population); and Medicaid (3.6% of the adult population and 17.1% of sub-adult population). Enrollment was much higher for African Americans and American Indians. American Indians had the highest rates of enrollment including: TANF (12.8% of the population); Food Stamps (28.4% of the population); and Medicaid (14.1% of the adult population and 59.8% of the sub-adult population).

Table 4: Indicators of Economic Status by Race (1997-1999 averages* unless otherwise noted)

Indicator	Total	Non-His. White	African American	Amer. Indian	Asian P.I.	Hispanic	Other***
US Median Family Income	$33,154	$36,067	$23,000	N.A.	N.A.	$22,033	$27,000
WY Median Family Income	$30,256	$31,000	$26,049	$11,920**	N.A.	$24,593	$18,283
US Below Poverty	16%	11%	32%	N.A.	N.A.	31%	20%
WY Below Poverty	15%	14%	N.A.	57.8%**	N.A.	20%	N.A.

* Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys of previous year. http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?
**1997 data obtained from Wind River Indian Needs Determination Survey.
***Includes American Indian, Asians and others
Note: Persons in poverty are defined as those who make less than 100% of the Federal Poverty Level (FPL). The FPL for a family of three was $13,290 in 1999

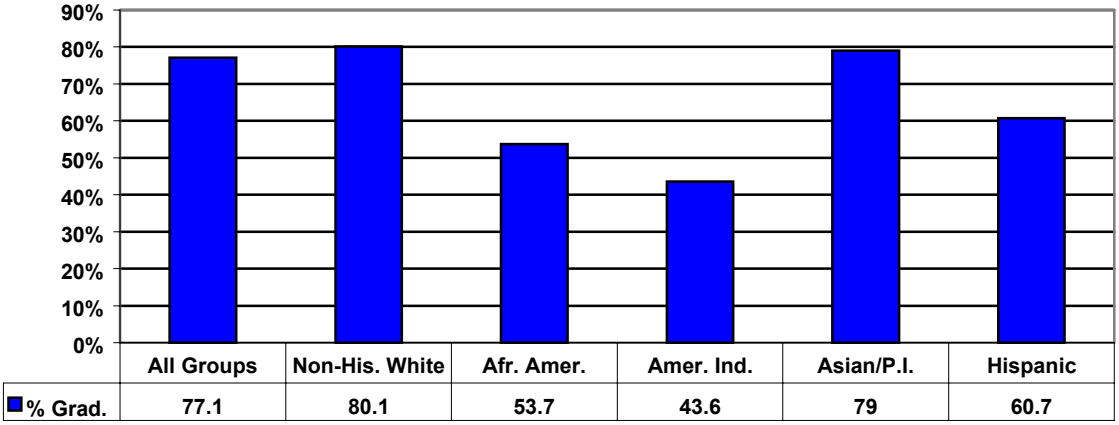
Table 5: Percent of Each Racial/Ethnic Group Enrolled in Public Assistance Programs (December 2000)
(percent of each group enrolled, not percent of enrollees that are from each group)

Indicator	Total	Non-His. White	African American	Amer. Indian	Asian/ P.I.	Hispanic	Other
TANF (POWER)*	.6%	.3%	2.7%	12.8%	.4%	.7%	N.A.
Food Stamps*	6.7%	6.0%	18.8%	28.4%	3.8%	10.0%	N.A.
Medicaid (adults)	3.6%	3.3%	8.1%	14.1%	1.3%	4.3%	9.8%
Medicaid (children)	17.1%	15.1%	57.6%	59.8%	13.1%	21.3%	4.9%

*Estimated from DFS data showing number of households participating in POWER and Food Stamps (assumes average household size of 3.55 persons)

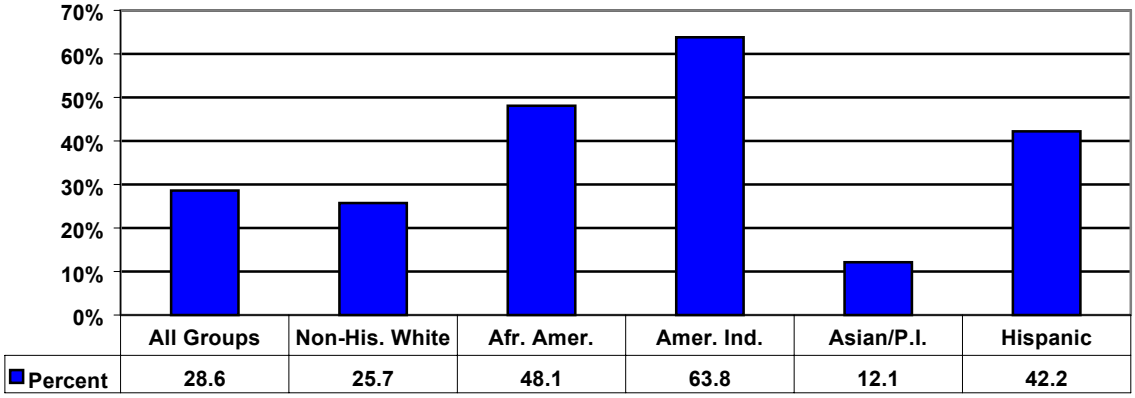
Lower levels of education and a high number of single parent families probably contribute to poor economic status. In Wyoming, high school graduation rates are lowest among American Indians and African Americans. The percent of births to unmarried mothers is also highest among these groups.

Wyoming High School Gradution Rates
1999-2000 School Year
(Source: WY Dept. of Education)



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
% Grad.	77.1	80.1	53.7	43.6	79	60.7

Percent of Births to Unmarried Mothers
(WY 1997-99, US 1998)
Source: WY Dept. of Health, Office of Vital Records



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
Percent	28.6	25.7	48.1	63.8	12.1	42.2

Health Status of Minority Populations in Wyoming
MORTALITY

Mortality rates are outlined in this section in a series of boxes. Included in each box is a short narrative and a list of related Healthy People 2010 objectives. Most of the Wyoming data were obtained from the Wyoming Department of Health, Office of Vital Records. Much of the national data was obtained from Centers for Disease Control web sites: http://wonder.cdc.gov/ or http://www.cdc.gov/nchs/.

Generally, mortality data are considered to be one of the most reliable kinds of heath data because they are derived from death certificates. However due to Wyoming's small population, the number of deaths for some minority groups is very small during a one year time frame. To increase reliability, several years of Wyoming data have been averaged for this report. Even so, some numbers are so small that they have wide confidence intervals. Nevertheless, they are included because they are the best numbers that are available. When sample size is less than 50, a note is included at the bottom of the graph. In these cases, readers should recognize that the data may not be highly reliable.

What are Age Adjusted Data?

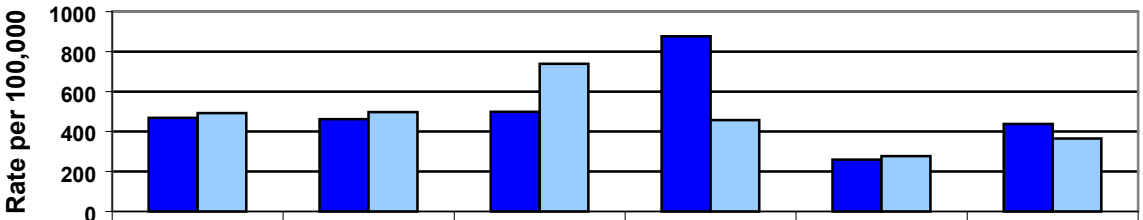
Age adjusting is a mathematical process that allows data to be compared over time and from one part of the country to another. In the past, the standard has been to adjust mortality data to the age composition of the U.S. population in 1940. More recently, some organizations have adopted the 2000 population as a standard. Unless otherwise indicated, all data in this report are adjusted to the 1940 population. The 1940 standard was selected for this report because that was the standard utilized by the Wyoming Office of Vital Records and other data sources at the time that data were obtained for this report.

BOX 1: OVERALL MORTALITY RATES

Overview: During the five year period from 1994-98, the overall mortality rate for all groups in Wyoming was slightly below the national average. There appears to be a disparity between racial/ethnic groups at the state and national levels.

Healthy People 2010 National Objective: The Healthy People 2000 objective was to decrease the total death rate to no more than 454 per 100,000 people. There is no comparable 2010 objective, but there is an overall goal to eliminate disparities.

Age Adjusted Death Rates
(WY 1994-98, US 1996)
Source: WY Dept. of Health, Office of Vital Records



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	468.1	461.3	499.1	877	260	437.3
US	491.6	496.2	738.3	456.7	277.4	365.9

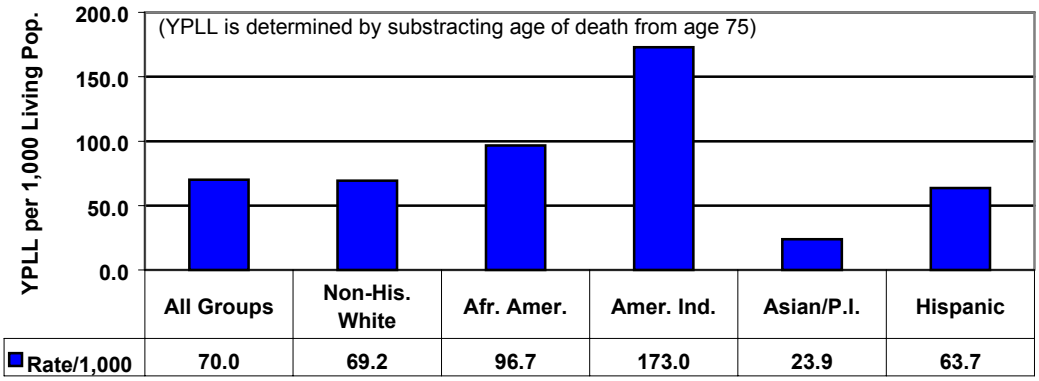
(Caution! Some WY rates are based on fewer than 50 deaths including: Asian/P.I. = 40)

BOX 2: YEARS OF POTENTIAL LIFE LOST (YPLL)

Overview: YPLL is calculated by subtracting the age at death from age 75. There appears to be a disparity between racial/ethnic groups in the state.

Healthy People 2010 National Objective: There is no objective specific to YPLL, but there is an overall goal to eliminate disparities.

Years of Potential Life Lost (YPLL)
1994-98 Annual Wyoming Average
Source: WY Dept. of Health, Office of Vital Records



BOX 3: LEADING CAUSES OF DEATH

Overview: In Wyoming, heart disease is the number one cause of death for all groups combined. Cancer is a close second. For African Americans and American Indians, unintentional injury ranks high.

Healthy People 2010 National Objective: There is no objective specific to cause of death.

Leading Causes of Death by Race in Wyoming 1995-98
(parenthesis indicates actual number of deaths)
Source: http://webapp.cdc.gov/sasweb/ncipc/leadcaus.html

Rank	All Groups	White*	African Amer.	Amer. Indian	Asian/P.I.
1	Heart Dis. (4,016)	Heart Dis. (3,941)	Heart Dis. (23)	Heart Dis. (47)	Cancer (11)
2	Cancer (3,454)	Cancer (3,396)	Cancer (18)	Unint. Injury (45)	Heart Dis. (5)
3	Stroke (1,055)	Stroke (1,038)	Unint. Injury (8)	Cancer (29)	Pneum./Infl. (4)
4	COPD (1,021)	COPD (1,012)	Diabetes (7)	Liver Dis. (20)	COPD (3)
5	Unint. Injury (962)	Unint. Injury (908)	Stroke (5)	Diabetes (16)	N.A.

*includes non-Hispanic white and white Hispanic

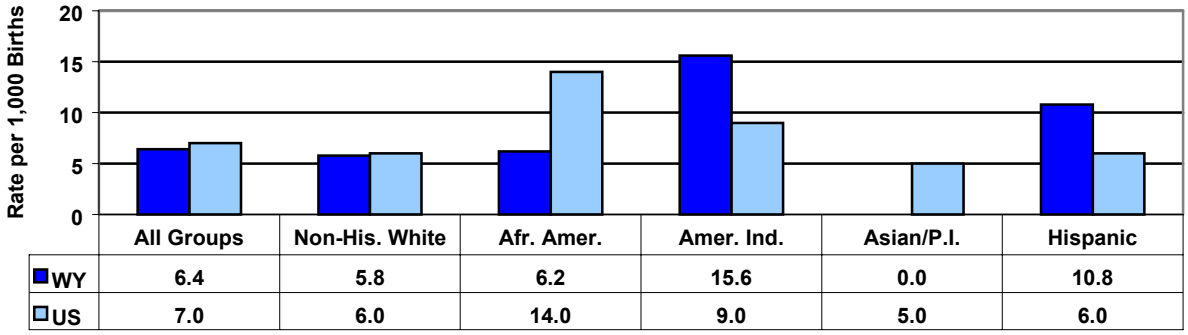
Note: Hispanics are not listed separately by this data source

BOX 4: INFANT MORTALITY RATES

Overview: There appears to be a disparity between racial/ethnic groups at the state and national levels. (Race is defined by the race of the mother. Infant is defined as any child under the age of 1year.) Also see: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?

Healthy People 2010 National Objective: Reduce the infant mortality rate to no more than 4.5 deaths per 1,000 live births.

Infant Mortality Rates
(WY 1996-98, US 1996-98)
Source: WY Dept. of Health, Office of Vital Records



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	6.4	5.8	6.2	15.6	0.0	10.8
US	7.0	6.0	14.0	9.0	5.0	6.0

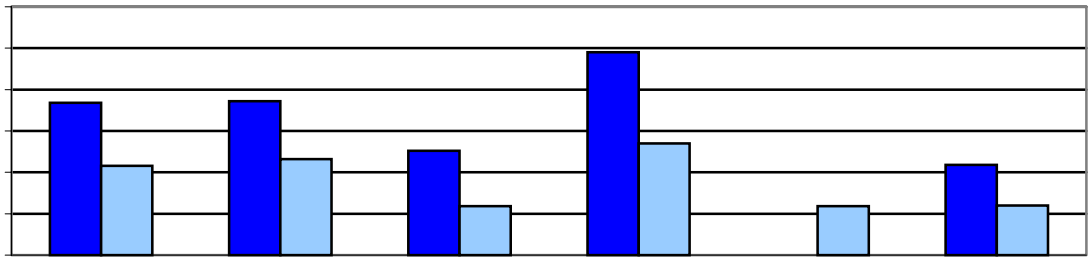
(Caution! Some WY rates are based on fewer than 50 deaths including: Afr. Am. = 1, Indian = 11, Asian = 0, Hispanic = 18)

BOX 5: SUICIDE RATES

Overview: Overall, Wyoming suicide rates are higher than national rates. There appears to be a disparity between racial/ethnic groups at the state and national levels. For more information see: http://webapp.cdc.gov/sasweb/ncipc/mortrate.html

Healthy People 2010 National Objective: Reduce suicides by 56% compared to 1998 rates.

Age Adjusted Suicide Rates

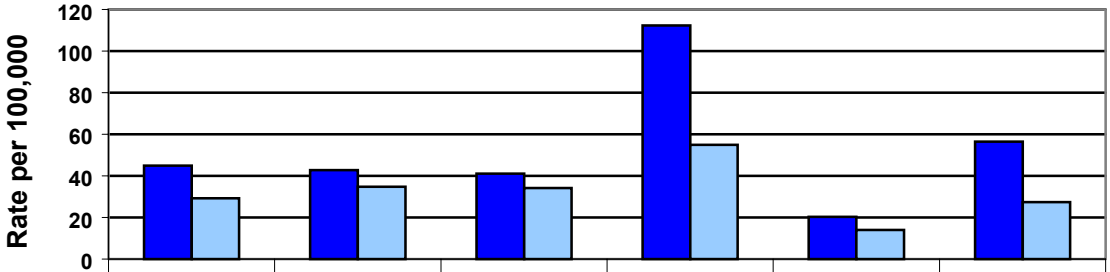


BOX 6: UNINTENTIONAL INJURY MORTALITY RATES

Overview: Overall, Wyoming unintentional injury rates are higher than the national rates. There appears to be a disparity between racial/ethnic groups at the state and national levels. For more information see: http://webapp.cdc.gov/sasweb/ncipc/mortrate.html .

