NATIONAL PARTNERSHIP FOR ACTION
to End Health Disparities

Mountain States Regional Health Equity Council Blueprint for Action

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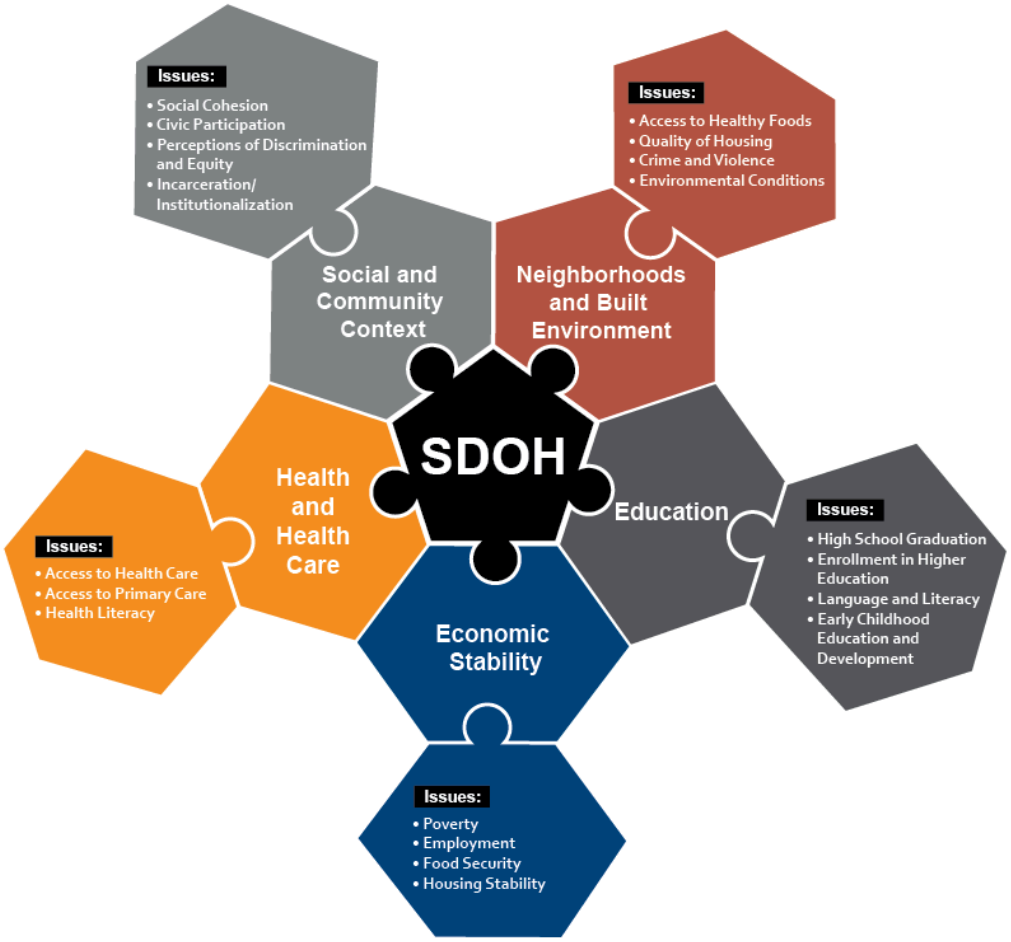
Introduction

The Mountain States region consists of six states: North Dakota, South Dakota, Wyoming, Montana, Utah, and Colorado. These states are mostly rural and frontier and are more geographically diverse than any other region in the United States. The region has some of the highest mountain peaks, deserts, and plains in the United States. However, this means they also have the least dense population. The 2010 U.S. Census Bureau lists the population at 11,157,409, which is only 3.25% of the U.S. population.

External factors like population distribution, neighborhood and the built environment, education, economic stability, health and health care, and social and community context influence overall health outcomes in the Mountain States region and beyond. These conditions are known as the social determinants of health (SDOH). For an example of how SDOH can affect health outcomes, consider the indicators for 'Neighborhoods and the Built Environment,' shown in the diagram below. Based on the neighborhood that an individual lives in, s/he may encounter high crime rates affecting personal safety, food deserts resulting in lack of access to healthy foods, and old housing stock leading to high asthma rates and lead exposure.



The SDOH disproportionately affect individuals and communities that systematically experience greater social and economic obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health, cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion. These differences in health linked to social, economic, and/or environmental disadvantage are known as health disparities. Through the combined efforts of implementers and policymakers throughout the Mountain States region, these health disparities can be eliminated and health equity - the highest level of health for all people – can be achieved.

Background

The National Partnership for Action to End Health Disparities (NPA) is a national initiative, coordinated by the U.S. Department of Health and Human Services' Office of Minority Health, dedicated to reducing health disparities. The NPA originated from a call to action and the recognition that reducing health disparities would take a multi-sector, systems-oriented, community-driven, partnership-based approach.

NPA activities tackle health disparities and the social determinants of health by addressing five goals (Appendix A):

Goal 1: Awareness	•Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial and ethnic minorities and underserved populations.
Goal 2: Leadership	•Strengthen and broaden leadership for addressing health disparities at all levels.
Goal 3: Health System and Life Experience	•Improve health and healthcare outcomes for racial and ethnic minorities and underserved populations.
Goal 4: Cultural and Linguistic Competency	•Improve cultural and linguistic competency and the diversity of the health-related workforce.
Goal 5: Data, Research, and Evaluation	•Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.

With the intent to create sustainable growth and structure, NPA activities are implemented through ten Regional Health Equity Councils (RHECs) with members who serve as leaders and catalysts to improve health equity. The RHECs play a critical role in coordinating and enhancing state and local efforts to address health disparities and the social determinants of health, driving collective action at the regional level.

The Mountain States RHEC is comprised of six states and maintains a diverse membership representing several sectors such as state government, higher education, health care delivery, and private foundations. The diversity in the Mountain States RHEC, including 30 federally-recognized tribes, ensures adequate input from diverse sectors in the council's efforts to understand and address health disparities in the region.

Regional Blueprint for Action

The Mountain States RHEC has developed this Blueprint for Action as a starting base to move their agenda forward in eliminating health disparities. The Blueprint embodies the goals and priorities of the NPA and is tailored to reflect regional priorities, build on existing strengths, and address existing gaps. The Blueprint is a concrete and actionable road map that highlights the priorities for the region and, more importantly, guides RHEC activities and collaborative strategies to address identified regional priorities. This Blueprint also serves to highlight opportunities for stakeholders to engage in actions to reduce or eliminate health disparities in the Mountain States Region. While the broader document outlines regional disparities disaggregated by health outcome and the social determinants of health, Appendix B includes detailed individual state profiles, outlining specific health disparities by race and ethnicity. This Blueprint will be updated regularly to ensure that the information is current and relevant to the health of the region.

Our Regional Blueprint guides the Mountain States RHEC's efforts to

- Strengthen health initiatives
- Leverage resources
- Implement and monitor strategies to end health disparities

Regional Context

While the Mountain States RHEC Blueprint embodies the goals and priorities of the NPA, it is tailored to reflect the:

- **Challenges** that the Mountain States Region faces in relation to demographics and geographic distribution, health and health care disparities, health care access, workforce development, and the impact of specific determinants of health
- **Existing strengths** within the Mountain States Region, namely communities that can help the Mountain States Region drive strong public policy and actions that promote health equity and the elimination of health disparities

The purpose of this Blueprint is to establish a context for understanding health and health care disparities in the United States, specifically within the Mountain States Region.

The demographic and health data in this section were selected for inclusion based on several criteria, including availability of state-level data and priority areas, association with leading causes of death, and identification by OMH and other agencies.

This section is intended to provide a snapshot of health disparities in the region and identify key data that can provide some context for health disparities and inform the Mountain States RHEC's strategies and actions. The information and data are also intended to serve as a reference for individuals and organizations that will shape policies and drive action on these strategies.

For the data presented, every attempt has been made to use the most up-to-date and reliable data sources, primarily from the U.S. Census Bureau, the Centers for Disease Control and Prevention (CDC), the U.S. Department of Agriculture's Economic Research Service, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the Rural Health Research Center. However, the availability of data for comparative purposes always poses a challenge. Several years may pass between data collection and its availability for public use. Furthermore, due to logistical challenges, there is a persistent shortage in sample size, such that statistically significant data are often not available for some populations. This is especially true when populations are grouped together for data collection purposes. For example, demographic data for Asian Americans, Native Hawaiians, and other Pacific Islanders are often collected together. The report notes where data were unavailable or unreliable.

Regional Strengths

Despite the many challenges that the Mountain States Region faces, such as a lack of resources, a shrinking workforce, a shortage of medical professionals, and overall unequal distribution of health care services in rural areas, the Mountain States RHEC recognizes that there is strength in preservation and within communities.

- Acclaimed research universities: the University of Colorado and University of Utah
- Increased collaboration between North Dakota and Wyoming State OMH offices with tribal communities
- The University of North Dakota School of Medicine and Health Sciences offers the Indians Into Medicine Program, with up to four graduates per year, and the University of Colorado's School of Public Health's

Centers for American Indian and Alaska Native Health includes the Centers for Excellence in the Elimination of Disparities.

- 16 tribal colleges and universities in Montana, North Dakota, South Dakota, and Wyoming
- Some rural and frontier communities within the Mountain States Region have engaged local physicians assistants and are able to get local townsfolk to volunteer as emergency medical technicians to ensure that services are available in medically underserved areas
- Wyoming is working on a statewide awareness campaign on the benefits of Medicaid expansion by partnering with the Medicaid Expansion Coalition and supporting grassroots efforts
- The Avera McKennan Hospital & University Health Center at the University of South Dakota, utilizes its video technology for Telemedicine, Distance Learning, and Videoconferencing. The technology is part of regional efforts to increase the availability of human and informational resources to other facilities and to strengthen the delivery of local healthcare services in communities throughout the region
- University of South Dakota has a medical school which graduates each year about 55 medical students/year in MD and MD/MPH programs. They also offer the following programs (for program descriptions, please visit http://www.usd.edu/medicine/ssom-diversity-programs):
  - Indians Into Medicine Program, The INMED program/ Diversity Programs
  - Native American Scholars Program (NASP)
  - American Indian Sciences and Engineering Society (AISES)
  - Asniya Elective
  - Sanford School of Medicine (SSOM) Cultural Colloquium
  - SSOM Cultural Colloquium
  - SSOM Diversity Dialogues
  - SSOM Diversity Health Affairs

Regional Challenges

The health disparities mentioned in this Blueprint can be linked to issues of overall access to health care, housing, education, food security, transportation, and workforce development. The Urban and Rural Health Chartbook states that residents who live in rural areas are likely to smoke more, exercise less, have less nutritional diets, and more likely to be obese than suburban residents.[1]

Workforce development and access to care are social determinants of health that have led to a shortage of medical providers and medical services, especially in oral and mental health care. With regard to workforce development, Wyoming and Montana do not have medical schools within their states. Therefore, students often go to bordering states like Colorado and Utah to receive their medical education and often do not return to their home state to practice.

Due to the geographic distribution and sometimes isolation, transportation can be difficult for individuals needing care at the few community health centers located in nearby communities. This creates an access-to-care issue, wherein individuals may have to travel up to two hours to get to the nearest center. Unfortunately,

[1] Morgan, A. (2002, summer). A national call to action: CDC's 2001 Urban and Rural Health Chartbook. Journal of Rural Health, 18(3), 382–383.

with the exceptions of Colorado, South Dakota, and Utah, the states lack the technology of telehealth[2] to see patients. Although the community health centers offer services under a sliding fee schedule for persons without health insurance, they frequently ask for and sometimes require payment up front for services. Medicaid expansion under the Patient Protection and Affordable Care Act (ACA) is not available in three of the six states (South Dakota, Utah, and Wyoming).

Understanding the demographics and geographic distribution of population groups is important in planning and addressing health needs in different parts of the region. The following demographic conditions affect the health and health care of individuals and communities within the Mountain States Region:

- A shortage of health care providers and ambulance services in rural areas and the reservations, particularly in North Dakota
- Poverty in rural areas
- Food deserts in rural frontier communities
- A low number of college-educated professionals
- Old infrastructures in buildings that predate the Americans with Disabilities Act and are not conducive to people with disabilities.