Healthy People 2010 National Objective: Reduce deaths caused by unintentional injuries by 50% compared to 1998 rates.

Age Adjusted Unintentional Injury Death Rates
(WY 1994-98; US 1998)
Source: WY Dept. of Health, Office of Vital Records



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	44.9	42.7	41.1	112.3	20.3	56.4
US	29.2	34.8	34.2	55	14	27.4

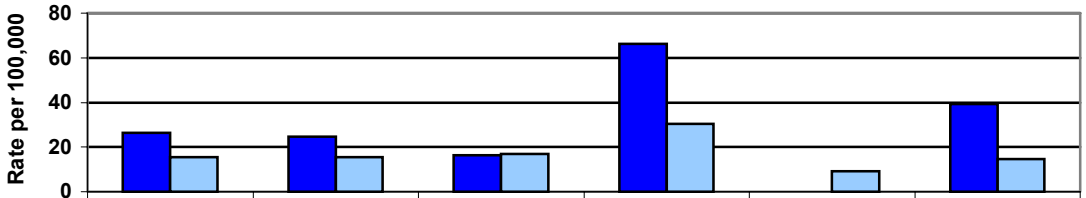
(Caution! Some WY rates are based on fewer than 50 deaths including: Afr. Am. = 9, Asian/PI = 3)

BOX 7: MOTOR VEHICLE ACCIDENT MORTALITY RATES

Overview: Overall, Wyoming motor vehicle accident rates are higher than the national rates. There appears to be a disparity between racial/ethnic groups at the state and national levels. For more information see: http://webapp.cdc.gov/sasweb/ncipc/mortrate.html

Healthy People 2010 National Objective: Reduce deaths caused by motor vehicle crashes by 41% compared to 1998 rates.

Age Adjusted Motor Vehicle Death Rates
(WY 1994 - 98, US 98)
Source: WY Dept. of Health, Office of Vital Records



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	26.4	24.7	16.4	66.1	0	39.3
US	15.6	15.6	16.8	30.4	9.3	14.7

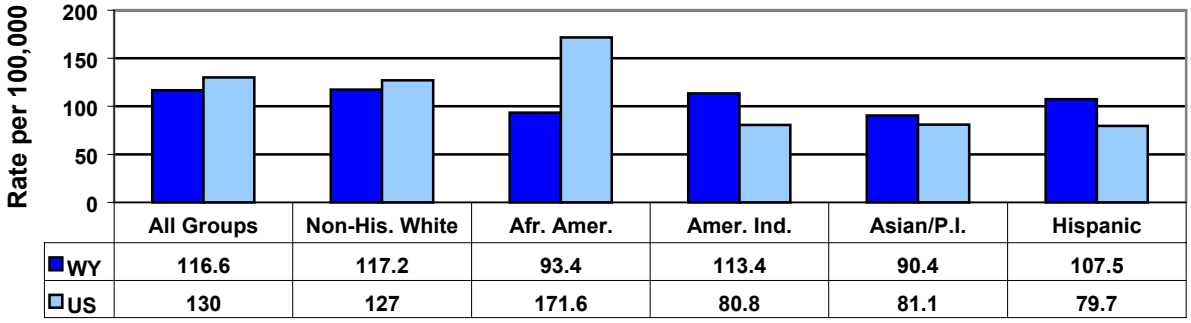
(Caution! Some WY rates are based on fewer than 50 deaths including: Afr. Am. = 4, Indian = 32, Asian/PI = 0)

BOX 8: CANCER MORTALITY RATES

Overview: There appears to be a disparity between racial/ethnic groups at the state and national levels. Also, see http://wdhfs.state.wy.us/cancer/

Healthy People 2010 National Objective: Reduce cancer deaths by 21% compared to 1998 rates.

Age Adjusted Cancer Death Rates
(WY 1994-98, U.S. 1995)
Source: WY Dept. of Health, Office of Vital Records



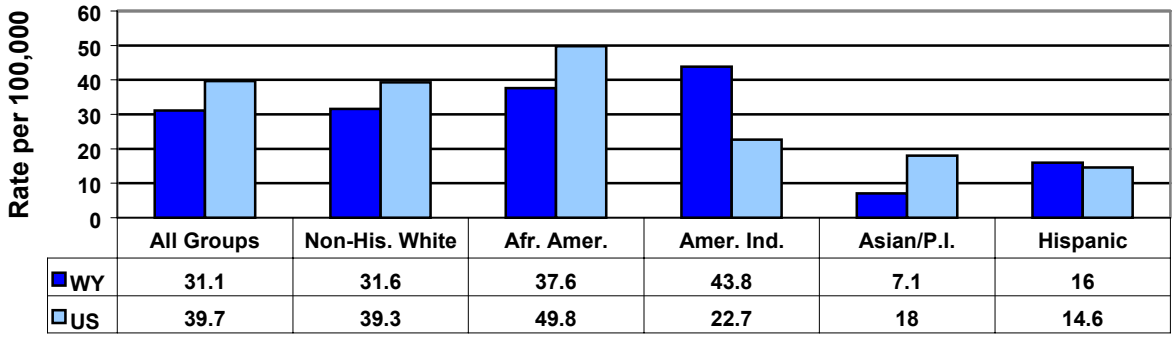
(Caution! Some WY rates are based on fewer than 50 deaths including: Afr. Am. = 19, Indian = 40, Asian/PI = 14)

BOX 9: LUNG CANCER MORTALITY RATES

Overview: There appears to be a disparity between racial/ethnic groups at the state and national levels.

Healthy People 2010 National Objective: Reduce lung cancer deaths by 22% compared to 1998 rates.

Age Adjusted Lung Cancer Death Rates
(WY 1994-98, US 1995)
Source: WY Dept. of Health, Office of Vital Records



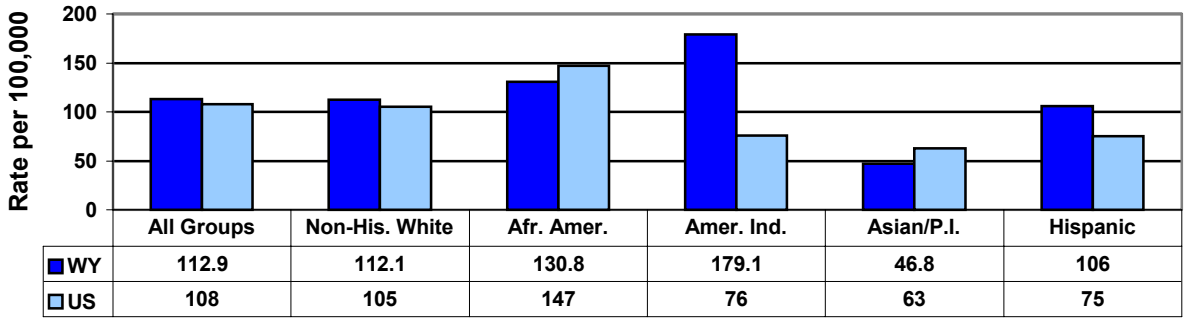
(Caution! Some WY rates are based on fewer than 50 deaths including: Afr. Am. = 6, Indian = 14, Asian/PI = 1, Hispanic = 21)

BOX 10: HEART DISEASE MORTALITY RATES

Overview: There appears to be a disparity between racial/ethnic groups at the state and national levels.

Healthy People 2010 National Objective: Reduce coronary heart disease deaths by 20% compared to 1998 rates.

Age Adjusted Heart Disease Death Rates
(WY 1994-98, US 1995)
Source: WY Dept. of Health, Office of Vital Records



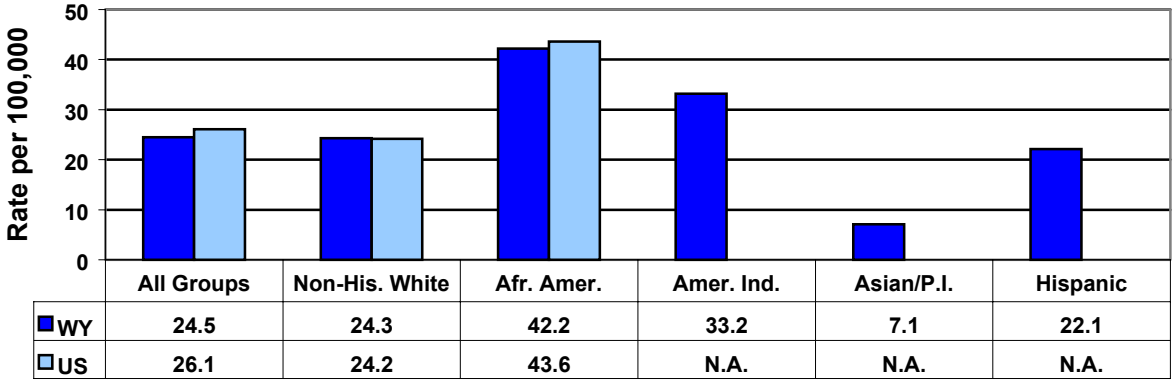
(Caution! Some WY rates are based on fewer than 50 deaths including:
Afr. Am. = 23, Asian/PI = 7)
Note: Hispanic column refers to all origins

BOX 11: STROKE MORTALITY RATES

Overview: There appears to be a disparity between racial/ethnic groups at the state and national levels.

Healthy People 2010 National Objective: Reduce stroke deaths by 20% compared to 1998 rates.

Age Adjusted Stroke Death Rates
(WY 1994-98, US 1998)
Source: WY Dept. of Health, Office of Vital Records



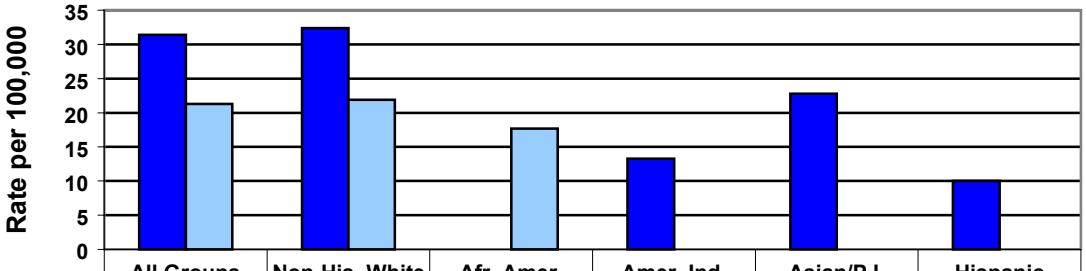
(Caution! Some WY rates are based on less than 50 deaths including:
Afr. Am. = 8, Indian = 13, Asian/PI = 1, Hispanic = 35)

BOX 12: CARDIOPULMONARY OBSTRUCTIVE DISEASE (COPD) MORTALITY RATES
Includes chronic bronchitis and emphysema

Overview: There appears to be a disparity between racial/ethnic groups at the state levels. Some national data are unavailable.

Healthy People 2010 National Objective: Reduce the COPD death rate for adults aged 45 years and older by 50% compared to 1998 rates.

Age Adjusted COPD Death Rates
(WY 1994-98, US 1998)
Source: WY Dept. of Health, Office of Vital Records



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	31.4	32.4	N.A.	13.3	22.8	10
US	21.3	21.9	17.7	N.A.	N.A.	N.A.

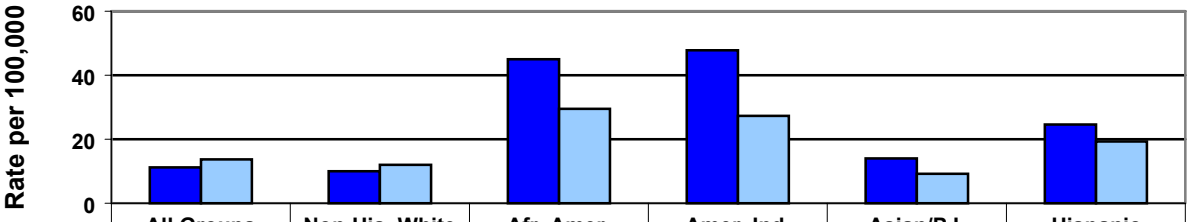
(Caution! Some WY rates are based on fewer than 50 deaths including: Afr. Am. = 0, Indian = 6, Asian/PI = 3, Hispanic = 19)

BOX 13: DIABETES MORTALITY

Overview: There appears to be a disparity between racial/ethnic groups at the state and national levels. Also, see http://wdhfs.state.wy.us/DIABETES/

Healthy People 2010 National Objective: Reduce the diabetes death rate by 43 percent compared to 1997rates.

Age Adjusted Diabetes Death Rates
(WY 1994-98, US 1997)
Source: WY Dept. of Health, Office of Vital Records



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	11.2	10	45	47.8	14	24.6
US	13.7	12	29.5	27.3	9.2	19.3

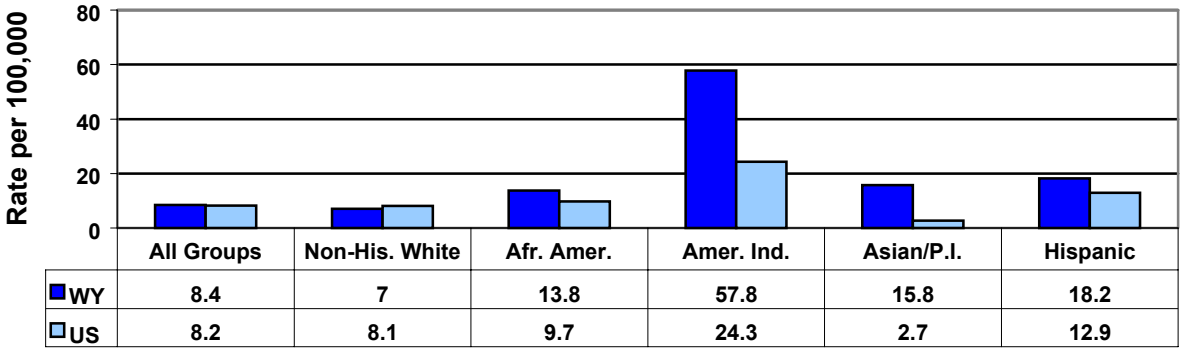
(Caution! Some WY rates are based on fewer than 50 deaths including: Afr. Am. = 7, Indian = 18, Asian/PI = 2, Hispanic = 34)

BOX 14: LIVER DISEASE MORTALITY

Overview: There appears to be a disparity between racial/ethnic groups at the state and national levels.

Healthy People 2010 National Objective: Reduce cirrhosis deaths by 69% compared to 1998 rates.

Age Adjusted Chronic Liver Disease Death Rates
(WY 1994-98, US 1998)
Source: WY Dept. of Health, Office of Vital Records



(Caution! Some WY rates are based on fewer than 50 deaths including: Afr. Am. = 2, Indian = 24, Asian/PI = 2, Hispanic = 21)

Health Status of Minority Populations in Wyoming
MATERNAL AND CHILD HEALTH

Most of the Wyoming data in this section were obtained from the Wyoming Department of Health, Office of Vital Records. Much of the national data were obtained from Centers for Disease Control web sites: http://wonder.cdc.gov/ or http://www.cdc.gov/nchs/.

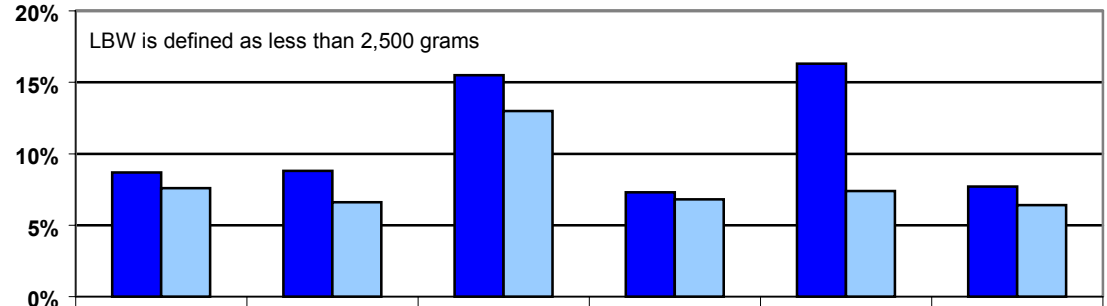
The included data are generally considered to be highly reliable because they are derived from birth certificates. However due to Wyoming's small population, the number of births for some minority groups is very small during a one year time frame. To increase reliability, several years of Wyoming data have been averaged for this report. Even so, some numbers are so small that they have wide confidence intervals. Nevertheless, they are included because they are the best numbers that are available. When sample size is less than 50, a note is included at the bottom of the graph. In these cases, readers should recognize that the data may not be highly reliable.

BOX 15: LOW BIRTH WEIGHT (LBW)

Overview: In 1998, Wyoming was tied for 6th among the 50 states for LBW for all races combined, and had the highest LBW rate for whites. There appears to be a disparity between racial/ethnic groups at the state and national levels.

Healthy People 2010 National Objective: Reduce LBW deliveries to no more than 5% of all births.

Low Birth Weight Rates
(WY 1997-99, US 1998)
Source: WY Dept. of Health, Office of Vital Records



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	8.7	8.8	15.5	7.3	16.3	7.7
US	7.6	6.6	13	6.8	7.4	6.4

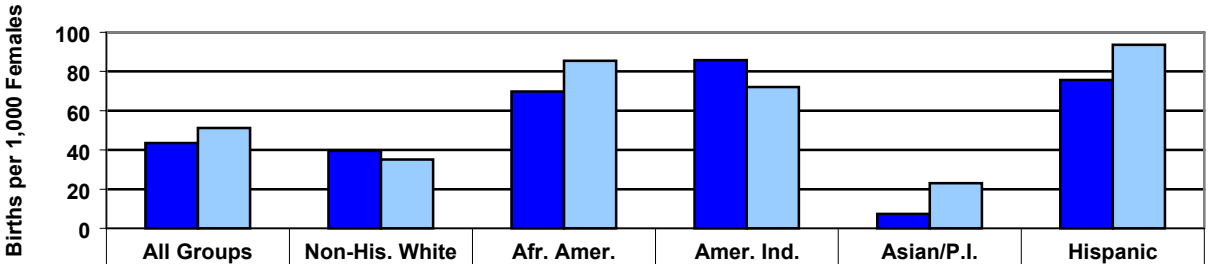
(Caution! Some WY rates are based on fewer than 50 births including: Afr. Am. = 28, Asian/PI = 23)

BOX 16: TEEN BIRTH RATES

Overview: Wyoming's teen birth rate is slightly less than the U.S. average. There appears to be a disparity between racial/ethnic groups at the state and national levels.

Related Healthy People 2010 National Objective: There is no objective for 15-19 year olds. There is an objective to reduce pregnancies among females aged 15-17 to no more than 68 per 1,000 adolescents.

Birth Rates for 15 to 19 Year Old Females
(WY 1997-99, US 1998)
Source: WY Dept. of Health, Office of Vital Records



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	43.5	39.5	69.7	85.8	7.3	75.6
US	51.1	35.2	85.4	72.1	23.1	93.6

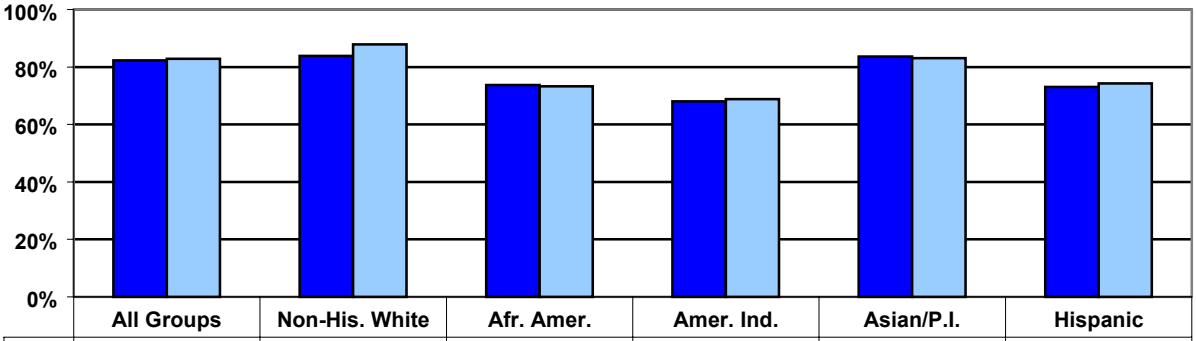
(Caution! Some WY rates are based on fewer than 50 births including: Afr. Am. = 37, Asian/PI = 4)

BOX 17: PRENATAL CARE

Overview: Overall rates for prenatal care in Wyoming are similar to the nation. There appears to be a disparity between racial/ethnic groups at the state and national level.

Healthy People 2010 National Objective: Increase to at least 90% the proportion of pregnant mothers who receive prenatal care in the first trimester.

Prenatal Care in First Trimester
(WY 1997-99, US 1998)
Source: WY Dept. of Health, Office of Vital Records



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	82.3	83.9	73.7	68	83.6	73
US	82.8	87.9	73.3	68.8	83.1	74.3

Health Status of Minority Populations in Wyoming
BEHAVIORAL RISK FACTORS

Much of the data in this section were taken from the Behavioral Risk Factor Surveillance Survey http://apps.nccd.cdc.gov/brfss/index.asp. Every state participates in this on-going telephone survey that is designed by, and partially funded by, the Centers for Disease Control (CDC) in Atlanta, Georgia. Each month, randomly selected Wyoming citizens are asked a number of questions relating to health behaviors. The monthly results are combined and published in an annual report. While BRFSS provides excellent information, its has a couple of limitations. First, it does not reach people without a telephone. Second, the sample size is not large enough to provide reliable information for small population groups and geographical areas smaller than the state level.

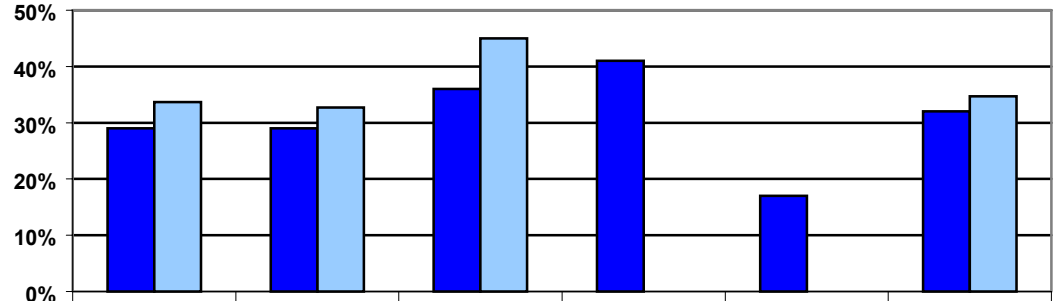
Two other sources of data are utilized in this section. One is provided by the recently completed needs assessment project provided by the Wyoming Department of Health, Division of Substance Abuse. The project consisted of a number of data collection activities, including an extensive one-time high school student written survey and an extensive one-time adult telephone survey. The other source of data is the Youth Risk Behavior Survey (YRBS), which is conducted by the Wyoming Department of Education every two years. Because this survey is somewhat limited in size, results are not presented for each minority group. Instead, YRBS results are presented for all races combined.

BOX 18: PERCENT OF ADULTS WHO ARE OVERWEIGHT

Overview: Overall, Wyoming rates for being overweight (BMI > 27.8 males and >27.3 females) are slightly less than the national average. There appears to be a disparity between racial/ethnic groups at the state and national levels. Also, see http://apps.nccd.cdc.gov/brfss/index.asp

Healthy People 2010 National Objective: Increase to 60% the number of adults at a healthy body weight (BMI >18.5 and <25)

Percent of Adults Who Were Overweight
(WY 1995-99; US 1999)
Source: BRFSS



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	29.0%	29.0%	36.0%	41.0%	17.0%	32.0%
US	33.7%	32.7%	45.0%	N.A.	N.A.	34.7%

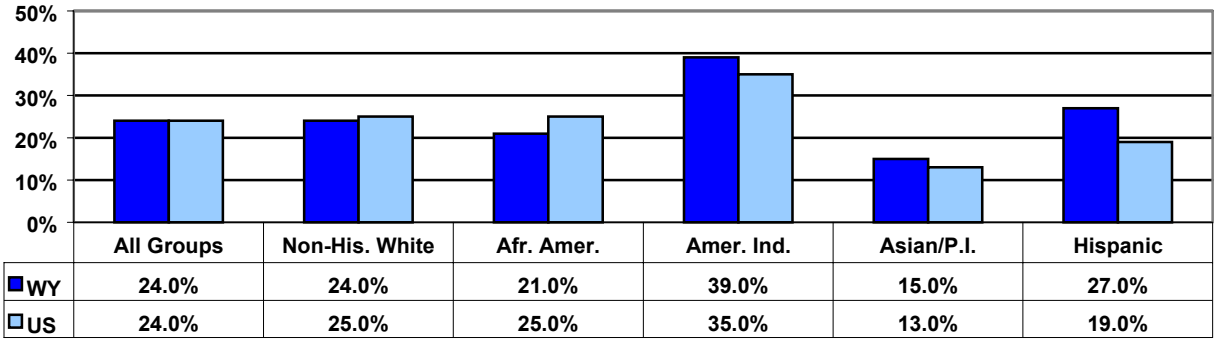
(Caution! Some WY rates are based on a sample size less than 50 including: Asian/PI = 46)

BOX 19: ADULT CIGARETTE SMOKING

Overview: Overall, Wyoming smoking rates are similar to the national rates. There appears to be a disparity between racial/ethnic groups at the state and national levels. Also, see http://apps.nccd.cdc.gov/brfss/index.asp

Related Healthy People 2010 National Objective: Reduce to 12% the proportion of adults who smoke cigarettes.

Percent of Adults Who Smoke Cigarettes
(WY 1995-99, US 1998)
Source: BRFSS



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	24.0%	24.0%	21.0%	39.0%	15.0%	27.0%
US	24.0%	25.0%	25.0%	35.0%	13.0%	19.0%

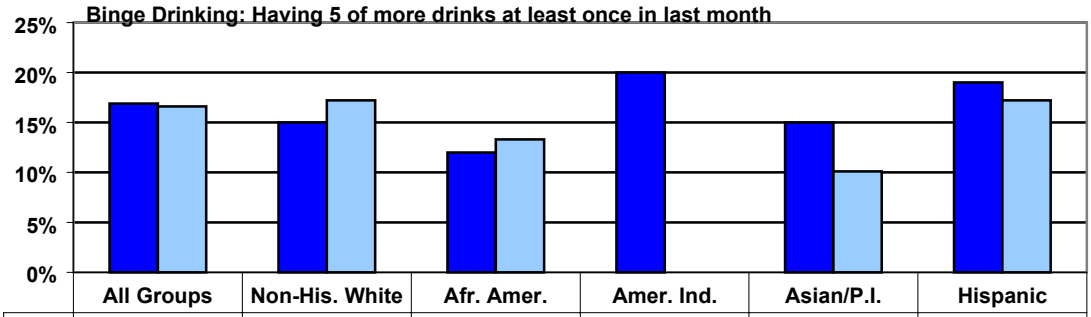
(Caution! Some WY rates are based on a sample size less than 50 including: WY Asian/PI = 46)

BOX 20: ADULT BINGE DRINKING

Overview: Overall, the Wyoming rate is similar to the national rate. There appears to be a disparity between racial/ethnic groups at the state and national levels. Also, see http://apps.nccd.cdc.gov/brfss/index.asp

Related Healthy People 2010 National Objective: Reduce the adult binge drinking rate to 6.0 percent.

Percent of Adults Who Participated in Binge Drinking
(WY 1994-97, 1999, US 1999)
Source: BRFSS



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	16.9%	15.0%	12.0%	20.0%	15.0%	19.0%
US	16.6%	17.2%	13.3%	N.A.	10.1%	17.2%

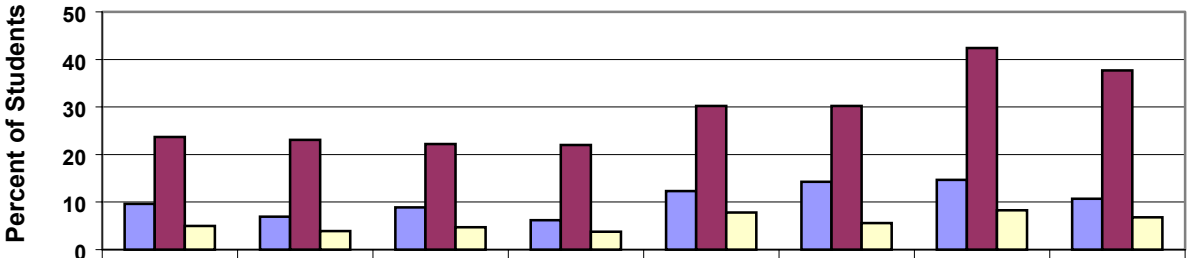
(Caution! Some WY rates are based on a sample size less than 50 including: Asian/PI = 47)

BOX 21: WYOMING TEEN DRUG AND ALCOHOL ABUSE

Overview: There appears to be a disparity between racial/ethnic groups in the state. (Data were obtained from a written survey of about 11,000 students in the 10th and 12th grades.)

Related Healthy People 2010 National Objective: Increase to 16.1 percent the number of adolescents (aged 12 to 17) who remain alcohol free and to 17.4 percent the number who remain marijuana free. There are also several related objectives (see: http://www.health.gov/healthypeople/).

Alcohol/Drug Abuse Among Wyoming High School Students: 1997- 98
(Source: WY Dept. of Health, Substance Abuse Division, Wyoming Needs Assessment Project)



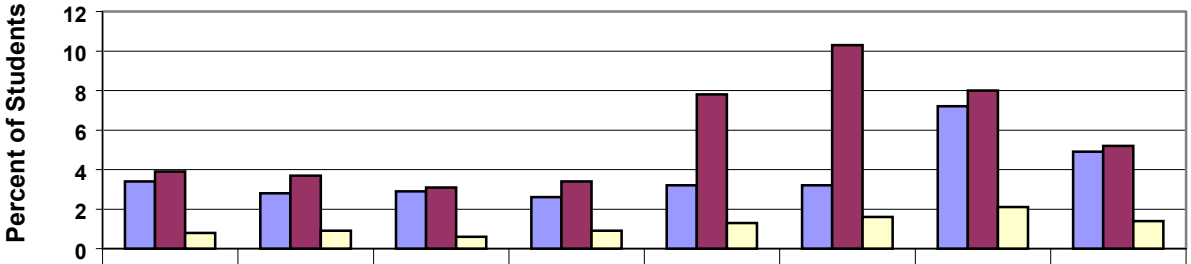
	All Males	All Females	White Males	White Females	Indian Males	Indian Females	Hispanic Males	Hispanic Females
Alcohol	9.6	6.9	8.9	6.2	12.3	14.3	14.7	10.7
Drugs	23.7	23.1	22.2	22	30.2	30.2	42.4	37.7
Both	5	3.9	4.7	3.8	7.8	5.6	8.3	6.8

BOX 22: WYOMING TEEN DRUG AND ALCOHOL DEPENDENCE

Overview: There appears to be a disparity between racial/ethnic groups in the state. (Data were obtained from a written survey of about 11,000 students in the 10th and 12th grades.)

Related Healthy People 2010 National Objective: There are no objectives specific to dependence, but there are some related treatment objectives (see http://www.health.gov/healthypeople/).