Regional Demographics

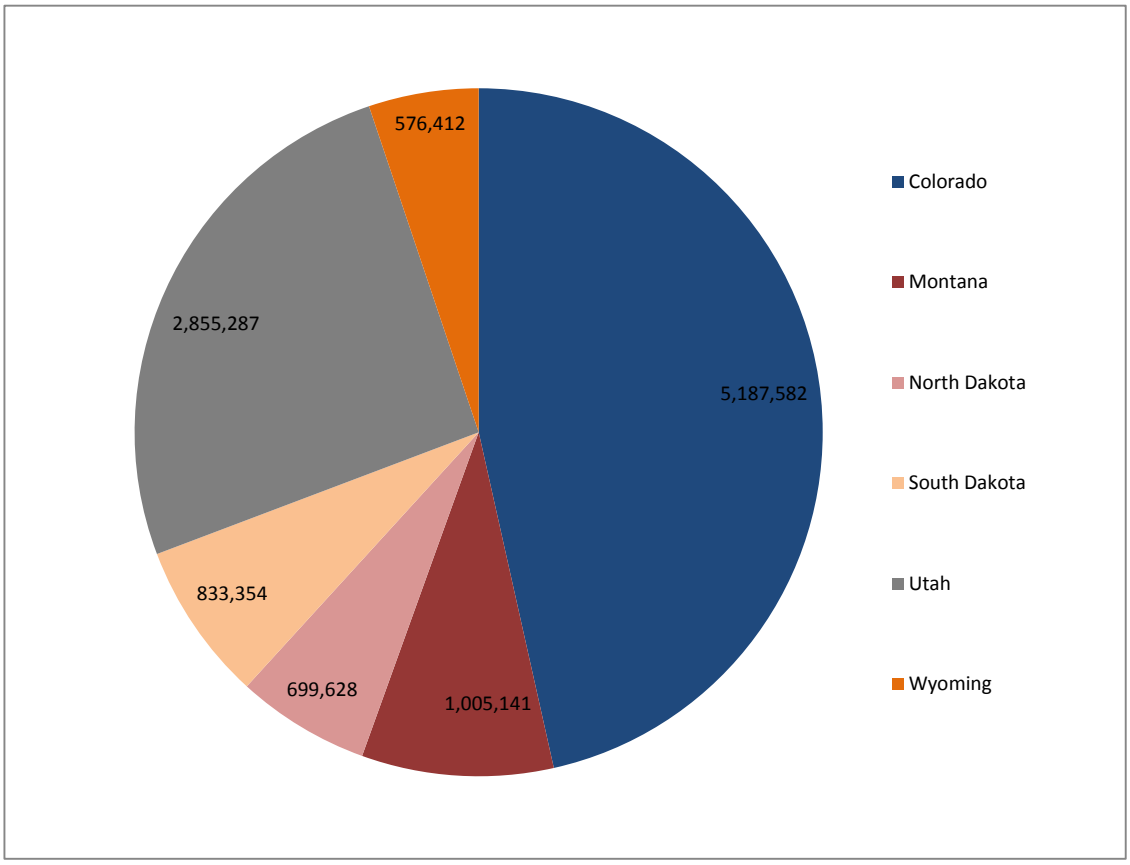
The U.S. census estimates that in 2013, there were more than 11 million people in the six Mountain States—just 3.5% of the U.S. population. These states make up 16% of the country's land mass,[3] and much of this population is rurally distributed.[4] Residents of rural areas and small cities make up 74% Montana, 70% South Dakota, 60% North Dakota, and 76% Wyoming, which is substantially higher than the U.S average of around 30%. On the other hand, while they have vast rural areas, high percentages of the population in Utah (81%) and Colorado (77%) live in large, densely populated urban area.

[2] Telehealth is the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. HRSA.gov. Glossary of Terms. http://www.hrsa.gov/ruralhealth/about/telehealth/glossary.html#t

[3] U.S. Census Bureau. Unpublished data from the MAF/TIGER database. Accessed November 2014. https://www.census.gov/geo/reference/state-area.html.

[4] Bishop, B. (2012, April). How rural are the states? *The Daily Yonder*. Accessed November 2014. http://www.dailyyonder.com/how-rural-are-states/2012/04/02/3847.

Figure 1: Region Population[5]



Race/Ethnicity

A breakdown by state and race/ethnicity is represented in **Table 1**.[6][7] The predominant race/ ethnicity in all six states is White, representing more than 83% of the population. The largest minority group is Hispanic individuals, who make up 14% of the population. Colorado has the largest Hispanic population at 21%, followed by Utah at 13.3%.

[5] U.S. Census Bureau. ACS demographic and housing estimates. *2012 American Community Survey 1-Year Estimates*. Accessed November 2014. http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

[6] Ibid.

[7] Native Hawaiians & Pacific Islanders, A Community of Contrasts, 2014. EPIC (Empowering Pacific Islander Communities) and Asian Americans Advancing Justice, 2014. Accessed November 2014. http://empoweredpi.org/wp-content/uploads/2014/06/A_Community_of_Contrasts_NHPI_US_2014-1.pdf

Table 1: Population by Race & Ethnicity								
	Total	White	Black or African American	American Indian Alaska Native	Asian	Native Hawaiian Other Pacific Islander	Some Other Race	Hispanic
Colorado	5,187,582	4,527,141	264,690	103,105	200,532	13,755	262,683	1,088,742
%	100%	87%	5%	2%	4%	0%	5%	21%
Montana	1,005,141	921,097	8,444	81,218	11,394	2,501	8,047	31,465
%	100%	92%	1%	8%	1%	0%	1%	3%
North Dakota	699,628	639,536	13,977	44,470	8,900	1,649	5,406	16,672
%	100%	91%	2%	6%	1%	0%	1%	2%
South Dakota	833,354	728,083	18,182	83,595	11,253	1,136	9,424	24,769
%	100%	87%	2%	10%	1%	0%	1%	3%
Utah	2,855,287	2,580,238	46,478	49,030	86,157	38,966	131,082	379,433
%	100%	90%	2%	2%	3%	1%	5%	13%
Wyoming	576,412	540,418	11,245	22,431	7,201	994	12,968	54,316
%	100%	94%	2%	4%	1%	0%	2%	9%
Total Region	11,157,404	9,936,513	363,016	383,849	325,437	59,001	429,610	1,595,397
%	100%	89%	3%	3%	3%	1%	4%	14%

While the U.S. population as a whole is only 1.2% American Indian (AI) or Alaskan Native (AN), several of the Mountain States have much higher percentages: South Dakota (8.5%), Montana (6.5%), and North Dakota (5.5%). More than 30 different federally recognized tribal entities are represented in this region (**Table 2**),[8] and the major cities of the region have a significant number of urban AIs living in nontribal settings. Finally, Asian and Black individuals each account for 3% of the regional population, and Native Hawaiians and other Pacific Islanders (NHPI) represent 1% of the population, the largest number of which reside in Utah.

[8] A list of tribes is at http://en.wikipedia.org/wiki/List_of_federally_recognized_tribes_by_state and updated with information from the following source: U.S. Department of the Interior, Bureau of Indian Affairs. (2014, January 29). Indian entities recognized and eligible to receive services from the U.S. Bureau of Indian Affairs. *Federal Register, 79*(19).

Table 2: Federally Recognized Tribes within the Area of Mountain States Region	
Federally Recognized Tribe	**State**
Arapahoe Tribe of the Wind River Reservation	WY
Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation	MT
Blackfeet Tribe of the Blackfeet Indian Reservation of Montana	MT
Cheyenne River Sioux Tribe of the Cheyenne River Reservation	SD
Chippewa-Cree Indians of the Rocky Boy's Reservation	MT
Confederated Salish & Kootenai Tribes of the Flathead Reservation	MT
Confederated Tribes of the Goshute Reservation	NV, UT
Crow Creek Sioux Tribe of the Crow Creek Reservation	SD
Crow Tribe of Montana	MT
Flandreau Santee Sioux Tribe of South Dakota	SD
Fort Belknap Indian Community of the Fort Belknap Reservation of Montana	MT
Lower Brule Sioux Tribe of the Lower Brule Reservation	SD
Navajo Nation	AZ, NM, UT
Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation	MT
Northwestern Band of Shoshoni Nation of Utah (Washakie)	UT
Oglala Sioux Tribe of the Pine Ridge Reservation	SD
Paiute Indian Tribe of Utah	UT
• Indian Peaks Band of Paiutes	UT
• Kanosh Band of Paiutes	UT
• Koosharem Band of Paiutes	UT
• Cedar City Band of Paiutes	UT
• Shivwits Band of Paiutes	UT
Rosebud Sioux Tribe of the Rosebud Indian Reservation	SD
Shoshone Tribe of the Wind River Reservation	WY
Sisseton-Wahpeton Oyate of the Lake Traverse Reservation	SD
Skull Valley Band of Goshute Indians of Utah	UT
Southern Ute Indian Tribe of the Southern Ute Reservation	CO
Spirit Lake Tribe	ND
Standing Rock Sioux Tribe of North & South Dakota	SD, ND
Three Affiliated Tribes of the Fort Berthold Reservation	ND
Turtle Mountain Band of Chippewa Indians of North Dakota	ND, MT, SD
Ute Indian Tribe of the Uintah & Ouray Reservation	UT
Yankton Sioux Tribe of South Dakota	SD
Ute Mountain Tribe of the Ute Mountain Reservation	CO, UT, NM

The percentage of foreign-born individuals now living in the region has increased at a rate far beyond the national average. For example, from 1990 to 2012, the percentage of foreign-born individuals increased by 245%, 2.3 times the national average of 107%.[9] From 1990 to 2012, the foreign-born population of Colorado increased by 256%, such that the percentage of foreign-born individuals reached 10% of the population. Utah

[9] Migration Policy Institute. State immigration data profiles. CO, MT, ND, SD, UT, WY. Accessed August 2014. http://www.migrationpolicy.org/programs/data-hub?qt-data_hub_tabs=0#datahub-tabs.

increased by 311%, reaching 8.3% foreign-born individuals in 2012 (**Table 3**).[10] The majority of these individuals are not U.S. citizens, and many lack access to health care insurance.

Table 3: Foreign Born Population in 2012 and Percent Increase since 2000								
	CO	MT	ND	SD	UT	WY	Region	US
Foreign Born in 2012	506,358	18,344	19,380	22,857	240,872	19,520	827,331	40,824,658
Percent of Total	9.8%	1.8%	2.8%	2.7%	8.4%	3.4%	7.4%	13.0%
Percent Change 1990-2000	159.7%	11.9%	29.0%	74.6%	170.8%	46.5%	142.4%	57.4%
Percent Change 2000-2012	36.9%	19.0%	60.0%	69.4%	51.8%	74.2%	42.5%	31.2%

Language

Access to health care is a challenge for individuals who do not speak English fluently, as health care providers are often unprepared to meet their linguistic needs. A breakdown of the primary languages spoken at home in each Mountain State is presented in **Table 4**.[11]

Table 4: Languages Spoken at Home in Mountain States Region										
State	English Only		Spanish		Other Indo-European Languages		Asian & Pacific Island Languages		Other Languages	
	#	%	#	%	#	%	#	%	#	%
Colorado	4,025,066	83%	578,348	12%	113,295	2%	90,520	2%	43,358	1%
Montana	906,009	96%	14,359	2%	12,933	1%	4,436	1%	8,563	1%
North Dakota	616,306	94%	10,320	2%	14,351	3%	4,411	1%	6,120	1%
South Dakota	725,611	94%	14,676	2%	12,478	2%	5,856	1%	16,050	2%
Utah	2,215,204	85%	259,525	10%	50,298	2%	55,158	2%	17,173	1%
Wyoming	497,464	92%	29,179	5%	5,972	1%	3,595	1%	2,186	0%
Total Region	8,985,660	87%	906,407	9%	209,327	2%	163,976	2%	93,450	1%

Driven in part by the increase in the number and percentage of foreign-born persons, particularly in Colorado and Utah, there is now a substantial amount of linguistic diversity in the region. In five of the six states, 5% or more of the population speaks a language other than English at home; in Utah and Colorado, the percentage

[10] Ibid.
[11] U.S. Census Bureau: American Fact Finder. Selected social characteristics in the United States. *2012 American Community Survey 1-Year Estimates.* Accessed November 2014. http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

exceeds 14%.[12] In Utah, Colorado, and Wyoming, Spanish is the language of a majority of the non-English speakers, but many other languages are also present from Eastern Europe, East and Southeast Asia, Africa, and Oceania. The Utah Office of Refugee Services counts 53 languages spoken by refugees in Utah.[13]

Regionally, among the people who speak a language other than English, more than 5% report speaking English "less than very well.[14]" More than 10% of individuals in Colorado and Utah speak Spanish; among these individuals, approximately half report speaking English "less than very well."

Disability

The 2012 ACS 1-year estimate reports that 12.2% of the total U.S. noninstitutionalized population lives with a disability. Approximately one in eight Americans (12.2%) live with disability and many face unique challenges to health and well-being. In the Mountain States Region, 10.2% of the total population lives with disability.[15] There is some variation in the disabled population rates within racial and ethnic minority populations (10.2% of the Hispanic population, 10.9% of the White and of the Black populations[WU1] [JFK2] , and 13.8% of the AI/AN population). Rural disabled populations (12.3% of the Mountain States Region nonmetropolitan county population) tend to be proportionately larger than urban comparison populations,

The Americans with Disabilities Act, the Individuals with Disabilities Education Act, the Fair Housing Act, and other state and federal legislation grant equal access to health services regardless of disability status. In addition, a range of services and supports exist in the Mountain States Region that are designed to promote the safety and well-being of persons with disabilities. These supports include state, tribal, and local early identification and intervention services; special education and 504 educational services;[16] vocational rehabilitation services; blind and low-vision services; assistive technology programs; mental health centers; area agencies on aging; aging and disability resource centers; centers for independent living; state assistive technology programs; long-term care services and supports (the Mountain States Region has 53 approved CMS 1915(c) waivers);[17] disability rights and protection programs; and advocacy initiatives. Still, populations with disabilities experience lower rates of preventive health care and employment and higher rates of abuse, neglect, chronic disease, infection, and injury.