Alcohol/Drug Dependence Among Wyoming High School Students: 1997- 98
(Source: WY Dept. of Health, Substance Abuse Division, Wyoming Needs Assessment Project)



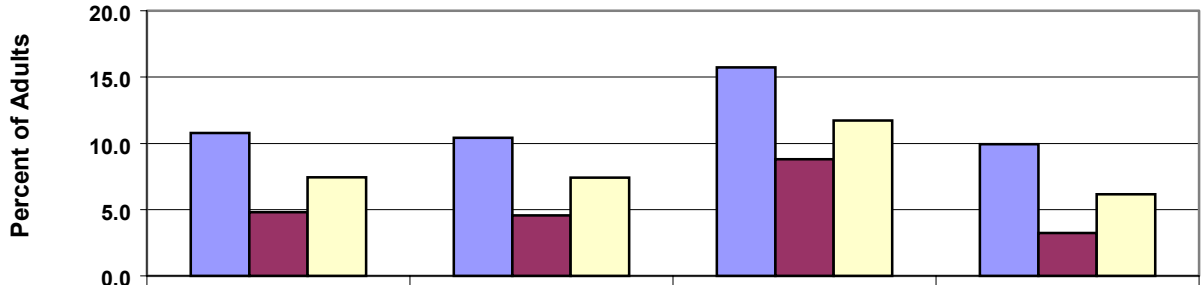
	All Males	All Females	White Males	White Females	Indian Males	Indian Females	Hispanic Males	Hispanic Females
Alcohol	3.4	2.8	2.9	2.6	3.2	3.2	7.2	4.9
Drugs	3.9	3.7	3.1	3.4	7.8	10.3	8	5.2
Both	0.8	0.9	0.6	0.9	1.3	1.6	2.1	1.4

BOX 23: WYOMING ADULT ALCOHOL ABUSE AND DEPENDENCE

Overview: There appears to be a disparity between racial/ethnic groups in the state. (Data were obtained from a one-time phone survey conducted in 1998. It is suspected that resulting data tend to under report actual rates.)

Healthy People 2010 National Objective: Reduce to 6 percent the number of adults participating in binge drinking in the past 30 days. There also some related objectives (see: http://www.health.gov/healthypeople/).

Alcohol Abuse/Dependence Among Wyoming Adults 1998
(Source: WY Dept. of Health, Substance Abuse Division, Wyoming Needs Assessment Project)



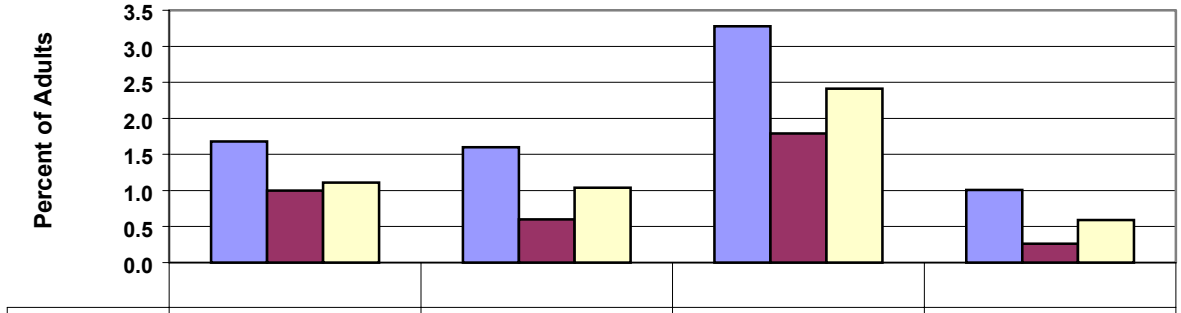
	All Groups	Non Hispanic White	Native American	Hispanic
Male	10.8	10.4	15.7	10.0
Female	4.8	4.6	8.8	3.2
Both Sexes	7.4	7.4	11.7	6.2

BOX 24: WYOMING ADULT DRUG ABUSE AND DEPENDENCE

Overview: There appears to be a disparity between racial/ethnic groups in the state. (Data were obtained from a one-time extensive phone survey conducted in 1998. It is suspected that resulting data tend to under report actual rates.)

Healthy People 2010 National Objective: Reduce to 5.8 percent the number of adults using any illicit drug in the past 30 days. There are also some related treatment objectives (see: http://www.health.gov/healthypeople/)

Drug Abuse/Dependence Among Wyoming Adults 1998
(Source: WY Dept. of Health, Substance Abuse Division, Wyoming Needs Assessment Project)



Male	1.7	1.6	3.3	1.0
Female				

BOX 25: WYOMING YOUTH BEHAVIOR

Overview: Every two years, since 1991, a Youth Risk Behavior Survey has been conducted in Wyoming's high schools. Unfortunately, the sample size is not large enough to provide reliable data about minority groups. The information presented below provides an overview of teen behavior for all races combined. It may be reasonable to assume that minority youths participate in similarly risky behaviors. Also, see http://www.k12.wy.us/publications/reports.html

Wyoming Rank When Comparing 1997 Weighted Data Between 26 States/Territories (an additional 15 States with unweighted data included in parenthesis)

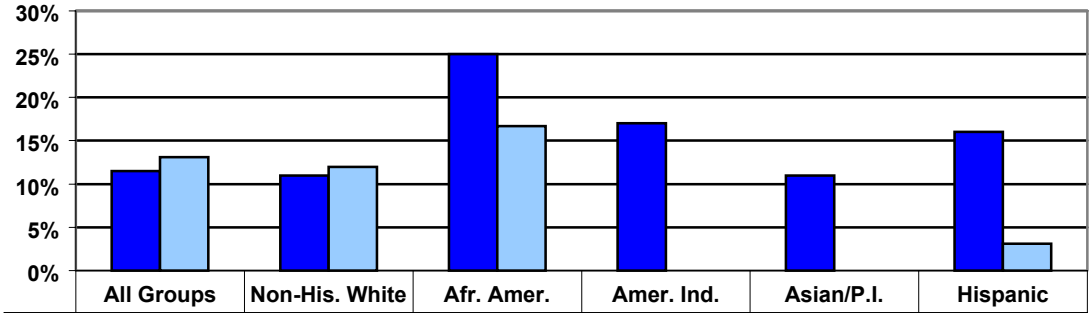
- 3rd highest in drinking and driving (4th if unweighted states included)
- 3rd highest in not wearing seatbelts
- 1st for smokeless tobacco use
- 3rd in current alcohol use (4th if unweighted states included)
- 3rd in drinking before the age of 13
- 3rd in current cocaine use
- 1st in lifetime crack or freebase use
- 2nd in number of kids sniffing substances to get high
- 2nd in injected drug use
- 1st in cocaine use before the age of 13
- 3rd in using alcohol or drugs before last sexual encounter
- 8th in being taught about HIV/AIDS in school (13th if unweighted states included)
- 9th in participating in vigorous physical activity (13th if unweighted states included)
- 18th in condom use among sexually active youth (25th if unweighted states included)
- 17th in participation in moderate physical activity (22nd if unweighted states included)

BOX 26: PERCENT OF ADULTS REPORTING POOR HEALTH STATUS

Overview: Overall, fewer Wyoming adults report fair to poor health status than adults nationally. There appears to be a disparity between racial/ethnic groups at the state and national levels. Also, see http://apps.nccd.cdc.gov/brfss/index.asp

Healthy People 2010 National Objective: There is no objective relating specifically to self reported health status.

Percent of Adults Reporting Fair to Poor Health Status
(WY 1995-99; US 1999)
Source: BRFSS



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	11.5%	11.0%	25.0%	17.0%	11.0%	16.0%
US	13.1%	12.0%	16.7%	N.A.	N.A.	3.1%

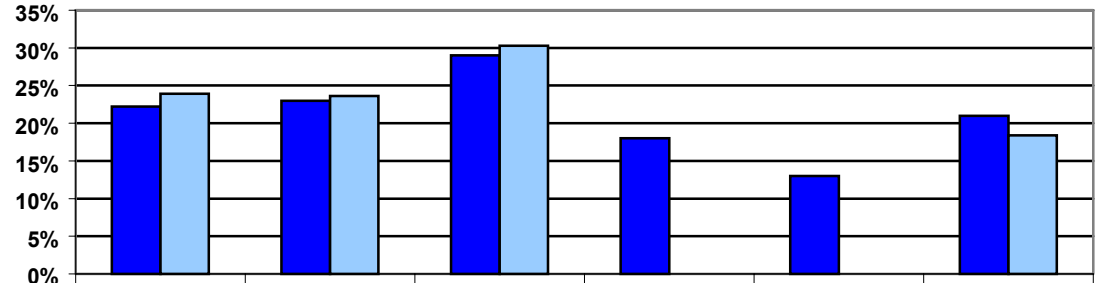
(Caution! Some WY rates are based on a sample size less than 50 including: Asian/PI = 47)

BOX 27: PERCENT OF ADULTS WHO HAVE BEEN TOLD THEY HAVE HIGH BLOOD PRESURE

Overview: Overall, the percent of people in Wyoming with high blood pressure is slightly less than the national average. There appears to be a disparity between racial/ethnic groups at the state and national levels. Also, see http://apps.nccd.cdc.gov/brfss/index.asp

Healthy People 2010 National Objective: Reduce the proportion of adults with high blood pressure to 16 percent.

Percent of Adults Reporting High Blood Pressure
(WY 1995, 1997- 99; US 1999)
Source: BRFSS



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	22.2%	23.0%	29.0%	18.0%	13.0%	21.0%
US	23.9%	23.6%	30.3%	N.A.	N.A.	18.4%

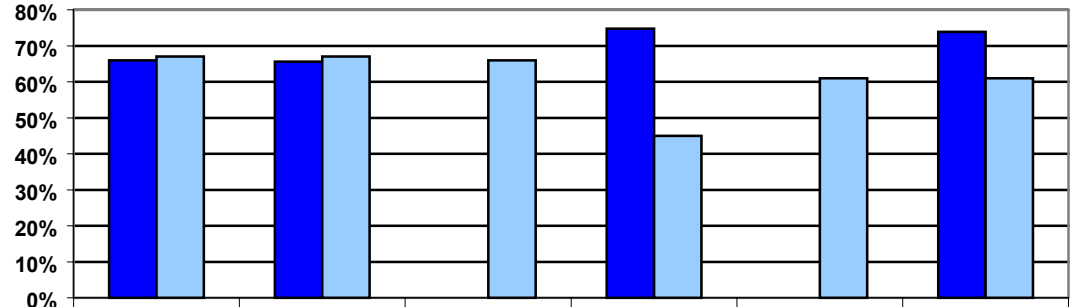
(Caution! Some WY rates are based on a sample size less than 50 including: Afr. Am. = 49, Asian/PI = 38)

BOX 28: BREAST CANCER SCREENING

Overview: Overall, Wyoming breast cancer screening rates are slightly below the national rates. There appears to be a disparity between racial/ethnic groups at the state and national levels. Also, see http://apps.nccd.cdc.gov/brfss/index.asp

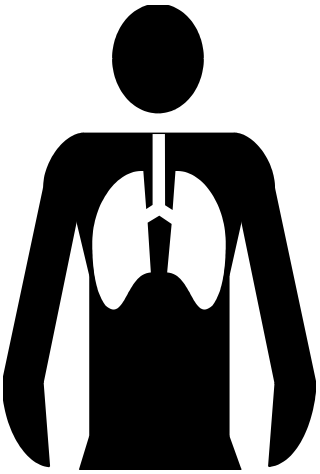
Related Healthy People 2010 National Objective: Increase to 70% the proportion of women aged 40 years and older who have received a mammogram within the preceding two years.

Percent of Adult Females Age 40+ Who Have Had a Mammogram in Past 2 Years
(WY 1997-99, US 1998)
Source: BRFSS



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	66.0%	65.6%	N.A.	74.8%	N.A.	73.9%
US	67.0%	67.0%	66.0%	45.0%	61.0%	61.0%

Health Status of Minority Populations in Wyoming
MORBIDITY/INCIDENCE



Unlike mortality data, which has a single point of collection (the death certificate), morbidity data are collected by a variety of government programs focusing on specific diseases. Many of these programs have worked long and hard to develop reporting networks that rely heavily on reports from medical professionals throughout the state. Some of the more commonly tracked morbidity rates are presented in this section, including: tuberculosis; sexually transmitted disease; and HIV/AIDS. Also presented are immunization, rates which have a direct relationship with infectious diseases rates.

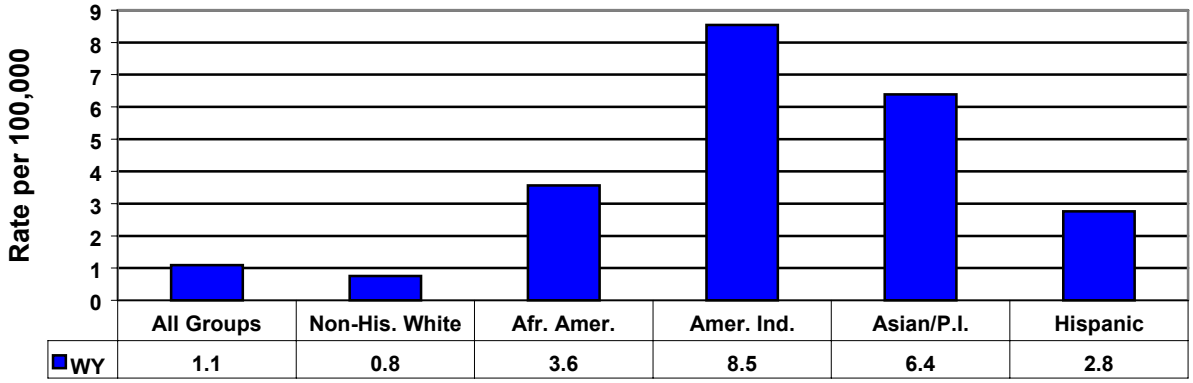
Because of differences in reporting systems, and because of the small incidence rates for some diseases in Wyoming, it is difficult to construct meaningful state and national comparisons. Therefore, state and national comparison data are not provided in this section.

BOX 29: TUBERCULOSIS

Overview: Wyoming is fortunate to have a relatively small number of TB cases (only about 5 new cases per year or about 1 per 100,000 population). There appears to be a disparity between racial/ethnic groups in the state. Also, see http://wdhfs.state.wy.us/tb/

Healthy People 2010 National Objective: Reduce to 1.0 per 100,000 the number of new cases reported each year.

Average Number of TB Cases Reported Annually Between 1985-2000
(Source: WY Dept. of Health, TB Program)



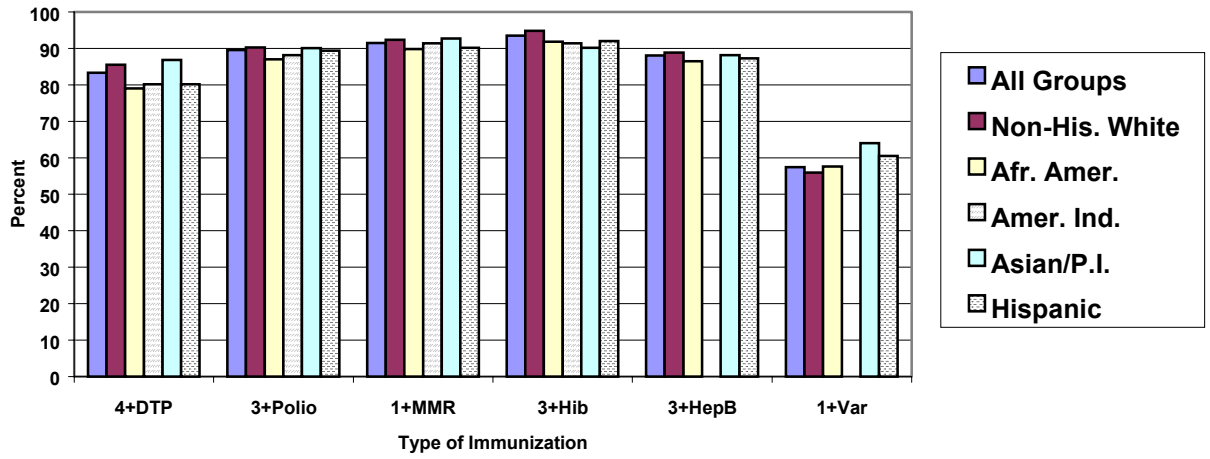
(Caution! Some WY rates are based on less than 50 cases including: Afr. Am. = 2, Indian = 14, Asian/PI = 3, Hispanic = 14)

BOX 30: IMMUNIZATIONS

Overview: In 1999, the overall immunization rate for children through age 2 in Wyoming was 72% (Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertusis, Hemophilus Influenza and Hepatitis B). Unfortunately, immunization data by race are not available for Wyoming. National data are presented below. There appears to be a slight disparity between the racial/ethnic groups in the nation. Also, see http://wdhfs.state.wy.us/immunization/

Healthy People 2010 National Objective: For children 19-35 months of age, increase to 90% the following immunization rates: 4 doses diptheria-tetnus-acellular pertussis; 3 doses polio; 1 dose measles-mumps-rubella; 3 doses Haemophilus influenzae; 3 doses hepatitis B; and 1 dose varicella.