Resources to sustain services and supports are stretched in the Mountain States Region by public programmatic access issues; shortages of qualified staff (personal care attendants; vocational rehabilitation counselors; special education teachers; adaptive physical education programs; certified sign language interpreters; disability rights lawyers; health care professionals, such as physicians and nurses with disability cultural competencies; and specialists like physiatrists, mental health professionals, and pediatric dentists); long distances and lack of accessible public transportation options; limited/or lack of rural infrastructure invested in institutional care; and limited funding, leading to lengthy waiting lists for home and community-based long-term services and supports.

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[12] U.S. Census Bureau: American Fact Finder. Selected social characteristics in the United States. *2012 American Community Survey 1-Year Estimates.* Accessed November 2014. http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

[13] Utah Department of Workforce Services, Refugee Services Office. Refugees 101: An overview of refugees and refugee resettlement. Accessed November 2014. https://jobs.utah.gov/refugee/volunteer/refugees101.pdf.

[14] U.S. Census Bureau: American Fact Finder. Selected social characteristics in the United States. *2012 American Community Survey 1-Year Estimates.* Accessed November 2014. http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

[15] U.S. Census Bureau. (2014, February 15). Table S2801. *American Community Survey 5-Year Estimates, 2008–2012.* Retrieved from http://factfinder2.census.gov.

[16] Individuals with Disabilities Education Act Section 504
Accessed December 2014. http://www.ada.gov/cguide.htm#anchor65310

[17] Centers for Medicare and Medicaid Services. CMS 19151915(c) Waivers by State. Accessed December 2014. http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-Roadmap/Resources/State-Federal-Relationships/1915c-Waivers-by-State.html

Components of the ACA[18] offer new approaches and resources for addressing these challenges. Additionally, the Department of Homeland Security has a dedicated staff member, the Region VIII Disability Integration Specialist, to support emergency management entities to adopt a whole-community approach to emergency management that organizes a range of community resources to better support the community's range of functional needs

Health and Health Care Disparities

While health care in the United States is considered to be among the best in the world, access to affordable, and preventive care is not consistent across social groups and between urban and rural settings. Many individuals and families in the Mountain States Region live in areas that have a shortage of physicians. They may not have health insurance; they may live in neighborhoods served by under-resourced hospitals; or they may receive a lower quality of care because of stereotyping, language barriers, or poor health literacy. These disparities further exacerbate disparities in health. It is hard to manage a chronic disease like asthma or diabetes when there is no doctor nearby or when a patient is without health insurance.

Sidebar box: Disparities among Native Hawaiians and Pacific Islanders[19]
Some of the most critical health and health care disparities that the Mountain States Region faces are in access to care, uninsured populations, suicide and mental health issues, automobile accident deaths, and chronic obstructive pulmonary disease.

Access to Services

Medically Underserved Areas (MUA): In the Mountain States Region, there are nearly 1,000 HHS-designated MUAs in the disciplines of mental health, dentistry, and primary care. Of the 11,335,332 citizens living in the Mountain States Region, roughly 1,648,796 live in MUAs.[20]

*Certain diseases dispropo*rtionately impact Native Hawaiians and Pacific Islanders, yet many lack access to affordable and culturally appropriate health care.

- Heart disease is the leading cause of death for NHPI.
- Cancer is the fastest-growing cause of death among many NHPI groups including Native Hawaiians, Samoan Americans, and Guamanian or Chamorro1 Americans.
- NHPI have higher rates of diabetes and obesity than average.
- The number of suicide deaths among NHPI individuals increased 170% between 2005 and 2010.Many NHPI experience barriers to care.
- Immigration status, language barriers, and cost are barriers to care for NHPI

[18] Money Follows the Person Demonstration Grants [CO, MT, ND, SD] and the Community First Choice Option [1915(k), Montana]); the 2013 reauthorization of the Rehabilitation Act, called the Workforce Innovation and Opportunity Act; and CDC Disability and Health Programs (Montana and North Dakota)
[19] Native Hawaiians & Pacific Islanders, A Community of Contrasts, 2014. EPIC (Empowering Pacific Islander Communities) and Asian Americans Advancing Justice, 2014. Accessed November 2014. http://empoweredpi.org/wp-content/uploads/2014/06/A_Community_of_Contrasts_NHPI_US_2014-1.pdf
[20] National Women's Law Center. *People in medically underserved areas.* Accessed November 2014. http://hrc.nwlc.org/status-indicators/people-medically-underserved-areas.

A large part of this challenge is due to the extensive rural makeup of these states. More than 40% of people in Montana, South Dakota, and North Dakota live in rural areas outside of small and large urban settings, compared to 19.3% in the United States overall. Accordingly, more than 20% of the population in each of these three states lives in MUAs, and these states are ranked at 45 and above out of the 50 states for the percentage of the population living in MUAs. The high number of MUAs stands out as an access issue for the region.

Physician Workforce Availability: There are 475 health provider shortage areas (HPSAs) in the Mountain States Region overall, with a 45% shortage of full-time health care providers in those areas (**Table 5**).[21]

Table 5. Health Provider Shortage Areas in the Mountain States Region

	Primary Care			Mental Health without Facilities			Dental		
State	**HPSAs**	**FTEs Short**	**% Short**	**HPSAs**	**FTEs Short**	**% Short**	**HPSAs**	**FTEs Short**	**% Short**
Colorado	108	134	42.8%	62	23	23.5%	83	86	56.5%
Montana	103	45	46.7%	69	21	74.5%	75	28	65.4%
North Dakota	77	34	63.2%	48	9	20.9%	34	7	53.6%
South Dakota	85	28	55.7%	48	22	84.8%	56	24	73.9%
Utah	56	61	33.2%	37	41	34.3%	51	62	40.2%
Wyoming	36	13	30.5%	16	6	26.1%	22	7	38.4%
Total Region	465	315	45.2%	280	122	38.8%	321	214	54.2%

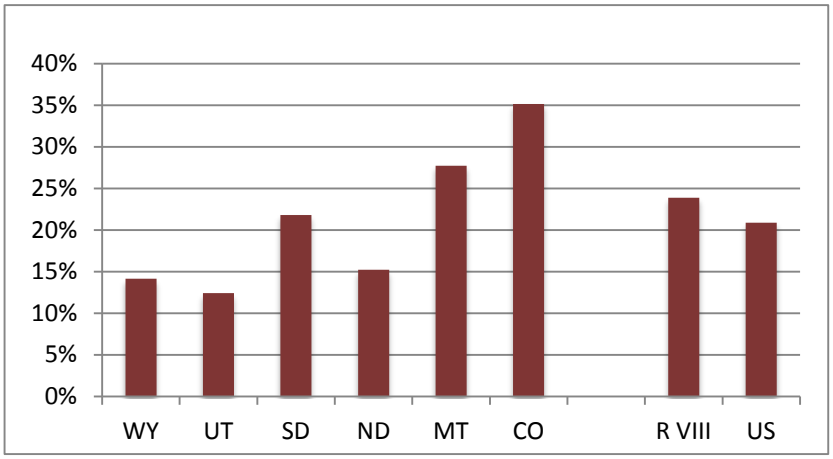
HPSAs in North Dakota and South Dakota have the highest shortages, being 61% and 55% short in full-time health care providers, respectively. Recruitment of health care providers to rural areas poses a challenge in the region.

Access to Community Health Centers: There are 64 community health centers serving low-income populations in the Mountain States Region, but the majority of these are quite small; and except in Colorado and Montana, they serve a relatively small proportion of the total at-need population (**Figure 2**).[22]

[21] Health Resources and Services Administration, Bureau of Clinician Recruitment and Services. (2014, August 7). *Designated health professional shortage areas statistics: Third quarter of fiscal year 2014 designated HPSA quarterly summary as of June 30, 2014.* HRSA Data Warehouse 1 of 14.

[22] Data from UDS Mapper, a HRSA-funded project directed by the Robert Graham Center, developed by John Snow, Inc., at http://www.udsmapper.org/

Figure 2. Percentage of Low Income Population Served by Health Centers



Insurance: In the Mountain States Region in 2012, around 14% of the civilian noninstitutionalized population was uninsured, accounting for about 1.6 million uninsured individuals.

- **Insurance and poverty**: This percentage is higher for individuals below the FPL. In Montana, South Dakota, Utah, and Wyoming, more than 50% of nonelderly adults (under age 65) below 135% of the FPL are uninsured, and more than 80% of those below 100% of the FPL are uninsured.[23]

- **Insurance and minority status**: This percentage is also higher for minorities. Based on data from the region, compared to Whites, Hispanics are up to three times as likely and Blacks are twice as likely to be uninsured. It is important to note that the Indian Health Service is not considered insurance coverage. AI/ANs are even less likely to have insurance coverage, with the following states having the following percentages of uninsured: Colorado, 22.9%; Montana, 40.5%; North Dakota, 31.5%; South Dakota, 31%; Utah, 31.6%; and Wyoming, 42.4%.[24]

- **Impacts of nonexpansion of Medicaid**: Montana, South Dakota, Utah, and Wyoming are currently not planning to expand Medicaid. The Kaiser Family Foundation (**Table 6**)[25] estimates that 140,860 people who could have received health insurance through Medicaid will be denied health care insurance. They predict that nonexpansion of Medicaid will result in a number of adverse consequences:

- 12,888 people with depression will not be identified and treated
- 7,649 persons needing diabetic medications will not receive medication.
- 2,917 women will not get screening mammograms.
- 7,558 women will not receive cervical cancer screenings.

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[23] Garfield ,K. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. Kaiser Family Foundation. Accessed March 2014. http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

[24] Kauffman & Associates, Inc. (2011, May 20). *Health care reform: Tracking tribal, federal, and state implementation.* Retrieved from http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSHealthCareReform5202011.pdf.

[25] Garfield ,K. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. Kaiser Family Foundation. Accessed March 2014. http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

- 4,141 individuals will experience catastrophic medical expenses (more than 30% of their family income).
- 129–362 persons will die.[26]

Table 6: Coverage Gap Population by State[27]					
State	**Total Uninsured Nonelderly Adults**	**All <138% FPL Uninsured**	**Exchange Eligible (100-138% FPL)**	**Mandatory Medicaid Eligible (0-100% FPL)**	**# in Coverage Gap**
Montana	148,667	71,679	31,539	7,646	40,140
South Dakota	87,862	45,500	20,020	4,496	25,480
Utah	275,476	105,182	47,332	7,889	57,850
Wyoming	75,609	29,475	12,085	1,932	17,390
Total Region	587,614	251,835	110,975	21,963	140,860

Death Rates by Principal Cause

The Mountain States Region experiences approximately the same all-cause age-adjusted death rate as the U.S. as a whole, with marginally lower rates from heart disease and cancer. Infant mortality is generally at the U.S. average in the region; although, there are pockets of concern about perinatal deaths among AI populations and Pacific Islanders in Utah. Rates of death from all accidents, motor-vehicle accidents, and suicide stand out as particularly high (**Table 7**).[28]

Table 7: Region VIII Cause-of-Death Rates vs U.S. Rates for Selected Causes								
	All Cause (2010)	**Infant Mortality (2010)**	**Heart Disease & Stroke (2010)**	**Cancer (2010)**	**Diabetes (2010)**	**Accidents (2010)**	**Suicide (2010)**	**Motor Vehicle (2011)**
National	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Colorado	0.9	1.0	0.8	0.9	0.7	1.1	1.4	0.8

[26] Data from the following sources: **(1)** Dickman, S., Himmelstein, D., McCormick, D., & Woolhandler, S. (2014, January 30). Opting out of Medicaid expansion: The health and financial impacts. *Health Affairs blog.* Accessed March 2014. http://healthaffairs.org/blog/2014/01/30/opting-out-of-medicaid-expansion-the-health-and-financial-impacts/
(2) Substance and Mental Health Services Administration. Enrollment under the Medicaid expansion and health insurance exchanges. Accessed November 2014. http://store.samhsa.gov/shin/content//PEP13-BHPREV-ACA/NSDUH_state_profile_Colorado_508_final_exam.pdf.
[27] Garfield ,K. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. Kaiser Family Foundation. Accessed March 2014. http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.
[28] Data from the following sources: **(1)** Centers for Disease Control and Prevention. *Sortable risk factors and health indicators.* Accessed August 2014. http://wwwn.cdc.gov/SortableStats/. **(2)** Murphy, S. L., Xu, J., & Kochanek, K. D. (2013, May 8). Deaths: Final data for 2010. *National Vital Statistics Reports, 61*(4). Light green fill indicates regional outcomes at least 15% better than the U.S. average; red indicates at least 15% worse.

Table 7: Region VIII Cause-of-Death Rates vs U.S. Rates for Selected Causes								
	All Cause (2010)	Infant Mortality (2010)	Heart Disease & Stroke (2010)	Cancer (2010)	Diabetes (2010)	Accidents (2010)	Suicide (2010)	Motor Vehicle (2011)
Montana	1.0	1.0	0.9	1.1	0.9	1.4	1.8	2.0
North Dakota	0.9	1.1	0.9	1.1	1.1	1.0	1.3	2.1
South Dakota	1.0	1.1	0.9	1.2	1.2	1.2	1.4	1.3
Utah	0.9	0.8	0.8	0.8	1.1	1.1	1.5	0.8
Wyoming	1.0	1.1	0.9	1.0	0.9	1.6	1.8	2.3
>15% Better than U.S. Avg.			Within +/- 15% of U.S. Avg.			>15% Worse than U.S. Avg.		