National Immunization Rates for Children 19-35 Months of Age
(Source: National Immunization Program http://www.cdc.gov/nip/vfc/)

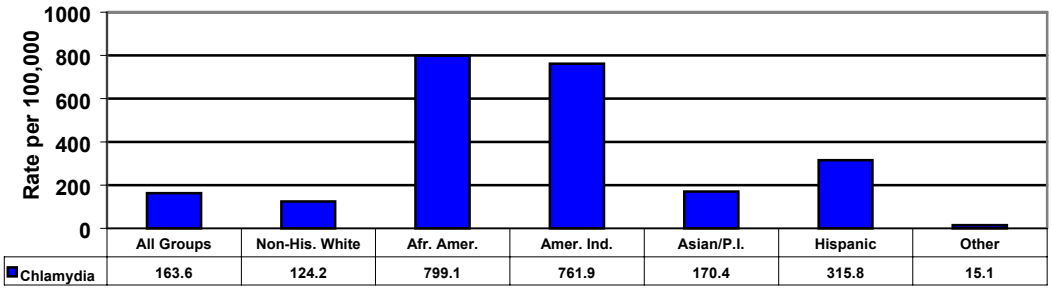


BOX 31: CHLAMYDIA

Overview: Chlamydia rates in Wyoming tend to be slightly lower than national rates. There appears to be a disparity between racial/ethnic groups in the state. Also, see http://wdhfs.state.wy.us/std/

Healthy People 2010 National Objectives: 1) Reduce to 3% the number of infected females aged 15-24 attending family planning clinics. 2) Reduce to 3% the number of infected females aged 15-24 attending STD clinics. 3) Reduce to 3% the number of infected males aged 15-24 attending STD clinics.

New Chlamydia Cases Reported in Wyoming in 2000
Both Sexes Combined
(Source: WY Dept. of Health, STD Program)



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic	Other
Chlamydia	163.6	124.2	799.1	761.9	170.4	315.8	15.1

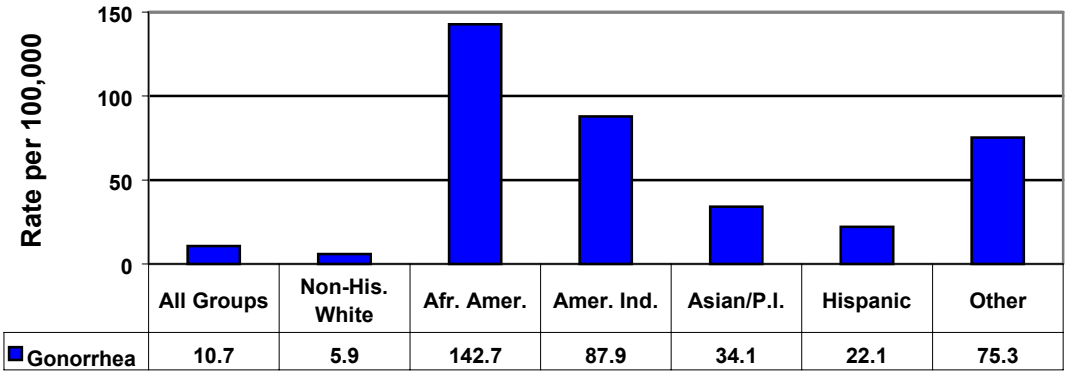
(Caution! Some rates are based on less than 50 cases including:
African American = 28, Asian/PI = 5, Other = 1)

BOX 32: GONORRHEA

Overview: Gonorrhea rates in Wyoming tend to be considerably below the national average. There appears to be a disparity between racial/ethnic groups in the state. Also, see http://wdhfs.state.wy.us/std/

Healthy People 2010 National Objective: Reduce new cases to 19 per 100,000 population.

New Gonorrhea Cases Reported in Wyoming in 2000
Both Sexes Combined
(Source: WY Dept. of Health, STD Program)



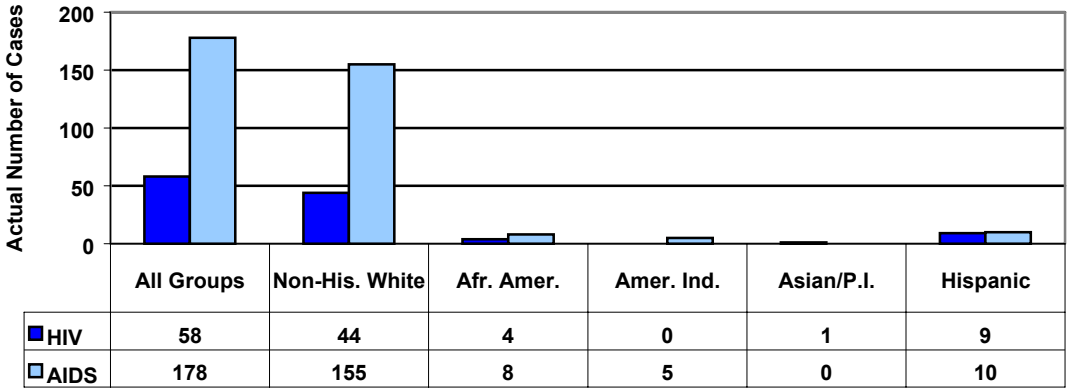
(Caution! Some rates are based on less than 50 cases including: Afr. Am. = 5, Indian = 9, Asian/PI = 1, Hispanic = 7, Other = 5

BOX 33: HIV/AIDS

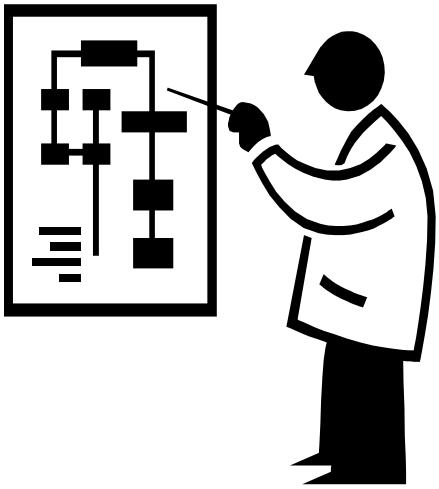
Overview: A cumulative total of 178 AIDS cases and 58 HIV cases have been reported in Wyoming since 1984. In 2000, four new AIDS cases and zero new HIV cases were reported. The numbers are too small to determine if there is a disparity. Also, see http://wdhfs.state.wy.us/AIDS_PREV/

Healthy People 2010 National Objective: Reduce the number of new AIDS cases among those age 13 and older to 1.0 per 100,000 persons each year.

Total Number of AIDS/HIV Cases Reported in Wyoming between 1984 and June 2000 (based on diagnostic status in 2000)
(Source: WY Dept. of Health, HIV/AIDS Program)



Overview of Health Status Data



When mortality, morbidity and behavioral risk factor rates for each racial/ethnic group are compared to those for all Wyomingites as a whole, health problems specific to each group can be identified. It is important that these areas of special concern be identified so that strategies can be developed to address them. The following overview is presented with the belief the first step toward correcting health disparities is to identify them. (Note: Some of the following statements are based on small numbers. Please read the cautionary statement one page 12.)

African Americans: In Wyoming, African Americans have much worse than average rates (as compared to the population as a whole) of stroke mortality, diabetes mortality, low birth weight births, self reported poor health status, high blood pressure, incidence of chlamydia, and incidence of gonorrhea (Table 6). They have somewhat worse rates of lung cancer mortality, Years of Potential Life Lost (YPLL), heart disease mortality, prenatal care, birth rates to 15-19 year olds, adults who are overweight and incidence of tuberculosis. Heart disease is the leading cause of death.

American Indians: In Wyoming, American Indians have much worse than average rates of overall mortality, Years of Potential Life Lost, infant mortality, suicide, unintentional injury mortality, motor vehicle accident mortality, lung cancer mortality, heart disease mortality, diabetes mortality, liver disease mortality, birth rates for 15 to 19 year olds, prenatal care, adult cigarette use, adult binge drinking, adults who are overweight, incidence of tuberculosis, incidence of Chlamydia and incidence of Gonorrhea (Table 6). They have somewhat worse rates of overall cancer mortality, stroke mortality, and self reported poor health status. Unintentional injury is a leading cause of death among Wyoming's American Indians.

Asian/Pacific Islanders: In Wyoming, Asian/Pacific Islanders have much worse than average rates of low birth weight births and incidence of tuberculosis (Table 6). Respiratory diseases are the 3rd and 4th leading causes of death among Asian/Pacific Islanders.

Hispanics: In Wyoming, Hispanics have somewhat worse than average rates of infant mortality, unintentional injury mortality, motor vehicle accident mortality, diabetes mortality, liver disease mortality, births to 15 to 19 year olds, prenatal care, adult cigarette use, adult binge drinking, self-reported poor health status, incidence of turberculosis, incidence of chlamydia, and incidence of gonorrhea (Table 6).

Non-Hispanic Whites: In Wyoming, Non-Hispanic Whites have somewhat worse than average rates of suicide, overall cancer mortality, COPD mortality and high blood pressure (Table 6). Heart disease is the leading cause of death.

Table 6: Areas Where Health Status for Racial/Ethnic Groups is Worse than the Health Status for All Wyomingites as a Whole.
(much worse, * somewhat worse)**

Health Status Indicator	Non-Hisp. White	African American	American Indian	Asian/P.I.	Hispanic
Mortality					
Overall Mortality			**		
YPLL per 1,000 Living Population		*	**		
Infant Mortality			**		*
Suicide	*		**		
Unintentional Injury Mortality			**		*
Motor Vehicle Accident Mortality			**		*
All Cancer Mortality	*		*		
Lung Cancer Mortality		*	**		
Heart Disease Mortality		*	**		
Stroke Mortality		**	*		
COPD Mortality	*				
Diabetes Mortality		**	**		*
Liver Disease Mortality			**		*
Maternal and Child Health					
Low Birth Weight		**		**	
Birth Rates for 15 to 19 Year Olds		*	**		*
Prenatal Care		*	**		*
Behavioral Risk Factors					
Adults Who Are Overweight		*	**		
Adult Cigarette Use			**		*
Adult Binge Drinking			**		*
Self Reported Poor Health Status		**	*		*
High Blood Pressure	*	**			
Morbidity (incidence)					
Tuberculosis Incidence		*	**	**	*
STD (Chlamydia)		**	**		*
STD (Gonorrhea)		**	**		*

Access to Health Care

Access to health care can help reduce health status disparities. This section examines the number of uninsured people in each minority/ethnic group and looks at government health program utilization rates in an attempt to determine if an access disparity exists.

Government programs for which data are presented include: Medicaid; Kid Care; Children With Special Health Care Needs (CSHCN); Primary Care Delivery Sites; the Indian Health Service; Public Health Nursing; and Medicare. (For a more detailed description of program's policies and eligibility requirements, see the appendix.) The data presented show the percentage of each racial/ethnic group enrolled in each program. This was determined by dividing the number of enrollees for each group by the total state population of each group.

As with the section on health status indicators, a series of boxes is presented first. An overview is presented at the end of the section.

Some of the Healthy People 2010 Objectives for Access to Health Care
(For a complete list see: http://www.health.gov/healthypeople/)

Reduce to 0 percent the proportion of children and adults under 65 without health care coverage.

Increase the proportion of patients who have coverage for clinical preventive services as a part of their health insurance.

Increase to at least 95 percent the proportion of people who have a specific source of ongoing primary care.

Increase to at least 95 percent the proportion of children 18 years and under who have a specific source of primary care.

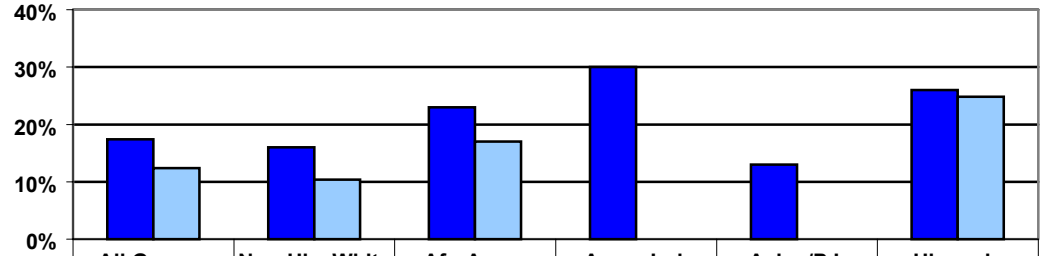
Reduce by 50 percent the number of individuals lacking access to a primary care provider in underserved areas.

BOX 34: THE UNINSURED

Overview: Overall, a greater percentage of people in Wyoming are uninsured compared to the national average. There appears to be a disparity between racial/ethnic groups at the state and national levels. (The disparity indicated for Americans Indians may be misleading because many Indians have access to Indian Health Services.) Note: the US numbers are obtained from BRFSS and are a 'median' of all states.

Healthy People 2010 National Objective: The objective is to have 100 percent of the population insured.

Percent of Adults Reporting No Health Insurance
(WY 1995-99; US 1999)
Source: BRFSS



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic
WY	17.4%	16.0%	23.0%	30.0%	13.0%	26.0%
US	12.4%	10.4%	17.0%	N.A.	N.A.	24.8%

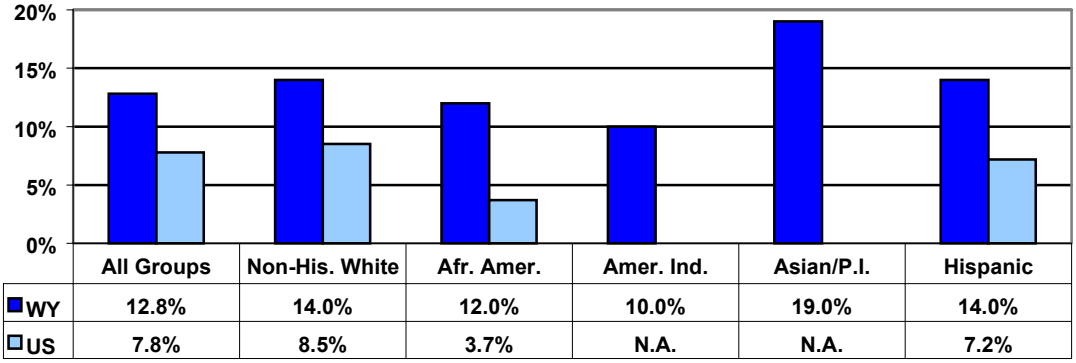
(Caution! Some WY rates are based on a sample size less than 50 including: Asian/PI = 47)

BOX 35: PERCENT OF ADULTS REPORTING 5 OR MORE YEARS SINCE LAST ROUTINE CHECKUP

Overview: Overall, adults in Wyoming report less frequent checkups than the national average. There appears to be a disparity between racial/ethnic groups at the state and national levels.

Healthy People 2010 National Objective: There is no objective relating specifically to checkups.

Percent of Adults Reporting 5 or More Years Since Last Routine Checkup
(WY 1995-99; US 1998)
Source: BRFSS



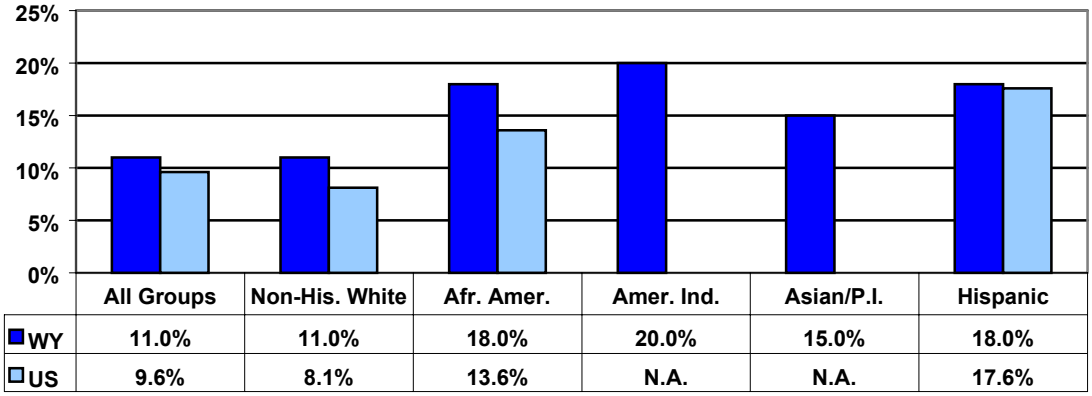
(Caution! Some WY rates are based on a sample size less than 50 including: Asian/PI = 47)

BOX 36: PERCENT OF ADULTS REPORTING NOT BEING ABLE TO SEE DOCTOR DUE TO COST

Overview: Overall, more adults in Wyoming report not being able to see a doctor due to cost than adults throughout the nation. There appears to be a disparity between racial/ethnic groups at the state and national levels.