Suicide: According to CDC, suicide was the 10th leading cause of death for all ages in 2010. The death rate due to suicide was higher than the national average in all of the Mountain States Region and overall was 17.9/100,000, compared to the national rate of 12.2/100,000. The highest rates were in Montana and Wyoming (about 22/100,000 in both), but all states in the region were above 15/100,000.

- **Suicide in AI populations**: The number of deaths was disproportionately high among AI populations with 28.4/ 100,000 in Montana and 32.5/100,000 in South Dakota. See **Table 8** for suicide rates among the AI population as compared to the U.S. Average.[29][30]

Table 8: Suicide Rates in Region VIII States by Race & Ethnicity and U.S. Averages						
Region/State	All Races	White (Non-Hispanic)	Black (Non-Hispanic)	American Indian	Asian or Pacific Islander	Hispanic
US	12.2	15.0	5.7	17.0	6.3	6.0
Colorado	16.9	18.8	11.3	φ	φ	11.8
Montana	22.1	20.1	φ	28.4	φ	φ
North Dakota	15.6	15.0	φ	φ	φ	φ
South Dakota	17.5	15.5	φ	32.5	φ	φ
Utah	18.5	20.2	φ	φ	φ	9.8
Wyoming	22.4	23.3	φ	φ	φ	φ
φ Sample size too small to report						

[29] Data from the following sources: **(1)** Centers for Disease Control and Prevention. *Sortable risk factors and health indicators.* Accessed August 2014. http://wwwn.cdc.gov/SortableStats/. **(2)** Murphy, S. L., Xu, J., & Kochanek, K. D. (2013, May 8). Deaths: Final data for 2010. *National Vital Statistics Reports, 61*(4). Light green fill indicates regional outcomes at least 15% better than the U.S. average; red indicates at least 15% worse.

[30] Centers for Disease Control, Winnable Battle Risk Factors and Health Indicators - Suicide Death Rate by States. Accessed May 7, 2014. http://www.cdc.gov/nchs/deaths.htm

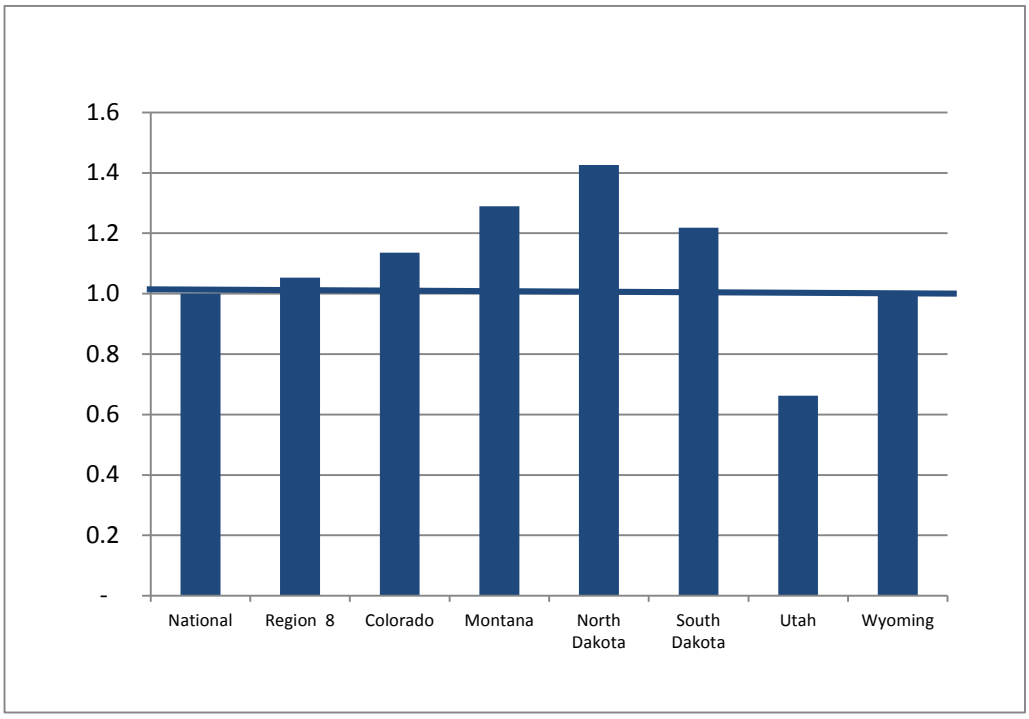
Automobile Accident Deaths: According to CDC, motor vehicle-related injuries are a leading cause of death for people in the United States. In 2011, the motor vehicle death rate in Montana, North Dakota, and Wyoming was more than 20/100,000 people, compared to the national average of 10.4/100,000 people.

The top four states with the highest motor vehicle-related death rates among AI/ANs aged 1–44 years were from the Mountain States Region, ranging from 66 to 82 deaths per 100,000. [19]

- **Seatbelt use:** These findings may be connected to lower rates of observed seat belt use in adults, which ranged from 77% to 80.90% in these states, compared to the national average of 86%; and in youths, which ranged from 84.2% to 88.8%, compared to the national average of 92.3%.[31]

- **Binge drinking:** Binge drinking, a possible indicator of alcohol use disorder, was higher in the region. This finding may be connected to higher rates of automobile accident deaths in the region. While the national average is 16.9%, the percentage is more than 20% in Montana, North Dakota, and South Dakota. Also, while the national average for youth binge drinking is 21.9%, it is more than 25% in Montana, Wyoming, South Dakota, and North Dakota. Furthermore, AI/ANs are six times more likely to die from alcohol-related causes than the national average.[32] See **Figure 3** for a ratio of adult binge drinking rates in the Mountain States Region compared to the national average.[33]

Figure 3: Adult Binge Drinking as a Percentage of the U.S. Average

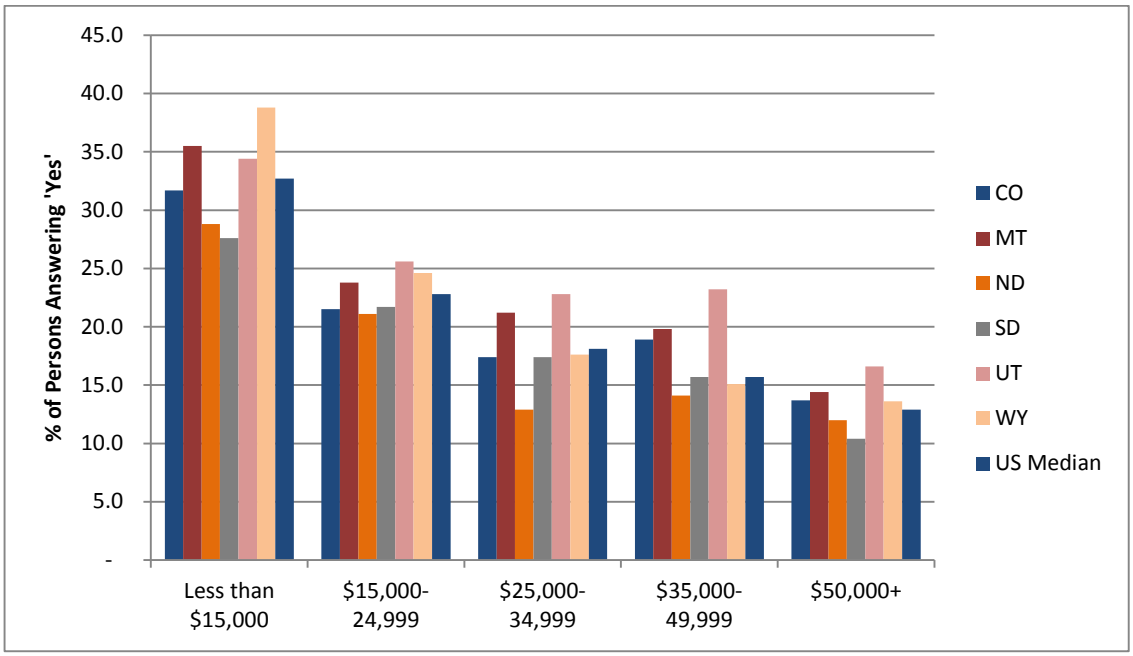


[31] Centers for Disease Control and Prevention. *Native American road safety.* Accessed November 2014. http://www.cdc.gov/features/tribalprograms.
[32] Indian Health Service, HHS. *IHS Fact Sheets: Indian Health Disparities.* Accessed December 2014. http://info.ihs.gov/Disparities.asp
[33] Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System: Prevalence and trends data: Alcohol consumption—2010.* Accessed November 2014. http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=AC&yr=2010&qkey=7307&state=All.

Other Conditions and Risk Factors

Depression: Approximately 18% of the United States population has, at some point in time, been told that they have a form of depression. In Montana and Utah, the percentage is at 20% and above. The percentage is nearly twice as high for individuals with incomes below $15,000 (**Figure 4**).[34]

Figure 4: Percent of Population 'Ever Told They Were Depressed' by Income for Mountain States Region & U.S. Averages

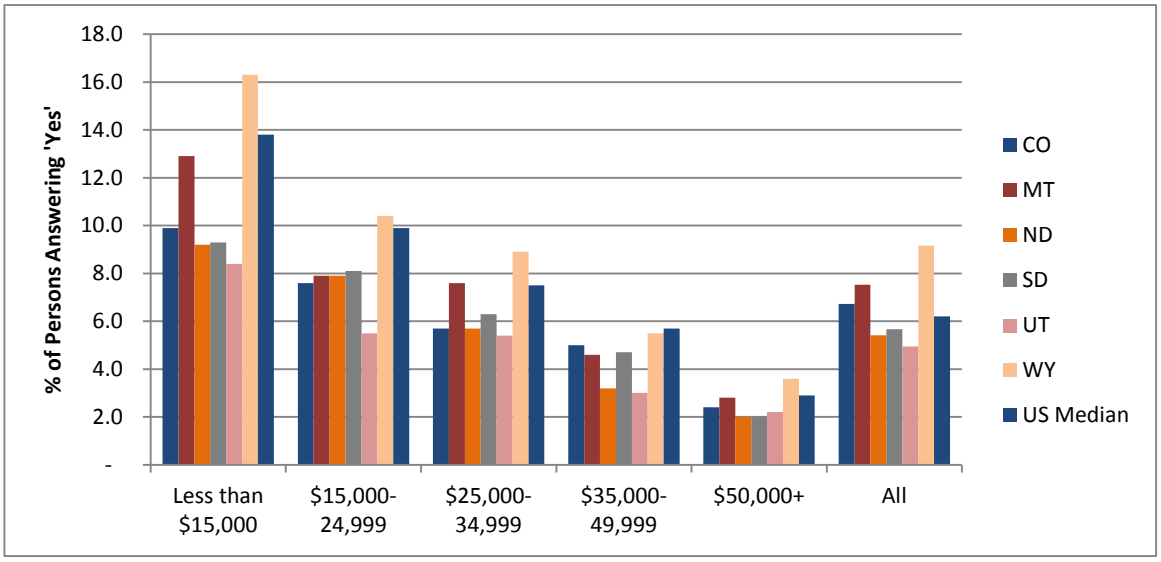


Chronic Obstructive Pulmonary Disease (COPD): According to CDC, COPD, a set of conditions including emphysema and chronic bronchitis, can limit air flow and cause breathing difficulties. COPD is the third leading cause of death in the United States. It is caused by tobacco use, air pollutants at home or work, or genetics.