Healthy People 2010 National Objective: There is no objective relating specifically to cost.

Percent of Adults Reporting Not Being Able to See Doctor Due to Cost
(WY 1995-99; US 1999)
Source: BRFSS



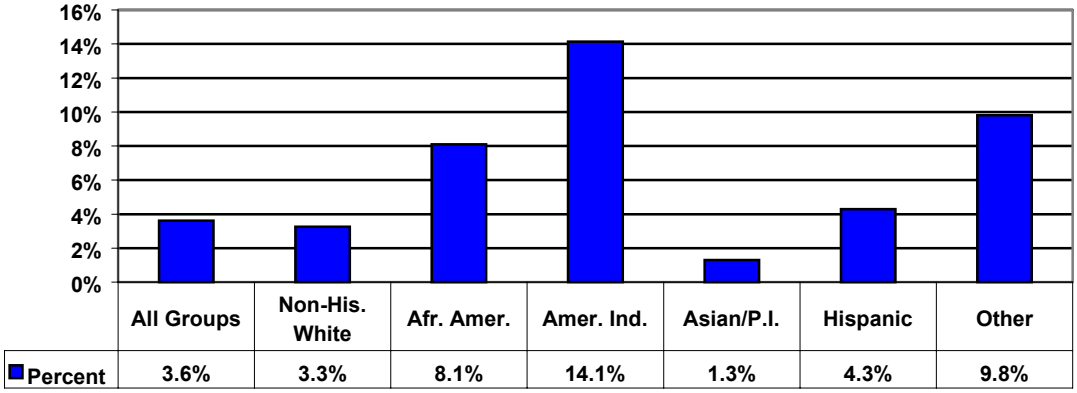
(Caution! Some WY rates are based on a sample size less than 50 including: Asian/PI = 47)

BOX 37: MEDICAID, ADULTS

Overview: Approximately 13,000 Wyoming adults were enrolled in Medicaid in December 2000. Except for Asian/Pacific Islanders, minority adults appear to be utilizing Medicaid more than the population as a whole.

Eligibility: Medicaid serves families with incomes up to 100% of poverty level.

Percentage of WY Adults Enrolled in Medicaid in Dec. 2000
(Source: Wyoming Dept. of Health Medicaid Program)



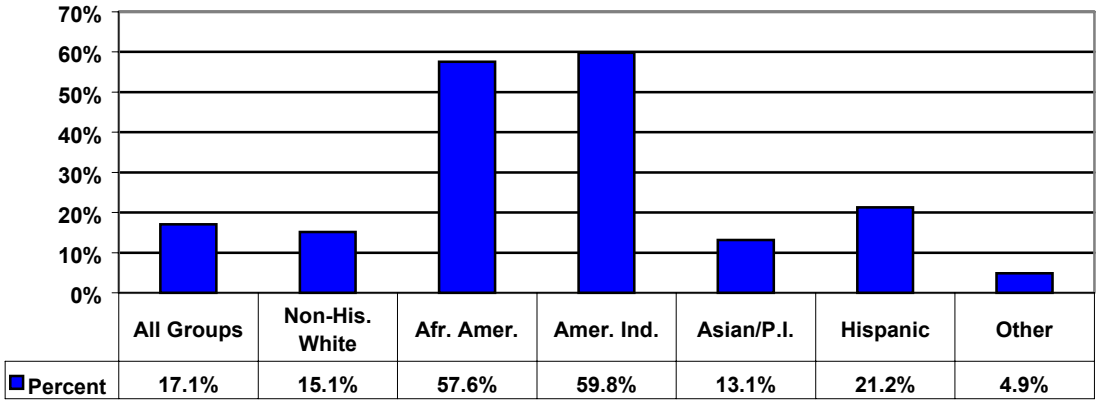
Total Adults Enrolled: 13,158

BOX 38: MEDICAID, CHILDREN

Overview: Approximately 22,000 children were enrolled in Medicaid in 2000. Except for Asian/Pacific Islanders, minority children appear to be utilizing Medicaid more than the population as a whole.

Eligibility: Medicaid serves families with incomes up to 100% of poverty level.

Percentage of WY Children Enrolled in Medicaid in Dec. 2000
(Source: Wyoming Dept. of Health, Medicaid Program)



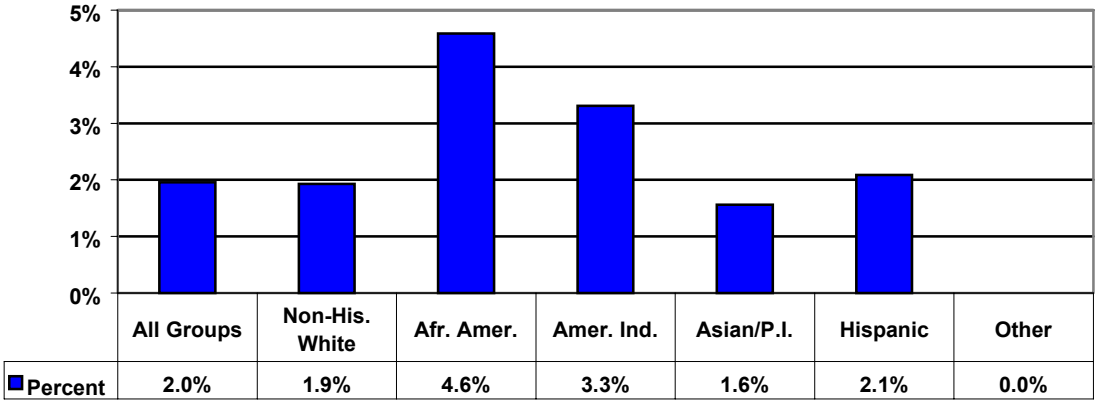
Total Children Enrolled: 21,988

BOX 39: KID CARE 1

Overview: Approximately 2,500 Wyoming children were enrolled in Kid Care in December 2000. Except for Asian/Pacific Islanders, minority children appear to be utilizing Kid Care more than the population as a whole.

Eligibility: Kid Care pays for health care services to families with incomes between 100% and 133% of federal poverty level.

Percentage of WY Children Enrolled in Kid Care in Dec. 2000
(Source: Wyoming Dept. of Health, Kid Care Program)



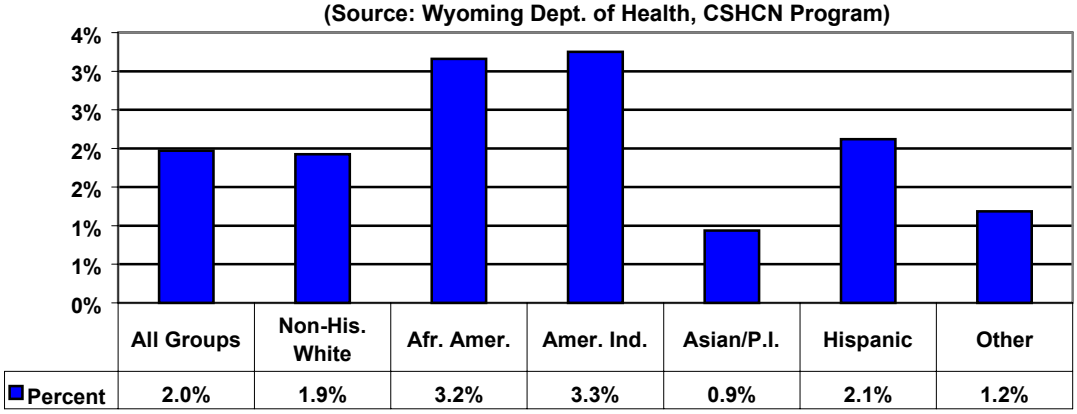
Total Children Enrolled: 2,524

BOX 40: CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Overview: The CSHCN Program, also called Children's Health Services, pays for medical services up to $40,000 per year per child. In many cases, these specialty services are provided out of state because they are not available in Wyoming. Except for Asian/Pacific Islanders, minority children appear to be utilizing CSHCN more than the population as a whole.

Eligibility: Up to age 19, and family income must be less than 185% of federal poverty level.

Percentage of WY Children Enrolled in the Children With Special Health Care Needs (CSHCN) Program (10/1/99 to 9/30/00)
(Source: Wyoming Dept. of Health, CSHCN Program)



Total Children Enrolled: 2,538

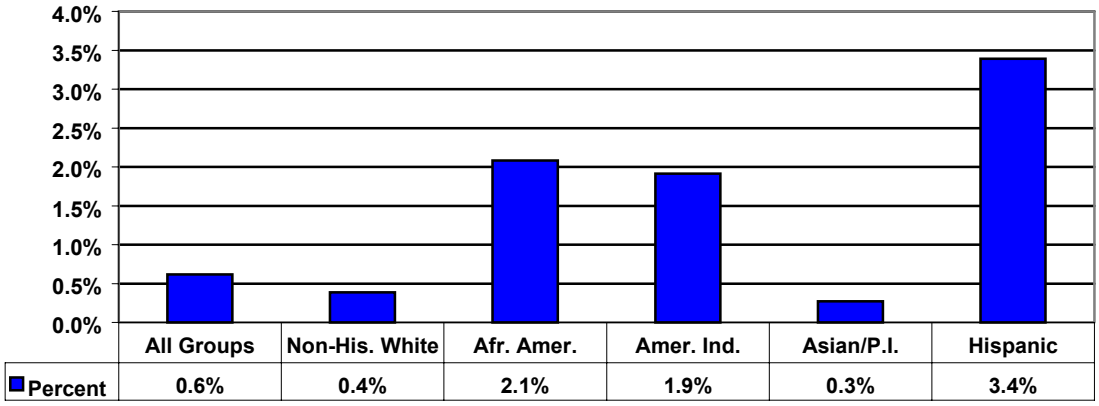
BOX 41: PRIMARY CARE DELIVERY SITES (PCDS)

(These sites received federal grants to provide basic clinical services to populations with specific needs.)

Overview: In 1999, PCDSs operated out of Cheyenne, Torrington, Casper, Worland and Sheridan. (Some of these sites served more than the city in which they are located.) In a few cases, funds are available for in-patient services, but that is rare. Except for Asian/Pacific Islanders, minority groups appear to be utilizing PCDS more than the population as a whole.

Eligibility: In 1999, the Cheyenne and Casper sites served primarily the homeless. The Torrington and Worland sites served primarily migrant farm workers. The Sheridan site served people suffering from work related respiratory problems. In 2000, a new Community Health Center was opened in Casper to provide primary health care to underserved populations.

Percentage of Population Utilizing Primary Care Delivery Sites in 1999
(Source: Wyoming Primary Care Association)



Total Served: 3,044

BOX 42: INDIAN HEALTH SERVICE

Overview: There are two Indian Health Service (IHS) facilities on the Wind River Indian Reservation. One serves primarily the Shoshone Tribe and the other serves primarily the Arapaho Tribe. Neither facility provides in-patient care. In-patient care is provided through a contractual arrangement with area hospitals.

Eligibility: The clinics are open to any low-income person, but most patients are American Indian.

Leading Causes of Direct Outpatient Visits, Wind River Service Unit

Diagnosis	1993	1994	1995	1996	1997	Ave. # of Visits
Diabetes Mellitus	4,363	4,546	5,056	4,894	5,430	**4,858**
All Other Respiratory Diseases	2,000	2,186	2,459	2,424	2,630	**2,340**
Acute Otitis Media (ears)	2,617	2,848	2,115	2,061	2,034	**2,335**
U/Respiratory Infection, Cough/Cold	1,815	1,932	2,148	2,211	2,658	**2,153**
Other Diseases of U/Respiratory Tract	1,591	1,819	2,171	2,212	2,570	**2,073**
Hypertensive Disease	1,904	1,865	1,931	1,638	1,720	**1,812**
R/Allergy, Asthma, Hay Fever	1,283	1,395	1,864	1,922	2,323	**1,757**
Pharyngitis, Tonsillitis, Non-Strep	1,361	1,900	2,003	1,785	1,652	**1,740**
Other Muscle-Skeletal, Con. Tissue. Disease	1,103	1,025	1,095	1,059	1,428	**1,142**
Other Mental Disorders	872	735	1,083	970	1,144	**961**

BOX 43: PUBLIC HEALTH NURSING

Overview: Public Health Nursing (PHN) has at least one office in every county in the state. PHN does not collect information about minority status. The table below summarizes services provided to all races between July 1, 1999 and June 30, 2000.

Eligibility: All services are provided without regard to race, and many services are provided without regard to income. However, most clients are from low-income families.

Statewide Count of Services Offered by Public Health Offices (7/1/99 to 6/30/00)	
Individual Client Service	**Number of Clients***
Adult Health For Chronically Ill	3,559
Communicable Disease	645
Home Health	770
Long Term Care Assessment	4,131
Maternal/Child/Family Services	7,706
Total	**16,811**

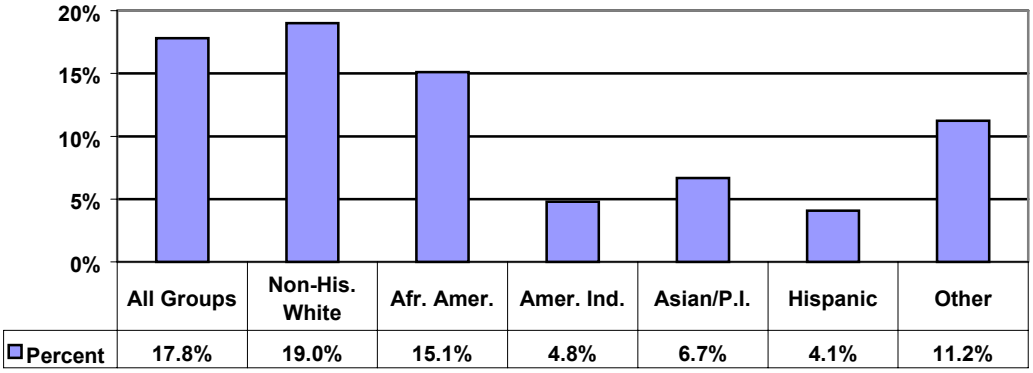
*Does not include the 171,280 visits made to public health nursing clinics.

BOX 44: MEDICARE (Adults 18+)

Overview: In 2000, 64,957 people were enrolled in Medicare in Wyoming. Note: The disparity that this chart seems to indicate may be due to differences in longevity, differences in income or differences in how racial/ethnic background is recorded (more discussion about this at the end of this section).

Eligibility: At least 65 years of age or disabled.

Percentage of WY Adults (age 18+) Enrolled in Medicare in Apr. 2000
(Source: HCFA's SDPS Database & US Census Bureau)



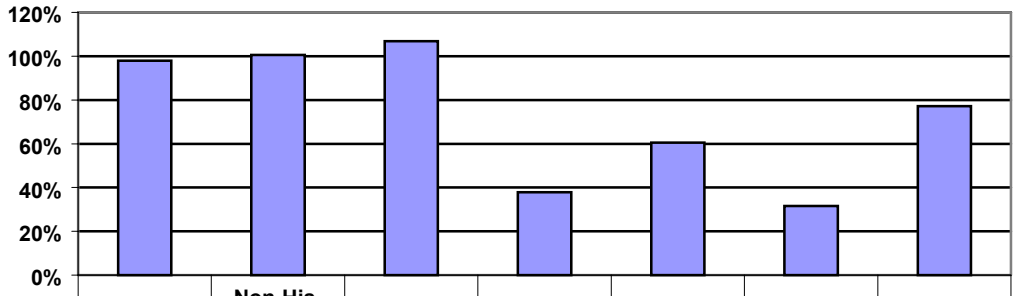
Total Adults Enrolled: 64,957

BOX 45: MEDICARE (Adults 65+)

Overview: In 2000, 56,521 adults age 65 and over were enrolled in Medicare. Note: The disparity that this chart seems to indicate may be due to differences in longevity, differences in income or differences in how racial/ethnic background is recorded (more discussion about this at the end of this section).