- A number of the Mountain States have higher percentages of people who reported being told they have COPD than the national average (6.2%), such as Colorado with an estimated 6.7%, Montana 7.53%, and Wyoming 9.16% (**Figure 5**).[35]
- Throughout the region, except for Utah, lower income is associated with COPD, such that for individuals with incomes less than $15,000, rates of COPD range from 9% to more than 16%.
- The age-standardized death rate from COPD is also high in Montana and Wyoming (48.5 and 66.3 people per 100,000, respectively), which puts them among the states with the highest death rates from COPD in the United States.[36]

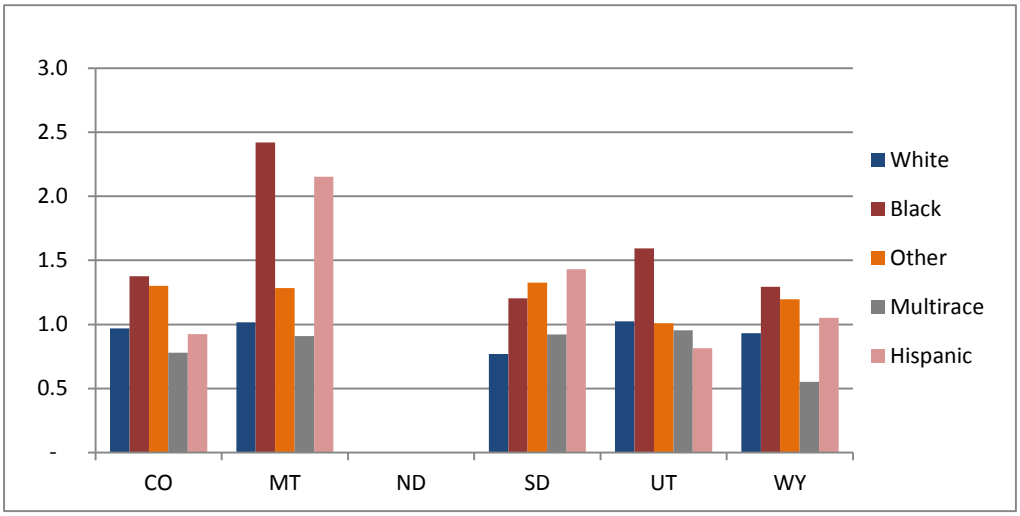
[34] Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. *Behavioral Risk Factor Surveillance System: Prevalence and trends data: Nationwide (states and DC)—2012 chronic health indicators.* Accessed August 2014. http://apps.nccd.cdc.gov/brfss/display.asp?cat=CH&yr=2012&qkey=8441&state=UB.
[35] Ibid.
[36] Centers for Disease Control and Prevention. (2014, May 1). *Chronic obstructive pulmonary disease (COPD): Data and statistics.* Accessed November 2014. http://www.cdc.gov/copd/data.htm.

Figure 5: Percent of Population 'Ever Told They Had COPD' by Income for Mountain States Region & U.S. Averages



Asthma: Asthma is a chronic lung disease that inflames and narrows airways. According to CDC, the rates of asthma are around the national average (13.2%) in the Mountain States Region. However, this varies greatly depending on race/ethnicity, with minorities disproportionately experiencing higher rates of asthma. For instance, in Montana, 13.2% of Whites have asthma compared to 38% of Blacks. While rates for most groups in the Mountain States Region approximate U.S. averages, the rate for Blacks is noticeably higher, especially in Montana, Colorado, and Utah.

Figure 6: Percent of Population with Asthma by Race & Ethnicity for Mountain States Region as a Ratio of U.S. Averages[37]



[37] Although Figure 6 does not include aggregate data for the percent of population in North Dakota with Asthma as a ratio of U.S. averages, CDC data shows that the adult self-reported lifetime Asthma prevalence rate is 1.8 for Black Non-Hispanic, 7.1 for Hispanic, 10.2 for White Non-Hispanic, 15.3 for Other Non-Hispanic, and 25 for Multi-race Non-Hispanic.

Asthma is also linked with obesity, as obesity is associated significantly with the development of asthma, worsening asthma symptoms, and poor asthma control. For instance, in Wyoming, 36.4% of people with asthma are also obese, compared to 24.6% of individuals who are obese but do not have asthma.

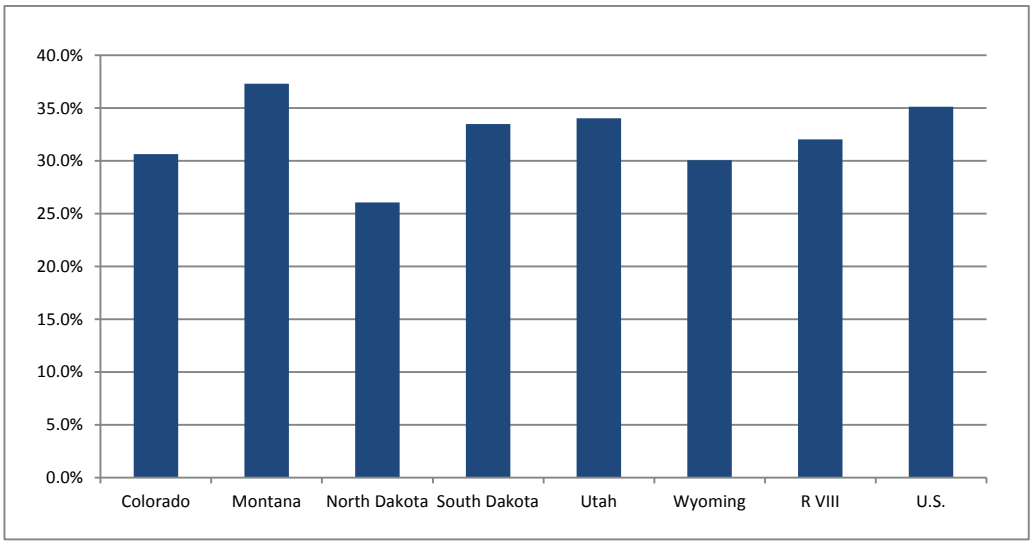
Obesity: Obesity is an important medical condition, as it increases one's risk of a multitude of health problems such as heart disease, diabetes, and high blood pressure. Obesity is on the rise across the nation, and currently more than one-third of U.S. adults are obese.[38] Obesity disproportionately affects minorities, with Blacks having the highest rate (47.8%). Within the Mountain States Region, South Dakota has the highest percentage of obese individuals (28.3%), followed by Wyoming (27.8%), according to a 2013 Gallup Poll. Additionally, for Wyoming, South Dakota, and North Dakota, more than 10% of high school students in each state are obese. . However, the region also boasts the two states with the lowest obesity rates: Montana with 19.4% and Colorado with 20.4%.

Social Determinants of Health

Income and Poverty: Socioeconomic status plays a significant role in health outcomes, especially as it relates to access to health insurance and health care, quality of health services, prevalence of risk factors, the opportunity for a healthy lifestyle, health literacy, and an independent likelihood of poorer health outcomes.

The population experiences significant levels of poverty. The 2013 ACS estimates that 32% of families and individuals in the region live below 200% of the Federal Poverty Level (FPL, **Figure 7**).[39] Of these, almost half have incomes below 100% FPL. This is particularly significant in Montana, South Dakota, Utah, and Wyoming, states that are currently not planning to expand Medicaid.

Figure 7: Percent of Population below 200% of Federal Poverty Level

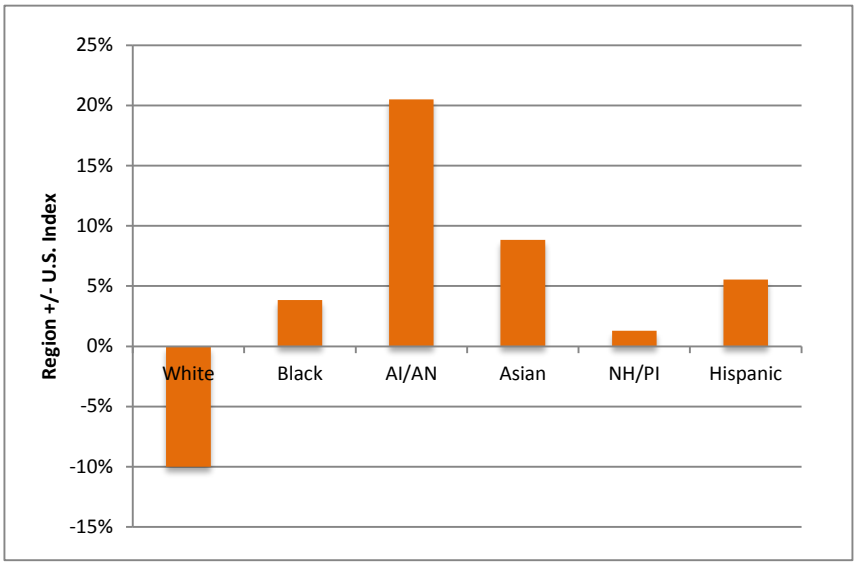


[38] Data from the following sources: **(1)** Ogden, C. L., Carroll, M. D., Kit, K. B., & Flegal, K. M. (2014, February 26). Prevalence of childhood and adult obesity in the United States, 2011–2012. *JAMA, 311*(8), 806–814. Accessed November 2014. http://jama.jamanetwork.com/article.aspx?articleid=1832542. **(2)** Centers for Disease Control and Prevention. (2014, June 12). *Adolescent and school health: Obese youth over time.* Accessed November 2014. http://www.cdc.gov/healthyyouth/obesity/obesity-youth-txt.htm.

[39] U.S. Census Bureau. Poverty status in the past 12 months. *2010 ACS 1-Year Estimates.* Accessed November 2014. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.

Existing data indicates poverty is greater for minorities throughout the Mountain States Region. Blacks, Native Americans, and Pacific Islanders experience poverty rates that are 50–400% greater than that of White populations (**Figure 8**).[40]

Figure 8: Regional Poverty Rates in Comparison to U.S. Averages, by Race and Ethnicity



Although medical care is essential for relieving suffering and curing illness, a person's health and likelihood of becoming sick and dying prematurely are greatly influenced by social factors (social determinants of health) such as education, income, quality of neighborhood environments, air quality, transportation, jobs, and food security. Key determinants of health in Mountain States include the following:

Education: Education has profound health effects. Nationally, those with a high school diploma are four times more likely to live past age 65.[41] A higher percentage of individuals who did not complete high school report being in "fair or poor health" and/or report that they lack health care coverage than those who graduated from high school or college.[42] On a national level, 31% of adults with less than a high school diploma had no visits to a doctor or any other health professionals in the past year, compared to 13% of adults with at least a bachelor's degree.[43]

On average, 80% of public high school students in the U.S. graduated in 2011-12. However, graduation rates in the U.S. differ by ethnicity. The percentages of AI/AN, Hispanic, and Black students in the U.S. who graduate are lower than the U.S. average, whereas Asian/Pacific Islander and White students have graduation rates higher than the U.S. average (**Table 9**).[44]

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[40] U.S. Census Bureau: American Fact Finder. Poverty Status in the Past 12 Mos, 2011 ACS 1-Yr Estimates, Accessed November 2014. http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

[41] Federal Interagency Forum on Aging-Related Statistics. Table: Population age 65 and over and age 85 and over, selected years 1900-2010 and projected 2020-2050. Accessed November 2014. http://www.agingstats.gov/Main_Site/Data/2012_Documents/Population.aspx

[42] S. Census Bureau. American Fact Finder. Educational Attainment. Accessed November 2014. http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

[43] Behavioral Risk Factor Surveillance System, Office of Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention, 2012 Data. Accessed July 2014. http://apps.nccd.cdc.gov/brfss/page.asp?cat=OH&yr=2012&state=All#OH

[44] Public high school 4-year adjusted cohort graduation rate (ACGR), by race/ethnicity and selected demographics for the United States, the 50 states, the District of Columbia, and other jurisdictions: School year 2011–12. Accessed December 2014. http://nces.ed.gov/pubs2014/2014391.pdf

The Mountain States demonstrate similar disparities in graduation rates by ethnicity. All states within this region have graduation rates lower than the U.S. average for American Indian/Alaska Native, Hispanic, and Black students. South Dakota and Wyoming have the lowest adjusted cohort graduation rates for AI/AN students in the region at 47% and 50% respectively.[45] These states represent two of the lowest graduation rates in the U.S. In addition, Hispanic and Black students in the region have lower graduation rates than the national and state averages. Most of the Mountain States report graduation rates at or above the U.S. average for Asian/Pacific Islander and White students.

Table 9: Public High School 4-year Adjusted Cohort Graduation Rate by Race/Ethnicity and State, 2011-2012

	Total	American Indian/Alaska Native	Hispanic	Black	Asian/Pacific Islander	White
U.S.	80	67	73	69	88	86
Colorado	75	58	62	66	82	82
Montana	84	63	79	79	92	87
North Dakota	87	63	73	76	86	90
South Dakota	83	47	67	67	84	89
Utah	80	64	66	64	78	83
Wyoming	79	50	67	66	86	82

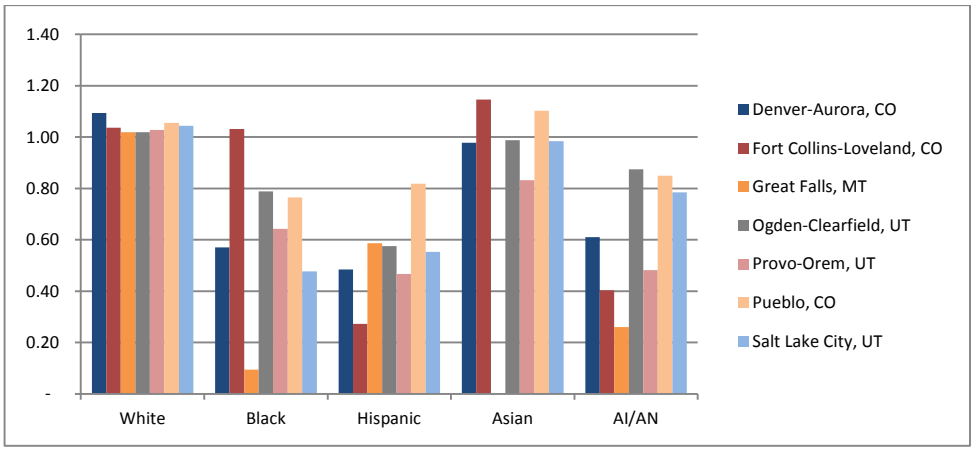
- **Housing:** Lack of housing affordability, quality, and stability can contribute to poor health. Low-income individuals and families are often relegated to neighborhoods with substandard and unsafe housing, overcrowding, high poverty rates, and limited opportunities for healthy lifestyles. Low-income and racial/ethnic-minority communities are often located in areas with high levels of air pollution, which is associated with triggers for asthma attacks, heart disease, and lung cancer.

  Affordability: About 60% of rental housing in the region has renters spending more than 25% of their gross household income on rent. Overall, racial/ethnic minorities are less able to afford housing ownership in major urban areas in the region. The housing opportunity index overall is lower for Black and Hispanic individuals in the region (**Figure 9**).[46]

[45] Public high school 4-year adjusted cohort graduation rate (ACGR), by race/ethnicity and selected demographics for the United States, the 50 states, the District of Columbia, and other jurisdictions: School year 2011–12. Accessed December 2014. http://nces.ed.gov/pubs2014/2014391.pdf

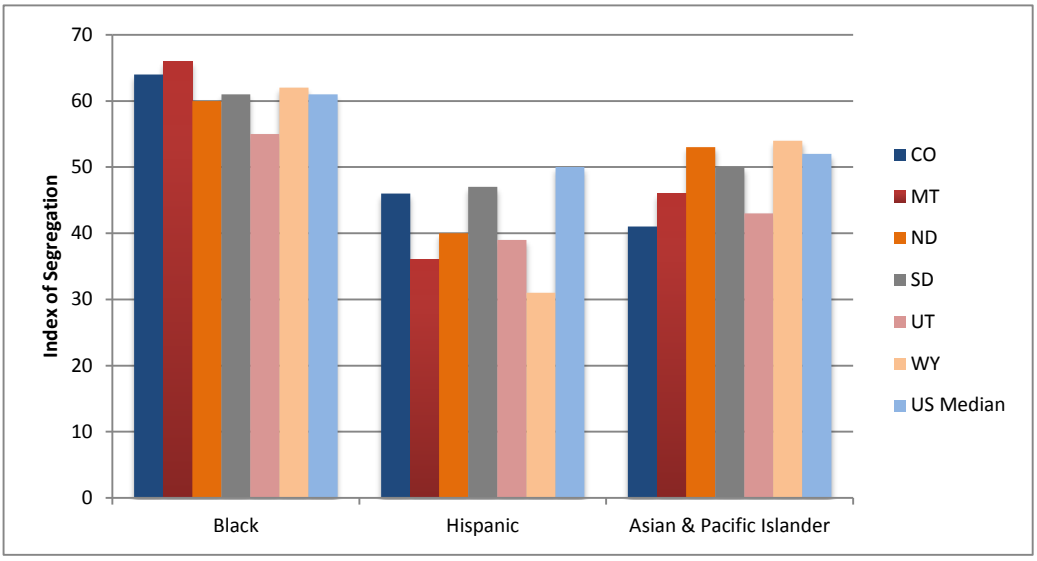
[46] Quint, R. (2011, May 3). Housing opportunity index by race/ethnicity in 2010. Special Studies. Accessed November 2014. http://www.nahb.org/generic.aspx?sectionID=734&genericContentID=157443&channelID=311.

Figure 9: Housing Opportunity Index for Selected Regional Metro Areas by Race & Ethnicity



- **Residential Segregation:** Segregation by race/ethnicity contributes to health disparities by limiting access to quality schools, employment, neighborhoods, and housing. Significant segregation exists in the region for Blacks: Montana ranks 14th; Colorado ranks 16th; and Wyoming, South Dakota, and North Dakota all rank in the 20s with respect to other U.S. states (**Figure 10**).[47] In these states, more than 60% of Blacks would have to move for an equal distribution of Whites and Blacks. Significant segregation also exists in the region between Whites and Asians such that Wyoming ranks 15th and North Dakota ranks 22nd, both with segregation indices of more than 50.[48]

Figure 10: Index of Segregation by Race for Mountain States & U.S. Medians



[47] University of Michigan, Population Studies Center. *New racial segregation measures for states and large metropolitan areas: Analysis of the 2005–2009 American Community Survey.* Accessed August 2014. http://www.psc.isr.umich.edu/dis/census/segregation.html.
[48] Segregation index scores can range in value from 0, indicating complete integration, to 100, indicating complete segregation.

Air quality: Poor air quality affects health by causing people to experience lung and throat irritation, breathing problems, and aggravating existing diseases such as asthma, bronchitis, emphysema, and lung cancer.

- According to the Environmental Protection Agency, 67 counties in Utah had more than 15 days of unhealthy air days during 2013, with 6 counties having more than 30 unhealthy air days, as well as 1 county each in Colorado, Montana, and North Dakota having more than 15 unhealthy air days during 2013.[49]

- The American Lung Association ranks a number of cities in the Mountain States Region as being some of the most polluted in the United States:[50] **Fort Collins, Colorado,** rated #22 in terms of ozone pollution; **Salt Lake City-Provo-Orem, Utah,** rated #8 in terms of short-term particle pollution; and **Missoula, Montana,** rated #12 in terms of short-term particle pollution.

Food Security: Household food security is the ensured access of all people to enough food for an active healthy life. Households do not have food security if they have uncertain or limited access to food through normal channels. Food security is linked to health outcomes. For instance, people who lack consistent access to nutritious food may be more likely to have unbalanced diets and skip meals. Also, children who live in food-insecure homes are susceptible to stunted grown, cognitive disabilities, and iodine and iron deficiencies.

- More than 700,000 low-income individuals in the Mountain States Region experience limited access to grocery stores in the region. Twenty-four percent of low-income individuals in the Mountain States Region have limited access to grocery stores, and this figure is much higher in the predominantly rural states such as North Dakota, South Dakota, and Wyoming (**Table 10**).[51] In the region as a whole, the majority of food deserts are in rural counties (food deserts in the image below are represented in green).

Table 10: Low-Income Populations with Limited Access to Grocery Stores, 2010

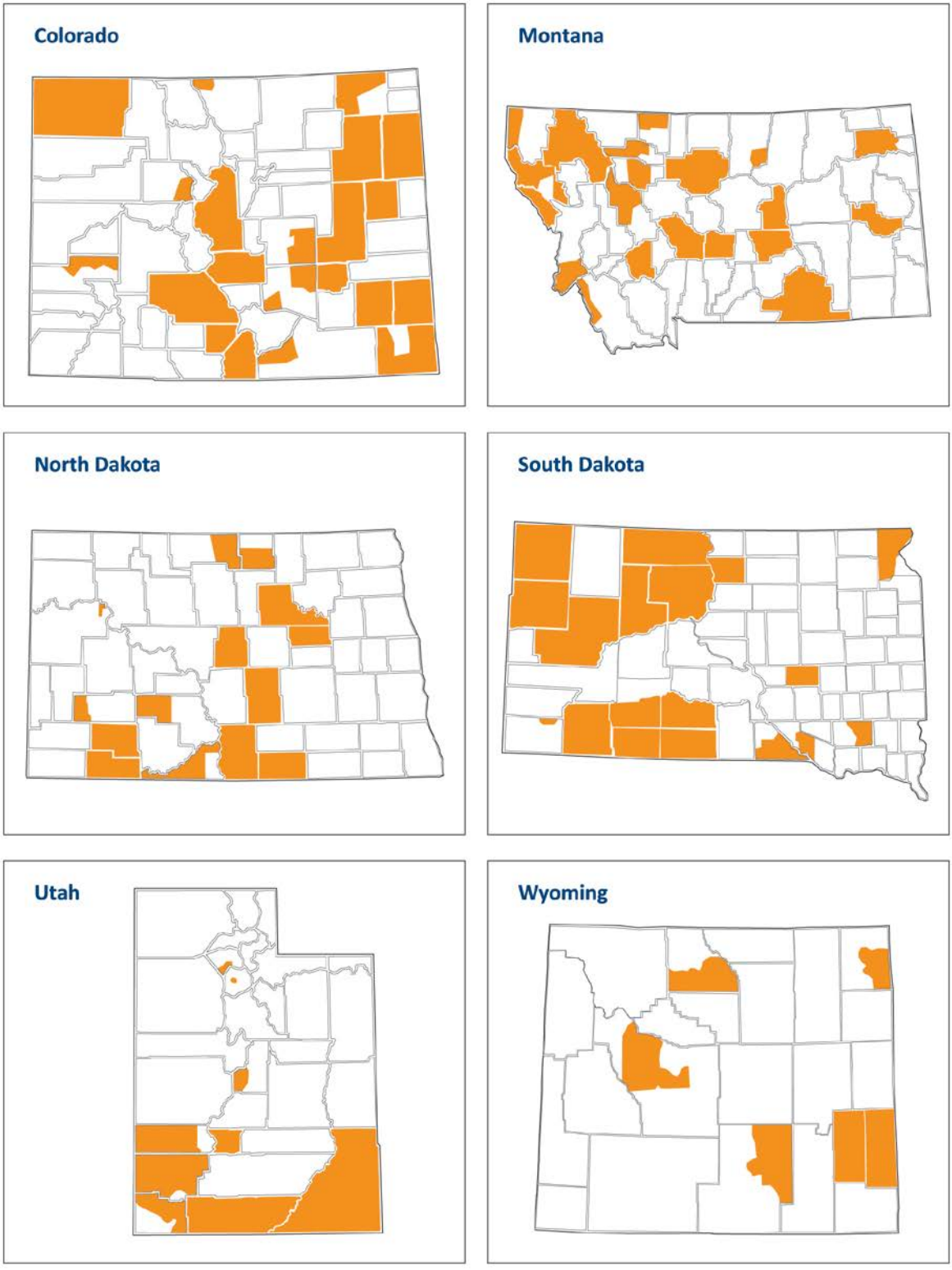
State	Total	% of Low All Low-Income
Colorado	291,590	21%
Montana	88,725	29%
North Dakota	60,360	42%
South Dakota	86,910	39%
Utah	144,691	18%
Wyoming	42,757	38%
Region Total	715,032	24%

[49] Environmental Protection Agency: Air Now State Summaries Number of Unhealthy Days in 2013. Accessed July 2014. http://www.epa.gov/cgi-bin/broker?condition=lung&citycounty=state&geocode=30+38+46&statecode=30+38+46&_debug=2&_service=aircomp&_program=dataprog.wcj_bycompare_state.sas&submit=Compare+My+Air

[50] State of the Air 2014 American Lung Association: Most Polluted Cities. Accessed July 2014. http://www.stateoftheair.org/2014/city-rankings/most-polluted-cities.html.

[51] U.S. Department of Agriculture, Economic Research Service. *Food access research atlas.* Accessed May 2014. http://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx.

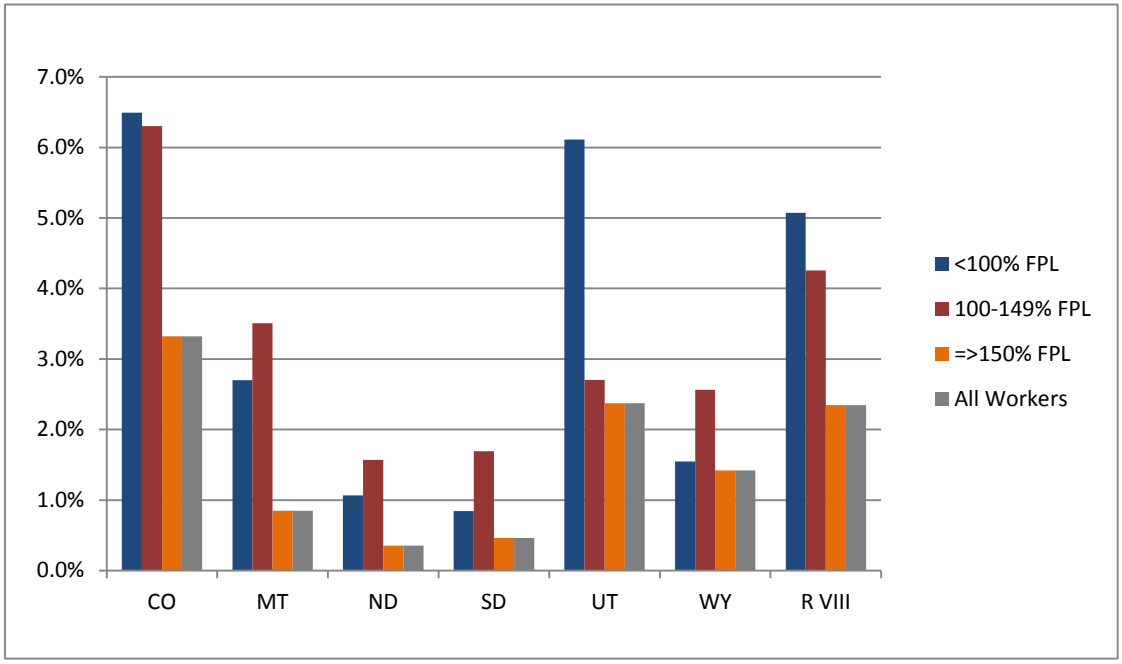
Figure 11: Highlighted Counties with Limited Access to Grocery Stores ("Food Deserts") in Mountain States Region



Transportation: Lack of affordable, reliable transportation in both urban and rural areas affects access to healthy foods, health care services, educational opportunities, physical activity levels, and employment. Transportation is also a public health issue in relation to public safety, air pollution, land use, equity, and accessibility.