Eligibility: At least 65 years of age or disabled.

Percentage of WY Adults (age 65+) Enrolled in Medicare in Apr. 2000
(Source: HCFA's SDPS Database & US Census Bureau)



	All Groups	Non-His. White	Afr. Amer.	Amer. Ind.	Asian/P.I.	Hispanic	Other
Percent	98.0%	100.6%	106.8%	37.8%	60.5%	31.6%	77.1%

Total Adults Enrolled: 56,521

Overview of Access Data

Approximately 17.4% of Wyoming adults are uninsured (Box 35). The percentage of uninsured in Wyoming is slightly higher than the national average for most minority groups and for the population as a whole. The highest percentage of uninsured is among American Indians (30%) and Hispanics (26%). (However, it should be noted that most American Indians have access to the Indian Health Services, and it is likely that they are relying on this rather than private health insurance.) The percentage of people reporting not being able to see a doctor due to cost and not having a routine checkup in the last five years is also higher in Wyoming (Boxes 35 & 36).

It is possible that the large number of small businesses in Wyoming, compared to other states, contribute to the high proportion of uninsured because small businesses are less likely to provide health insurance for their employees. Lack of insurance may contribute to the low rates of routine checkups, since the checkups would have to be self-paid.

More data are needed about the uninsured in Wyoming. At the present time, one of the best sources of information is the Behavioral Risk Factor Surveillance Survey (BRFSS). However, this survey has its limitations. Because it is designed to be a statewide survey, it does not have a large enough sample size to provide highly reliable data for subcategories, such as counties or minority groups, and it does not include information about children.

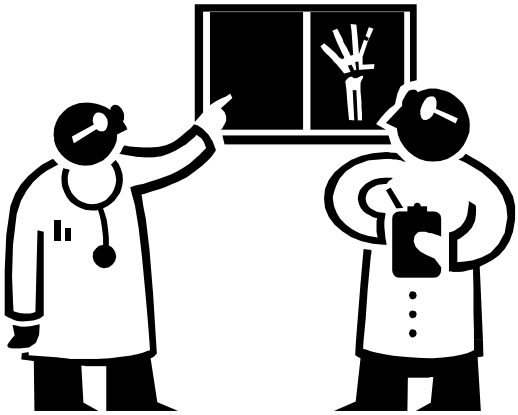
Except for Asian/Pacific Islanders, minority groups appear to be utilizing government health programs more than the population as a whole (Table 7). This is especially true for

Medicaid. Nearly 60 percent of African American children and American Indian children are enrolled in Medicaid.

On the other hand, American Indians, Asian/P.I., and Hispanics appear to be under represented among Medicare recipients (Table 7, Box 44, and Box 45). This may be partly explained by the different age structures of the groups. If a larger percentage of individuals die before they reach age 65, the group will be under-represented because Medicare primarily serves those age 65 and older (only 11% of Medicare recipients were under age 65 in 2000). It is also possible that due to lower income throughout their lives, some groups are less likely to qualify for Medicare. Another possibility is that the differences may be due to the way racial/ethnic membership is recorded by the Medicare program and/or errors in census data. Medicare program officials might want to take a closer look these and other possibilities to determine if an access disparity exists.

Table 7: Percentage of Each Racial/Ethnic Group Enrolled in Wyoming Health Care Coverage Programs

Program	All Groups	Non-His. White	African American	American Indian	Asian/P.I.	Hispanic
Medicaid, Adults	3.6%	3.3%	8.1%	14.1%	1.3%	4.3%
Medicaid, Kids	17.1%	15.1%	57.6%	59. 8%	13.1%	21.3%
Kid Care, Kids	2.0%	1.9%	4.6%	3.3%	1. 6%	2.1%
CSHCN, Kids	2.0%	1.9%	3.2%	3.3%	0.9%	2.1%
PCDSs, Kids & Adults	0.6%	0.4%	2.1%	1.9%	0.3%	3.4%
Medicare, Adults (age 18+)	17.8%	19.0%	15.1%	4.8%	6.7%	4.1%
Medicare, Adults (age 65+)	98.0%	100.6%	106.8%	37.8%	60.5%	31.6%



Results of Community Meetings and the Minority Health Survey

In order to inform the public about the minority health assessment and to obtain public input, five community meetings were held. Dates and locations were as follows: Cheyenne (March 29th); Casper (April 24th); Lander (May 1st); Green River (June 7th); and Gillette (June 26th). Also, a presentation was made at the Rural Health Conference in Laramie on May 16th.

A total of 91 people attended the community meetings. Attendance was as follows: 41 in Cheyenne; 25 in Casper; 15 in Lander; 4 in Green River; and 6 in Gillette. The meetings were used as the primary method of distributing a written survey (see appendix). However, surveys were also distributed in other ways. For example, a number of surveys were distributed through a Hispanic coalition in Cheyenne.

A total of 107 surveys were completed by individuals with the following racial/ethnic background: 41 non-Hispanic White; 9 African American; 18 American Indian; and 37 Hispanic. Other demographic characteristics of the respondents are summarized in Table 8.

Table 8: Demographics of Survey Respondents

Race/Ethnic Group:	
Non-Hispanic White	41
African American	9
American Indian	18
Asian/PI	0
Hispanic	37
Gender:	
Number of Females	72
Number of Males	27
Age:	
Age 18-24	8
Age 25-34	21
Age 35-44	24
Age 45-54	26
Age 55-64	1
Age 65+	7

Gross Household Income (month):	
$0-$500	3
$501-$1,000	10
$1,101-$1,500	11
$1,501-$2,000	14
$2,001-$2,500	9
$2,501-$3,000	7
$3,001-$3,500	10
$3,501-$4,000	8
$4,000+	24
Education:	
Did not graduate HS	12
HS graduate or GED	31
Some college	31
Bachelors	15
Masters	16
Doctorate	2

It should be pointed out that this was not intended to be a scientific survey. It was merely another means of obtaining community input. While the survey was not scientific, it captures the opinions of individuals with a minority racial/ethnic background, as well as the opinions of numerous professionals who work closely with minority groups. Survey results can be summarized as follows (also see appendix for tabulated responses to each survey question):

- Alcohol use, drug abuse, dental health and tobacco use are the leading community health concerns.
- Vision, dental health and exercise are leading personal health concerns.
- 83% of respondents had obtained health services in the past 12 months.
    - 36% had obtained services 1-2 times

    - 21% had obtained services 3-6 times
    - 11% had obtained services 7-12 times
    - 10% had obtained services more than 12 times
- 76% said the family physician was the health care provider of choice.
- A relatively small percentage listed public health, free clinic, tribal health healer, and other options as the provider of choice.
- When asked who pays for their health care, the leading answers were private insurance (61%) and self pay (23%). About 23% used government health programs.
- When asked why they did not seek health care services, the leading answers were lack of money and no health insurance.

In addition to completing a written survey, people attending the public meetings were asked to participate in a group discussion. Some of the key points expressed during the group discussions were:

Cheyenne Meeting (March 29, 2001)

- There is a need for more doctors, specifically doctors who are willing to work with low-income people.
- There is a need for vision and dental coverage.
- Individuals with private insurance cannot always afford the deductibles, so they put off health care needs.
- People fall between the cracks in terms of being eligible for services.
- Many people are not aware of available services. (i.e. free Breast and Cervical Cancer screening).

Casper Meeting (April 24, 2001)

- There is only one hospital and one pulmonary specialist, who is overwhelmed.
- Some insurance or programs have limits on the number of visits.
- Dental and eye care coverage is poor.
- There are waiting periods to get in to see a doctor.
- There are concerns about not being treated well by medical staff and Department of Family Services if on Medicaid.
- Intra-care won't accept Medicaid.
- Only about half of the dentists will accept Medicaid.
- Transportation to medical providers can be difficult.
- Some patients have difficulty understanding what the doctors tell them, especially at the hospital.
- Doctors need to be educated about cultural sensitivity and communicating with patients.
- There is a need for more nurse practitioners, and recruiting guidelines need to be more flexible.
- In some cases, if you don't have insurance, the medical provider will not see you.

Lander Meeting (May 1, 2001)

- The tribes are tired of studies being generated and the state using the numbers to obtain funding that does not come back to the Reservation.
- Because BRFSS uses a phone survey, and some American Indians don't have phones, the data may represent perceived norms instead of real norms.
- A better way to get Native American input would be to conduct one-on-one personal interviews.
- Also, the minority health project should use Indian Health Service data.

- The Eastern Shoshone Tribe has started the certification process for their own health programs to bring Federal dollars directly to the tribe.
- IHS is under-funded, with ever-rising medical expenses and budget cuts.
- If the project moves to phase II, it should move to improve the data and develop remedies to address these problems.
- Access varies throughout the state. Racial, ethnic and socioeconomic disparities exist.

Green River Meeting (June 7, 2001)

- CNAs are in short supply in the area.
- There is a need to educate legislators about several health issues.
- It may be interesting to look at data regarding the percentage of senior income spent on medications.
- Perhaps the higher rate of COPD in Wyoming is due to fact that there is a lot of mining in the state.
- Perhaps the higher rate of unintentional injuries in Wyoming is due to greater distances traveled, more alcohol consumption, more outdoor activities, and a greater distance to medical care.
- There is a need for more health data relating to children.
- A community single point of entry for health and social services may be a good thing.

Gillette Meeting (June 26, 2001)

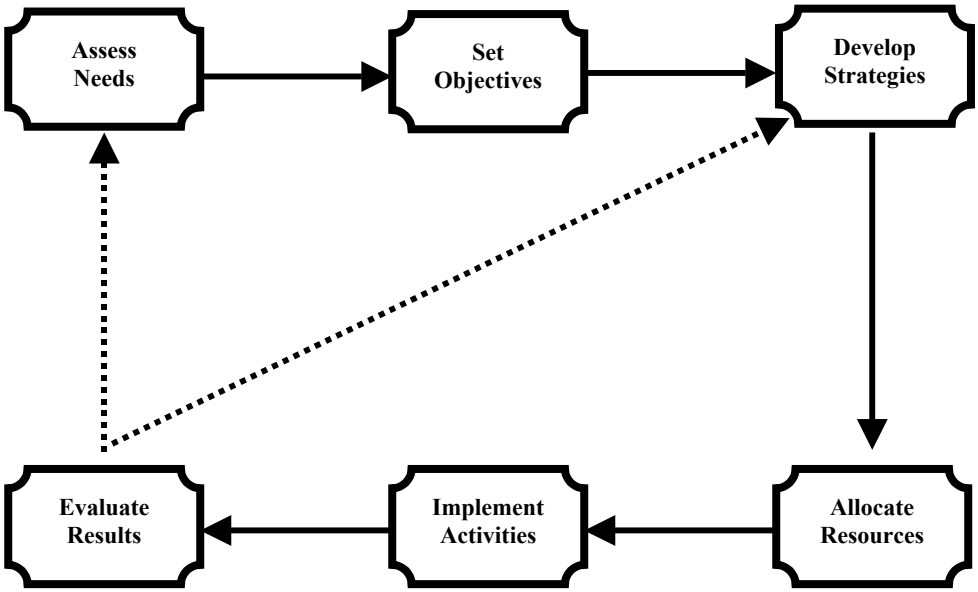
- Hispanics are the largest minority group in Gillette.
- Language barriers and lack of translators are a problem.
- Lack of transportation is likely a problem in some situations.
- Lack of education may be a barrier to health care.
- Although genetics may play a part in health disparities, it is not a clear reason for all disparities.
- Minority individuals seldom participate in crisis intervention programs in Gillette.
- Asian groups tend to care for each other and may not be receptive to government programs.
- In general the Hispanic culture tends to be receptive of health care, is supportive of each other, and takes care of the elderly. However, in general, Hispanics sometimes have difficulty following through with a health care regimen. Sometimes they have difficulty filling out applications due to a language barrier.
- One possible solution may be to establish preventive education in schools.
- In general, dental care and eye care are not accessible to low-income individuals.
- In the Northeastern part of the state, people who cannot afford health care can only receive major health care services at the emergency room.
- The area lacks a free clinic and has limited transportation to other areas.
- Doctors in the area may be receptive to a free clinic.
- One solution may be to transport needy individuals to the Community Health Center in Casper.
- Mental health care is a need in the Gillette area.
- Home visiting services could be useful for a number of health problems.

Because of the substantial health status disparities experienced by American Indians, extra efforts were made to obtain input from the Shoshone and Arapaho tribes on the Wind River Indian Reservation. In addition to the public meeting on May 1st, the Minority Health Steering Committee went on a guided tour of the reservation on May 2nd . Also, a representative of the Minority Health Steering Committee attended a tribal council meeting on June 6th. Committee

representatives also attended tribal council meetings on June 28th and June 29th. As a result of these efforts, both tribes have expressed support for the project and have provided access to data that were previously not available to the project.

Overview of Strategies that Could Make a Difference

Identifying disparities is the first of many steps toward reducing those disparities. The steps in the process typically include: a needs assessment; development of specific objectives; development of strategies; allocation of resources; implementation; and evaluation. The process is cyclical similar to that outlined below.



This report focuses heavily on the first step, the needs assessment. It clearly indicates that numerous disparities exist. However, it only begins to assess why the disparities exist and what can be done about them. Much additional effort will be needed to answer these questions.

While the report focuses heavily on the needs assessment phase, the information collected raises a number of questions that may guide subsequent projects to determine causes and possible solutions. These include:

- How strong is the correlation between poverty and health status?
- If there is a strong correlation, what is the potential value of employment training programs and/or specific economic development efforts?
- How strong is the correlation between level of education attainment and health status?
- What are the health status differences between subpopulations/geographical areas within the state (this project took largely a statewide look)?
- What affect do the following have on access to health care?
  - Transportation
  - Cultural values
  - Language barriers
  - Awareness of government assistance

- If cultural values are a significant factor, is there a need for cultural competency training of health care professionals?
- What is the relative importance of improving prevention programs compared to improving access to health care?
  - If all access barriers could be removed, would health status disparities be eliminated?
  - If everyone practiced near perfect health related behaviors (no smoking, proper exercise, etc.), would health disparities be eliminated?
- Specifically, what prevention programs are needed and which delivery models work best?
- Specifically, what access improvement programs are needed and which delivery models work best?

It is likely that reducing health status disparities will require improving access to primary care and promoting a number of prevention programs. The involvement of organizations specializing in economic development, job training and youth education may also be required.

Ideally, the planning process initiated by this report will be continued. If continued, the process should be guided by representatives of minority groups, as well as representatives of organizations that may potentially be involved with implementation, including: primary care; prevention; education; employment; etc. Ultimately, a minority health improvement plan should be developed. This may be a single comprehensive plan with different sections for different minority groups, or it may be a separate plan for each group.

Special Note Relating to Indian Health Issues

At several meetings, various tribal members expressed a desire to collect separate health status data for each of the two tribes. During recent years, the two tribes have been moving toward establishing separate services on the reservation. For example, there are two Indian Health Service clinics, one primarily for the Shoshone and one primarily for the Arapaho.

Because separate units of governance are being utilized to address Indian health problems, it may be appropriate to develop separate health improvement plans for each tribe. That would require collecting health status data for each tribe. While separate data may eventually be needed, this report takes a broader first step view of minority health and does not distinguish between the two tribes.

Appendix

(Summary Information About Programs That Are Important to Minority Populations)
(Tabulated Survey Results)

MEDICAID

Purpose: To provide a variety of medical assistance to needy individuals in Wyoming.