- In the Mountain States Region, transportation in the rural areas to health care settings and work takes a different form from that of major metropolitan areas (e.g., New York, San Francisco, Los Angeles). Citizens living in these areas may not have access to public transportation and may have long drives in order to get to health care settings and work.
- Transportation in the region correlates with income levels. The 2009 American Community Survey revealed that as earnings decrease, the use of public transportation increases. While 2.3% of individuals in the region overall use public transportation, 5.1% below 100% of the FPL use public transportation for work (**Figure 12**).[52] States that are more rural have lower usage of public transportation even for individuals in poverty, perhaps due to lack of access to public transportation.

Figure 12: Reliance on Public Transportation for Work in Mountain States Region



Jobs: Work can influence health in a number of ways. Employee benefits such as health insurance, wellness problems, and paid time off can improve access to health care and health outcomes. Low-income populations are less likely to have employment-based benefits that support good health. Work-related injury and illness contribute to poor health and are experienced more often by low-income populations, racial/ethnic minorities, and other underserved groups.

[52] U.S. Census Bureau: American Fact Finder. Means of transportation to work by selected characteristics for workplace geography. 2007–2009 American Community Survey 1-Year Estimates. Accessed August 2014. http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

Unemployment: While the overall unemployment rate in the Mountain States Region is lower than the national average (**Table 11**),[53] unemployment rates within racial/ethnic groups vary dramatically. AI/ANs are less likely to be employed than Whites in nearly every state,[54] especially in the Mountain States Region, Unemployment rates for tribally serviced individuals (center column, **Table 12**)[55] exceed the state averages shown in Table 11 by factors of two to eight. Moreover, the Board of Immigration Appeals estimates that slightly less than one-third of this population is not seeking work (column 3, **Table 12**). Hispanic individuals also experience higher rates of unemployment, according to data by the Economic Policy Institute (2013). For instance, the unemployment rate is 12.5% for Hispanics, compared to 7.7% for Whites, in Colorado. There was no data provided on Black and Asian individuals' unemployment rates.

Table 11: Unemployment Rates and Rank among All States for Region VIII States, June 2014 Report

	CO	MT	ND	SD	UT	WY
Unemployment Rate	5.5	4.5	2.7	3.8	3.5	4.0
US Rank	19	10	1	5	2	6

Table 12: Tribal Service Populations 16 and Older by Work & Availability for Work Status

State	Estimated Percent of Tribal Service Populations, Ages 16 and Over, Who are Working in Civilian Jobs	Estimated Percent of the Population 16 and Older Available for Work but not Working	Estimated Percent of the Population 16 and Older Not Available for Work
Colorado	51.1	16.2	32.7
Montana	47.8	19.5	32.7
North Dakota	45.3	21.9	32.8
South Dakota	40.2	27.1	32.7
Utah	41.5	25.8	32.7
Wyoming	58.6	8.6	32.8

[53] U.S. Department of Labor, Bureau of Labor Statistics. (2014, October 21). Local area unemployment statistics. Accessed May 2014. http://www.bls.gov/web/laus/laumstrk.htm.
[54] Austin, A. (2013, October 29). Native Americans are still waiting for an economic recovery. Accessed November 2014. http://www.epi.org/publication/native-americans-are-still-waiting-for-an-economic-recovery/.
[55] U.S. Department of the Interior, Office of the Assistant Secretary – Indian Affairs. (2014, January 16). *2013 American Indian population and labor force report,* pp. 33–34

Mountain States RHEC: Structure, Priorities, and Next Steps

Vision, Mission, and Priorities

Data on health disparities and the social determinants of health presented in this Blueprint will inform the vision, mission, and priorities of the Mountain States Regional Health Equity Council (RHEC). The RHEC's history, membership, structure, and initial work are cornerstones that the RHEC will build upon as they are developing these strategies.

Mountain States RHEC's vision: A region free of disparities in health and health care.

Mountain States RHEC's mission statement: To address the determinants of health and achieve health equity for all in the Mountain States Region through the development and coordination of new and existing partnerships, leaders, and stakeholders.

Mountain States RHEC's priorities:

- Increasing and improving access to care while addressing health disparities
- Providing education and awareness of cultural and linguistic competency within the region
- Increasing education on and awareness of the ACA within the region

Mountain States RHEC Priorities, 2014–2015	
NPA Goals	**Priorities**
Awareness	• Support sharing of information among community stakeholders to address health disparities and enable health equity via social media, namely Facebook
Leadership	• Share information on health disparities amongst underserved populations and ACA education with "young invincibles" through social media outlets (yNPA) o Have emerging scholars use Twitter and Facebook for a more robust social media presence o Have emerging scholars promote ACA education and enrollment events o Recruit youth as members to the council or as an ad hoc workgroup
Health System and Life Experience	• Identify social and economic determinants of health in region via the Blueprint • Identify ACA information to be shared via a webinar o Partner with Connect Health Colorado to assist in coordination of webinar for sharing ACA enrollment and education best practices
Cultural and Linguistic Competency	• Share information related to the enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards with provider communities in the region o Facilitate an enhanced CLAS Standards webinar to include monitoring and enforcement of CLAS Standards

	○ Present on enhanced CLAS Standards at the Eliminating Health Disparities Conference in Utah in May 2015 ○ Identify regional relevant standardized slides organizations can use (identified as community need)
Data, Research, and Evaluation	• Share information with policymakers that will inform the development of initiatives to address health disparities and enhancing health equity ○ Develop dissemination strategies and disseminate the Blueprint ○ Create a dashboard for ongoing monitoring of progress in addressing health disparities ○ Develop a one-page issue brief of emerging trends, featuring highlights from the Blueprint ○ Develop an archive of relevant analysis and data products on Mountain States RHEC disparities, collecting information on emerging issues

Membership and Structure

Membership includes 11 individuals from the public and private sectors who represent communities experiencing health disparities; state and local government agencies; individuals representing tribes, urban AI programs, or other AI organizations; health care providers and systems; health plans; businesses; academic and research institutions; foundations; and other organizations.

The Mountain States RHEC has established a workgroup structure to support the advancement of its mission and align with the NPA goals. Each state is charged with prioritizing the goal area strategies most relevant to the stakeholder communities represented by the members, ensuring that a focus on one or more of the social determinants of health is included in each of the workgroup's work and developing an annual work plan. Our workgroups include the following:

Mountain States RHEC Subcommittee Structure	
Subcommittee	**Description**
ACA Outreach and Awareness Committee	Focus is to share information among community stakeholders and youth to address the ACA and health disparities via social media outlets *Members: Alok Sarwal, Thelma Craig, Fahina Tavake-Pasi, and Anne-Christine Nyquist*
Cultural and Linguistic Competency	Focus is to promote the utilization and implementation of CLAS Standards *Members: Renee Gamino, Lillian Zuniga, Thelma Craig, and Jorge Arce-Laretta*
Data Committee	Focus is to share information with policymakers that will inform the development of initiatives to address health disparities and enhancing health equity *Members: Anne-Christine Nyquist, Phyllis Howard, John Grima, and Renee Gamino*

Initial Work of the RHEC

The initial work of the Mountain States RHEC was focused on building a governance structure to ensure long-term sustainability. The RHEC held their inaugural meeting on August 24-25, 2011 in Salt Lake City, UT. During

the two-day meeting, the RHEC drafted a mission and vision, established an initial committee structure, and developed member roles and responsibilities. They discussed the disparity issues and challenges specific to the region and heard from community and program representatives and state and local stakeholders.

The Mountain States RHEC began work on an Awareness Work Plan to focus on outreach via social media. A Facebook page was created, wherein council members posted weekly on region specific events and activities. In addition, the RHEC provided customized NPA Social Determinants of Health Fact Sheets for their region for the Wyoming Office of Multicultural Health.

Role in Creating Health Equity

Critical time was spent during the inaugural meeting defining the Mountain States RHEC purpose, role, and potential in addressing health disparities and creating health equity. The Mountain States RHEC is responsible for the following:

- Serving as a body of experts for driving a collaborative health equity agenda;
- Using inclusive stakeholder input to refine priority strategies;
- Developing an operational plan that outlines regional strategies for achieving health equity;
- Supporting and collaborating on projects of mutual benefit;
- Providing lateral, cross-boundary leadership and partnerships;
- Monitoring and assessing progress;
- Assuring accountability and driving sustainability;
- Educating policy and decision makers on issues of health equity, social determinants of health, and cultural competency;
- Building awareness of health equity issues in communities that are affected by social determinants of health;
- Building partnerships in the region to move health equity issues forward;
- Creating a Blueprint snapshot of the region to use as foundation for addressing health equity issues; and
- Connecting communities at the grassroots level.

Role in Supporting State, Tribal, and Local Activities

The Mountain States RHEC supports federal, state, and local governments in addressing health disparities amongst tribal communities. For instance, there were three successful activities conducted in partnership with the Wyoming Office of Multicultural Health and the North Dakota Health Equity Office. Two Mountain States RHEC members who are also state Office of Minority Health representatives were leads in planning the activities in Wyoming and North Dakota.

The Wyoming Office of Multicultural Health held the Know Your Civil Rights/Health Care Symposium on July 24, 2014, in partnership with the Northern Arapaho Office of Tribal Health, the Wyoming Office of Tribal Health, the Central Wyoming College Intertribal Cultural Center, Wyoming AARP, Mountain Pacific Quality Health, and the

Wyoming Association of Churches. There were 66 people in attendance. The purpose of the symposium was to provide tribal community health consumers and service providers with guidance about what quality health care parity is and its implementation. Consumers were provided with information about how to evaluate the effectiveness of their health care service provider and resource information about what they can do to improve their standard of health care.

The North Dakota Health Equity Office (HEO) partnered with the North Dakota State Office Minority Health representative and the Mountain States RHEC to hold two successful Tribal Forums that brought together AI individuals from the four AI reservations to discuss heath disparities and issues associated with health. The Tribal Forums increased awareness of the significance of Native American health disparities in the state.

Existing and Potential Partners

- HHS Federal Interagency Health Equity Team members—regional health administrators, regional directors, Regional Minority Health Consultants, state Office of Minority Health representatives, and CMS
- AARP
- The Colorado Alliance for Health Equity and Practice (CAHEP)
- The Northern Arapaho Office of Tribal Health
- The Central Wyoming College Intertribal Cultural Center
- Mountain-Pacific Quality Health
- The Wyoming Association of Churches
- Walgreens
- The Great Plain Tribal Chairman Health Board

Wins and Successes

- Developed a website (http://region8.npa-rhec.org/).
- Developed a Facebook page (https://www.facebook.com/RHEC8).
- An emerging leader from the University of Colorado pulled data and wrote the narrative of the Blueprint during the summer of 2014.
- Recruited for a youth ad hoc committee member to head start a social media campaign to reach out to youth on health disparities and the ACA.
- Held the *Advancing Health Equity Through Cultural Competency* webinar on April 17, 2014. Speaker: Mailyn Salabarria, Community Outreach Coordinator & Translations Associate Manager, One World Translation.
- Held CLAS webinar, *CLAS in Session: The National CLAS Standards and their implications for the Mountain States Region* on November 21, 2014. Speaker: Tawara Goode from National Center for Cultural Competence, Center for Child and Human Development, Georgetown University Medical Center.
- Partnered with the Northern Arapaho Office of Tribal Health, the Wyoming Office of Tribal Health, the Central Wyoming College Intertribal Cultural Center, Wyoming AARP, Mountain Pacific Quality Health, and

the Wyoming Association of Churches to hold the Know Your Civil Rights/Health Care Symposium on July 24, 2014.

- Partnered with CAHEP, Walgreens, the University of Colorado School of Pharmacy, and Connect for Health Colorado to market 11 health fairs (flu clinics and ACA education and enrollment activities) throughout the state of Colorado from October to November 2014.
- Partnered with Georgetown University National Center for Cultural Competence for the November 21, CLAS in Session: The National CLAS Standards and their Implications for the Mountain States Region Webinar.
- Developed ACA Awareness Factsheets for Young Invincibles for Utah and Colorado for 2015 Open Enrollment (http://region8.npa-rhec.org/in-the-spotlight/whatyouthneedtoknowabouthealthinsurancefactsheetforyounginvinciblesages18-35inCOUT).

Call to Action

Take Action: Advocate for a Collaborative Approach. Utilize a culturally competent collaborative approach to engage stakeholders of varied ethnic backgrounds, occupations, age and experience, sexual orientation/ identities, color, and creed in addressing health disparities to build health equity within their communities. Stakeholders can be empowered and inspired to become leaders to drive change in their communities.

Become A Partner: Utilize inclusive approaches to engage all communities, especially in underserved communities (youth, older adults, rural communities lacking access, etc…) in the fight to improve health equity while reducing disparities.

1) Identify and form partnerships with municipalities, tribes and community leaders and/or members, especially youth to identify opportunities to address access to resources and opportunities, health care, health equity, social determinants of health, and readiness.