Geographical Area Served: Entire state

Eligibility:

- Persons who are eligible for Supplemental Security Income (SSI). This includes persons age 65 and older and blind or disabled adults and children.
- Persons who are eligible for Temporary Assistance to Needy Families (TANF)
- Infants born to women who are receiving Medicaid at the time of the birth.
- Aged, blind & disabled persons in nursing homes who meet state eligibility requirements for long term care.
- Pregnant women whose income is less than 133 percent of the Federal Poverty Level.
- Kid Care Plan A - Children from infancy to age 6 whose parents' income is less than 133 percent of the Federal Poverty Level, & children from age 6 to 11 whose parents' income is less than 100% of the Federal Poverty Level.
- Persons eligible due to disregard of Social Security cost of living increases, earned income increases or child support increases.
- Foster care children under 21 years of age.
- Persons receiving home & community-based services.
- Persons receiving hospice care or services for tuberculosis - services are limited to medical care for their qualifying conditions.
- Qualified Medicare Beneficiary - limited to payment of Medicare premiums, coinsurance and deductibles.
- Specified Low-income Medicare Beneficiary (SLMB) - limited to payment of the Medicare Part B premium.
- Refugees and illegal aliens (eligible for emergency services only).

Contact Information:

Eligibility & Enrollment:

Contact the local Department of Family Services office

Services Covered:

1 (800) 251-1269

Also see:

http://wdhfs.state.wy.us/WDH/Medicaid.htm

KID CARE HEALTH PLANS

Purpose: To provide health care coverage for low-income children through 18 years of age.

Geographical Area Served: Entire state

Eligibility:

- Kid Care Plan A--See page 48
- Kid Care Plan B--Eligibility requirements and coverage are very similar to the Medicaid Kid Care Plan A. The major difference is that Kid Care Plan A provides services up to 100% of Federal Poverty Level (FPL), while Kid Care Plan B provides services from 101% FPL to 133% FPL and covers kids up to age 18.
- Kid Care Plan C--The plan is still in the developmental phase, and may be implemented in the future. The plan would provide coverage from 134% FPL to 150% FPL, and work under a private insurer voucher system.

Contact Information:

1 (888) 996-8786
http://kidcare.state.wy.us/index.htm

CHILDREN'S SPECIAL HEALTH SERVICES

Purpose: To provide health related services for high risk mothers, newborns and children with special health care needs. The program will provide up to $40,000, per individual, for specialty care that is often times only available out-of-state.

Geographical Area Served:

Entire state

Eligibility:

185% of Federal Poverty Level
up to 19 years of age for children
no age limit for high risk pregnant mothers

Contact Information:

Contact a local public heath office or call the state office at (307) 777-7941

PRIMARY CARE DELIVERY SITES (PCDSs)

Purpose: PCDSs are partially federally funded, community based sites that provide medical services to select populations including low-income, homeless, migrant workers and seasonal workers and those suffering from work related respiratory problems (especially miners).

Geographical Area Served: Migrants are served in the Big Horn Basin and in Southeast Wyoming. Homeless and low-income are served in Casper and Cheyenne. Respiratory services are provided through an office in Sheridan that serves a five state area.

Eligibility:
Worland: Migrants
Torrington: Migrants
Casper: Homeless & Under Served
Cheyenne: Homeless
Sheridan: Work-related respiratory problem

Contact Information:
Migrant Health Clinic, Worland, 754-5252
Health Care for the Homeless Clinic, Casper, 235-6116
Cheyenne Crossroads Clinic (homeless), 632-8064
Cheyenne Community Clinic (uninsured), 635-1621
Community Health Center (under-served), Casper, 233-6000
WY Respiratory Care & Educ. Assoc., Sheridan, 672-0046

INDIAN HEALTH SERVICE

Purpose: To provide public health and clinical health care services to American Indians. Inpatient services are provided by contractual arrangement with area hospitals.

Eligibility:
American Indians who are enrolled or descendents of a federally recognized tribe.

Geographical Area Served: Primarily the Wind River Indian Reservation. Although American Indians living in Sublette County, Hot Springs County, and Fremont County can also receive direct services per contract health regulations.

Contact Information:
Wind River Service Unit:
Ft. Washakie Health Center 332-7300
Arapahoe Health Center 856-9281

PUBLIC HEALTH NURSING

Purpose: Public health offices are located in every county. They provide a variety of services including: immunizations; family planning; well child clinic; adult health maintenance; nursing home pre-admission review; home visiting; communicable disease control; disease and prevention education; smoking cessation classes; health screening clinics; sanitation inspections; genetics clinics; breast feeding education; hearing and vision screening; HIV/AIDS counseling and testing; throat cultures; etc. (Note: not all offices provide all services.)

Eligibility:

There is no income limit for most services. However, most people receiving services are low-income.

Geographical Area Served:

Entire state

Contact Information:
State Office (Cheyenne): 777-7275
Albany County (Laramie): 721-2561
Big Horn County (Greybull): 765-2371
Campbell County (Gillette): 682-0274
Carbon County (Rawlins): 328-2607
Converse County (Douglas): 358-2536
Crook County (Sundance): 283-1142
Fremont County (Lander): 332-1132
Fremont County (Riverton): 857-3620
Goshen County (Torrington): 532-4069
Hot Springs County (Thermopolis): 864-3311
Johnson County (Buffalo): 684-2564
Laramie County (Cheyenne): 633-4000
Lincoln County (Kemmerer): 877-3780
Lincoln County (Afton): 886-9598
Natrona County (Casper): 235-9340
Niobrara County (Lusk): 334-2609
Park County (Cody): 587-2204
Park County (Powell): 754-5163
Platte County (Wheatland): 322-2540
Sheridan County (Sheridan): 672-9791
Sublette County (Pinedale): 367-2157
Sweetwater County (Rock Springs): 352-6868
Sweetwater County (Green River): 872-6320
Teton County (Jackson): 733-6401
Uinta County (Evanston): 789-9203
Uinta County (Lyman): 787-3800
Washakie County (Worland): 347-3279
Weston County (Newcastle): 746-4775

COMMUNITY MENTAL HEALTH

Purpose: To provide mental health counseling including suicide and substance abuse counseling

Geographical Area Served: Entire state

Eligibility:

There are various eligibility requirements depending on the service requested.

Contact Information:

Big Horn County Counseling
Basin (568-2020)
Lovell (548-6543)
Campbell County Counseling Ctr.
Gillette (687-5517)
Carbon Co. Counseling Center
Rawlins, WY (324-7156)
Central WY Counseling Center
Casper, WY (237-9583)
Eastern WY Mental Health Ctr.
Douglas, WY (358-2846)
Lusk, WY 82225 (334-3666)
Glenrock, WY 82637 (436-8335)
Fremont Counseling Service
Lander, WY (332-2231)
Riverton (856-6587)
Hot Springs Co. Counseling Svc.
Thermopolis (864-3138)
Jackson Hole Community Counseling Center
Jackson (733-4870)
Lincoln Co. Mental Health Assn.
Afton, WY (885-9883)
Kemmerer (877-4466)
Northern WY Mental Health Ctr.
Sheridan (672-8958) (674-4405) (674-5534)
Newcastle (746-4456)
Buffalo (684-5531)
Sundance (283-3636)
Park Co. Mental Health Center
Cody (587-2197)
Powell (754-3448)
Pioneer Counseling Services
Evanston (789-7915)
Lyman (786-2105)
Southeast WY Mental Health Ctr.
Cheyenne (634-9653) (632-9362) (632-9361)
Laramie (745-8915)
Torrington (532-4091)
Wheatland (322-3190)
Southwest Counseling Service
Rock Springs (352-6677)
Reliance (352-6689)
Green River (872-3205)
Sublette Community Counseling Svcs.
Pinedale (367-2111)
Big Piney (276-3594)
Washakie Mental Health Services
Worland (347-6165)
See also:
http://wdbh.state.wy.us/services/pmh/mhproviders.html

MEDICARE

Purpose & Services Offered: Nationwide, about 40 million people are enrolled in Medicare. The Medicare program has two parts. Part A of Medicare pays for skilled nursing care and hospital services. Medicare will pay for almost all hospital expenses except for a deductible and coinsurance. Part B of Medicare pays for other medical services, like visits to the doctor, laboratory and X-ray tests, etc. To be covered by Medicare Part B, recipients must pay a monthly premium, a deductible every year and coinsurance.

Geographical Area Served:
Entire state

Eligibility: The following groups are eligible:

- Most individuals aged 65 or older.
- Younger persons entitled to Social Security benefits including survivors and the disabled
- Most persons with end stage renal disease.

Contact Information:

Part A: Blue Cross/Blue Shield
1 (800) 442-2376

Part B: Blue Cross/Blue Shield
1 (800) 437-4762

Social Security Administration
1 (800) 772-1213

FAMILY PLANNING

Purpose: To provide family planning services.

Geographical Area Served: Entire state

Eligibility:

No specific eligibility requirements. Users pay per sliding fee scale.

Contact Information:

The Wyoming Health Council serves as administrative component which channels grants and oversight to the local community organizations that provide reproductive health care in Wyoming. The council can also provide referrals to reproductive health clinics in Wyoming.

WY Health Council http://www.whc.vcn.com/
410 Grand Avenue, Suite 205
Laramie , WY 82070
(307) 742-7700

See the following web site for county specific information:

http://wind.uwyo.edu/connect/pathways/topics.asp?Key=F&Topic=Family+Planning

WYOMING MINORITY HEALTH COMMUNITY SURVEY

County: Laramie (70); Natrona (14); Sweetwater (12); Fremont (8); Carbon (2); Campbell (1)

1. What are the biggest health concerns in your community? (Check all that apply)

35 Vision/Eye problems	27 Lung problems	39 Depression	35 Cancer
47 Dental/teeth	30 Heart problems	8 Lupus	30 Allergies
15 Hearing/ears	39 Diabetes/sugar	56 Drug Abuse	26 Asthma
11 Stomach problems	25 Exercise	62 Alcohol use	18 Arthritis
11 Environmental/water	23 Hypertension	44 Tobacco	15 HIV/AIDS
3 Sickle Cell Anemia	23 Nutrition	__Other:_____	

2. What are your personal health concerns? (Check all that apply)

44 Vision/Eye problems	10 Lung problems	17 Depression	15 Cancer
38 Dental/teeth	12 Heart problems	0 Lupus	22 Allergies
7 Hearing/ears	16 Diabetes/sugar	4 Drug Abuse	13 Asthma
11 Stomach problems	27 Exercise	6 Alcohol use	12 Arthritis
3 Environmental/water	12 Hypertension	10 Tobacco	2 HIV/AIDS
0 Sickle Cell Anemia	15 Nutrition	__Other:_____	

3. In the last 12 months, have you gone for health services/treatment?

18 No 86 Yes. If yes, how often? 37 1-2 times 22 3-6 times 11 7-12 times 10 more than 12 times

4. What is your most common reason for seeking health services/treatment?

41 Illness	6 Accident	27 Dental	4 Pregnancy
2 Mental Health	8 Injury	19 Eye care	11 Lab tests
48 Routine Check-up			__Other:_____

5. What kind of health care provider do you use most (check all that applies)?

79 Family Physician/Doctor	2 Tribal Medicine/Healer	5 Free Clinic/Health Center
8 Public Health Office	2 Spiritualist/Clergy	3 Community Health Center
8 Physician Assistant	3 Indian Health Srvs	16 Hospital Emergency
15 Nurse Practitioner	1 Herbalist	__Other:_____

6. How are your medical expenses paid for?

66 Private health insurance	17 Medicaid	2 Kid Care	3 Indian Health Services/Tribe
8 Medicare	12 VA/military	25 Self-pay	__ None of the above
0 Migrant health	__Other:_____		

7. Do you usually follow your health care provider's suggestions regarding the following topics?

Diet: 57 yes 35 no Minimize stress: 51 yes 32 no Weight Management: 45 yes 38 no
Exercise: 59 yes 33 no Take medications as prescribed: 88 yes 10 no

8. Do you use herbs and/or other homemade remedies ?

75 No 28 Yes, please explain:_____

9. What is the best time for you to receive health care services/treatment? (Check all that apply)

46 Anytime 18 Weekdays 14 Weekends 16 Mornings 17 Afternoons 13 Evenings

10. When you go for health care services/treatment, do you have difficulty speaking or understanding the health care provider because:

12 You speak a different language. If yes, what language? 9 Spanish __Sign Language
3 Tribal Language
__Other:_____
4 You don't understand the words they use

0 Hearing problems __Other reasons:_____

Did you use an interpreter? __No 6 Yes, if yes who was the interpreter? 3 Family Member
3 Neighbor/Friend __Health Care Staff
__Other:_____

11. If you do NOT seek health care services/treatment, what are the reasons? (Check all that apply)

7 No health insurance
21 Lack of money
3 Lack of Confidentiality/Privacy
0 Need Child Care
0 Bad service/Attitude of staff
2 Location of provider
3 Need Transportation
4 Hours of Operation
2 Do not trust health provider
1 Do not feel respected by staff
0 Prefer same sex provider
1 US Citizenship Status
__Other:_____

12. What is your age? 18-24=8; 25-34=21; 35-44=24; 45-54=26; 55-64=1; >65=7

13. What is your gender? 27 Male 72 Female

14. To which racial/ethnic group do you identify yourself?

9 African American
Specify:_____

0 Asian American/Pacific Islander
Specify:_____

37 Hispanic/Latino/Mexican American
Specify:_____

18 Native American/American Indian/Alaskan Native
Specify:_____

41 White/Caucasian
Specify:_____

__Other:_____
Specify:_____

15. What is the highest grade or level of school that you completed?

6 Less than high school
6 High School, but did not graduate
22 Graduated high school
9 GED
31 Some College
15 Bachelor's Degree
16 Master's Degree
2 Doctorate

16. How many people live in your household? 1=18; 2=17; 3=15; 4=25; 5=15; 6=5; 7=5; 8=1

How many people are employed who live in your household? 1=35; 2=41; 3=7; 4=5

17. What is your average monthly gross family income?

3 $0 - $500
10 $501. - $1000.
11 $1001- $1,500
14 $1,501 - $2,000
9 $2,001 - $2,500
7 $2,501 - $3,000
10 $3,001 - $3,500
8 $3,501 - $4,000
24 $4,001 – and over

Is this income combined with others (grandparent(s), friends, extended family) within your household? 10 Yes 76 No If yes, what is the combined average monthly gross income? _____

18. Do you have additional comments to share about your healthcare needs and concerns?

_____

An Assessment of the Health Status of the Health Populations in Wyoming

Erratta (January 8, 2002)

Table 1, page 7,
Asian/ P.I. 1990 population should be 2622, which results in a change of +11.9%

For clarification the note at the bottom of the table should read:

*Multiple race individuals included in 'other' group for 1st time in 2000, resulting in large percentage increase.

Table 1: Wyoming Minority Populations in 1990 & 2000

Race/Ethnic Group	1990	2000	Change
Non-Hispanic White	412,711	438,799	+6.3%
Hispanic	25,751	31,669	+23.0%
African American	3,426	3,504	+2.3%
Native American	8,857	10,238	+15.6%
Asian/P.I.	2,622	2,934	+11.9%
Other	221	6,638	*
Total	**453,588**	**493,782**	**+8.9%**
Total Minority	**40,877**	**54,983**	**+34.5%**

*Multiple race individuals included in 'other' group for 1st time in 2000, resulting in large percentage increase.

Page 13, Box 3: Leading Causes of Death
The following should be added after the table:
Note: Hispanics are not listed separately by this data source

Page 27, Box 28: Breast Cancer Screening
The following should be added after the table:
Note: Due to the small sample size, there is no Wyoming data for the African American and Asian/Pacific Islander.

Page 31
The paragraph titled "Hispanics" should be replaced with the following:

Hispanics: In Wyoming, Hispanics have somewhat worse than average rates of infant mortality, unintentional injury mortality, motor vehicle accident mortality, diabetes mortality, liver disease mortality, births to 15 to 19 year olds, prenatal care, adult cigarette use, adult binge drinking, self-reported poor health status, incidence of tuberculosis, incidence of chlamydia, and incidence of gonorrhea (Table 6).

Page 32, Table 6
Diabetes Mortality for Hispanics should have one star (*).
STD (Gonorrhea) for Hispanics should have one star (*)