2) Form partnerships and collaborate in workshop, meetings, conferences, and/or training such as ACA-training, cultural competency, positive youth development, and educational outreach. Work with representatives to provide in-kind (speakers) educational resources, sponsorships, and/or provide refreshments.

Share Your Successes:

1) Spread the word via print and digital media outlets and other media outlets (social media, radio, newspaper, etc.) can be used to empower individuals with the knowledge to raise awareness about activities that address the social determinants of health and cultural competency as well other NPA goals to end health disparities and improve health equity.

2) Be the instrument. Provide and share information about what organizations, communities or other entities are doing to address the shortage of healthcare providers, and other disparities in under-served areas in the region.

3) Respond to funding opportunities that address readiness and increased access to resources and opportunities (such as workforce development programs) focus on establishing workforce development programs to identify underserved population to train in areas of health and wellness, with the goal of increasing access and the number health care providers in areas of experiencing shortages.

Appendix A: Summary of NPA Goals and Strategies

Goal		Strategies
#	Description	
1	**AWARENESS:** Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial/ethnic-minority and underserved populations.	**1. Health Care Agenda.** Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal health care agendas.
		2. Partnerships. Develop and support partnerships among public, nonprofit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the life span.
		3. Media. Leverage local, regional, and national media outlets by using traditional and new media approaches as well as information technology to reach a multitier audience—including racial/ethnic-minority communities; youth and young adults; older persons; persons with disabilities; lesbian, gay, bisexual, and transgendered groups; and geographically isolated individuals—to encourage action and accountability.
		4. Communication. Create messages and use communication mechanisms tailored for specific audiences across their life span, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and reinvest in public health.
2	**LEADERSHIP:** Strengthen and broaden leadership for addressing health disparities at all levels.	**5. Capacity Building. Build capacity** at all levels of decision making to promote community solutions for ending health disparities**.**
		6. Funding Priorities. Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services.
		7. Youth. Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives.
3	**HEALTH SYSTEM AND LIFE EXPERIENCE:** Improve health and health care outcomes for racial/ethnic-minority and underserved populations.	**8. Access to Care.** Ensure access to quality health care for all.
		9. Children. Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; social and physical environments) for at-risk children, including children in out-of-home care.
		10. Older Adults. Enable the provision of needed services and programs to foster healthy aging.
		11. Health Communication. Enhance and improve health service experience through improved health literacy, communications, and interactions.
		12. Education. Substantially increase high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits.
		13. Social and Economic Conditions. Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes.

4	**CULTURAL AND LINGUISTIC COMPETENCY:** Improve cultural and linguistic competency and the diversity of the health-related workforce.	**14. Workforce.** Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities.
		15. Diversity. Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by health care organizations and systems.
		16. Ethics and Standards for Translation Services. Encourage translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation.
5	**DATA, RESEARCH, AND EVALUATION:** Improve data availability and the coordination, utilization, and diffusion of research and evaluation outcomes.	**17. Data.** Ensure the availability of disaggregated health data on all racial/ethnic-minority and underserved populations.
		18. Community-Based Research and Action and Community-Originated Intervention Strategies. Invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities.
		19. Coordination of Research. Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and health care disparities.
		20. Knowledge Transfer. Expand and enhance transfer of knowledge generated by research and evaluation for decision-making on policies, programs, and grant making related to health disparities and health equity.

Appendix B: Detailed Individual State Profiles (Data as of Fall 2012)

Colorado Profile

Colorado ranks among states with the lowest rates of death by heart disease, cancer, or diabetes-related causes. It is one of few states in which all population groups have achieved the Healthy People (HP) 2020 target for reducing lung cancer deaths. Colorado boasts the lowest obesity rate, the second lowest percentage of residents diagnosed with high blood pressure, and the third highest rate of physical inactivity in the nation. Conversely, Colorado ranks among states with the highest rates of death by suicide, chronic obstructive pulmonary disease, and unintentional injuries.

The population of Colorado is 5,024,748. Of those people, 82.8% identify as Hispanic or White. Fewer than 1% identify as AI/AN, while 2.9% identify as API. Approximately 7% identify as being of other races/ethnicities, 2.6% identify as being of two or more races/ethnicities, 4.3% identify as Black, and 21% identify as Hispanic.

Table 7: Colorado's Lowest-Ranked Health Indicators[56]

Major Causes of Death[57] (Rate per 100,000)	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Suicide	49.0	16.0	10.2
COPD (age 45 and older)	42.0	137.4	98.5
Unintentional injuries	31.0	42.7	36.0
Preventive Care (Percentage)[58]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Routine checkup in the past 2 years (2008–2010)	40.0	77.2	N/A
Dental visit within the past year (2008–2010)	32.0	67.2	N/A
Health Insurance Coverage (Percentage)	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Health insurance coverage (2008–2010, ages 18–64)	32.0	81.0	100.0

Health Disparities by Race/Ethnicity

The White population in Colorado has higher rates of chronic obstructive pulmonary disease and suicide compared to other populations. The rate of deaths due to diabetes-related causes is twice as high in the Black and Hispanic populations as in the White population. Rates of heart disease, cancer, and stroke are also higher in the Black population.

The state's Hispanic and AI/AN populations have rates of physical inactivity nearly twice those of the White population. Rates of smoking are also higher for these populations. Obesity rates are substantially higher for Black, Hispanic, and AI/AN populations than those of the White population. Dental visit rates are notably lower

[56] Ranked among the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands, where data are available and reliable. Source: U.S. Department of Health and Human Services, Office of Women's Health. *2011 health disparities profiles*. Retrieved from http://www.healthstatus2020.com/owh/disparities/ChartBookData_list.asp.

[57] The estimate is adjusted for all ages unless noted otherwise.

[58] The estimate is adjusted for 18 years of age and older unless noted otherwise.

for Black, Hispanic, and AI/AN populations than for the White population. Health insurance coverage is notably lower for Colorado's Hispanic and AI/AN population than for the White population.

Montana Profile

Montana ranks among states with the lowest rates of death due to coronary heart disease. The state has some of the highest rates of death by suicide, chronic obstructive pulmonary diseases, and unintentional injuries. Individuals in Montana have some of the lowest levels of high blood pressure and obesity in the United States. The proportions of residents in Montana who have had a recent cholesterol test, routine checkup, or dental visit are among the lowest in the United States, as is the percentage of residents with health care coverage.

The population of Montana is 974,989. Of those people, 89.7% identify as White, approximately 6% identify as AI/AN, fewer than 1% identify as API, fewer than 1% identify as being of other races/ethnicities, and 2% identify as being of two or more races/ethnicities.

Table 8: Montana Lowest-Ranked Health Indicators[59]

Major Causes of Death[60] (Rate per 100,000)	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Suicide	53.0	20.2	10.2
Chronic Obstructive Pulmonary Diseases (age 45 and older)	50.0	155.5	98.5
Unintentional Injuries	47.0	55.9	36.0
Health Risk Factors[13]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Smoking Currently (2008–2010)	30.0	18.4	12.0
Preventive Care (Percentage)[61]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Cholesterol screening in the past 5 years (2007–2009)	53.0	69.3	82.1
Routine checkup in the past 2 years (2008–2010)	52.0	71.7	N/A
Dental visit within the past year (2008–2010)	47.0	61.6	N/A
Health Insurance Coverage (Percentage)	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Health insurance coverage (2008–2010, ages 18–64)	42.0	78.4	100.0

[59] Ranked among the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands, where data are available and reliable. *Source: 2011 health disparities profiles.*
[60] The estimate is adjusted for all ages unless noted otherwise.
[61] The estimate is adjusted for 18 years of age and older unless noted otherwise.

Health Disparities by Race/Ethnicity

In Montana, rates of death due to coronary heart disease are notably higher for the state's AI/AN population. The rates of death by diabetes-related causes and unintentional injuries for the AI/AN population double those of the White population. Rates of cancer, stroke, chronic obstructive pulmonary disease, influenza, and pneumonia are also higher for the AI/AN population in Montana. Levels of high blood pressure, smoking, and obesity are notably higher for the AI/AN population in the state.

North Dakota Profile

North Dakota has relatively low rates of death by chronic obstructive pulmonary diseases and lung cancer. North Dakota ranks among those states with low rates of diagnosed high blood pressure. The state ranks among those that have relatively higher levels of health insurance coverage.

The population of North Dakota is 646,844. Of those people, 91.0% identify as White, approximately 5% identify as AI/AN, fewer than 1% identify as API, fewer than 1% identify as being of other races/ethnicities, and 1.3% identify as being of two or more races/ethnicities. U.S. Census data suggest that 2.5% of the population identify as Hispanic and 1% identify as Black.

Table 9: North Dakota Lowest-Ranked Health Indicators[62]

Major Causes of Death[63] (Rate per 100,000)	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Suicide	39.0	13.9	10.2
Colorectal Cancer	33.0	17.9	14.5
Diabetes-related	31.0	77.1	65.8
Coronary heart disease	29.0	135.6	100.8
Health Risk Factors[13]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Obesity (2008–2010, age 20 and older)	36.0	28.8	30.6
No leisure time physical activity (2008–2010)	36.0	25.5	32.6
Eats five or more fruits and vegetables a day (2007–2009)	36.0	21.9	N/A
Smoking currently (2008–2010)	29.0	18.3	12.0
Preventive Care (Percentage)[64]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Routine checkup in the past 2 years (2008–2010)	36.0	77.9	N/A
Cholesterol screening in the past 5 years (2007–2009)	34.0	73.5	82.1

[62] Ranked among the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands, where data are available and reliable. *Source: 2011 health disparities profiles.*
[63] The estimate is adjusted for all ages unless noted otherwise.
[64] The estimate is adjusted for 18 years of age and older unless noted otherwise.

Health Disparities by Race/Ethnicity

The rates of death due to all causes, unintentional injuries, and diabetes-related causes are respectively two, three and a half, and four times higher in the AI/AN population than in the White population. Rates of cancer are also two times higher for the AI/AN population than for the White population.

Diagnosed high blood pressure and obesity are also higher for the AI/AN population. The proportion of the AI/AN population that smokes is more than double that of the White population. Rates of physical inactivity are higher for the Black, Hispanic, and AI/AN populations than for the White population. Rates of cholesterol screening, dental screening, and health insurance coverage in the AI/AN are notably low.

South Dakota Profile

South Dakota has relatively low rates of death by heart disease and cancer and relatively high rates of death by unintentional injuries and suicide. South Dakotans have relatively low rates of diagnosed high blood pressure and some of the lowest rates of residents eating five or more fruits and vegetables per day. Obesity rates are consistent with those of the middle range states.

The population of South Dakota is 853,175. Of those people, 87.2% identify as White, approximately 9% identify as AI/AN, 1% identify as API, 1% identify as being of other races/ethnicities, 1.6% identify as being of two or more races/ethnicities, 3.1% identify as Hispanic, and 1.45% identify as Black.

Table 10: South Dakota Lowest-Ranked Health Indicators[65]

Major Causes of Death[66] (Rate per 100,000)	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Suicide	43.0	14.5	10.2
Unintentional Injuries	39.0	47.2	36.0
COPD	34.0	131.3	98.5
Influenza and Pneumonia	32.0	18.9	N/A
Colorectal Cancer	31.0	17.5	14.5
Health Risk Factors[13]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Eats five or more fruits and vegetables a day (2007–2009)	52.0	16.9	N/A
Obesity (2008–2010, age 20 and up)	38.0	29.2	30.6
No leisure time physical activity (2008–2010)	31.0	25.0	32.6
Preventive Care (Percentage)[67]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Routine checkup in the past 2 years (2008–2010)	35.0	78.5	N/A
Cholesterol screening in the past 5 years (2007–2009)	40.0	72.2	82.1

[65] Ranked among the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands, where data are available and reliable. *Source: 2011 health disparities profiles.*
[66] The estimate is adjusted for all ages unless noted otherwise.
[67] The estimate is adjusted for 18 years of age and older unless noted otherwise.

Health Disparities by Race/Ethnicity

Rates of death by unintentional injuries and diabetes-related causes are both approximately four times as high in the AI/AN population as in the White population. Rates of death related to suicide, influenza, and pneumonia for the AI/AN population are almost double those for the White population. Obesity and smoking rates are notably higher for the AI/AN population.

Rates of cholesterol screening are lower for the AI/AN population. Rates of dental screening are lower for the AI/AN and Hispanic populations compared to the White population. The proportion of residents with health insurance coverage is notably low for the AI/AN and Hispanic populations.

Utah Profile

Utah has some of the lowest rates of death for most of the presented measures. It has the lowest rates of death by coronary heart disease and some of the lowest rates of death by colorectal cancer and lung cancer in the nation. In fact, Utah is one state in which all population groups have achieved the HP 2020 target for reducing coronary heart disease deaths and the 2020 target for reducing total cancer deaths. The state is among those with low rates across most of the presented health risk factors. Utah is among the leaders in the nation for low proportions of current smokers and has low rates of high blood pressure, obesity, and physical inactivity. Across most health risk factors, rates in the Hispanic population parallel those of the White population. The state is among the states with the lowest rates for cholesterol screening and routine checkup.

The population of Utah is 2,784,572. Of those people, 89.1% identify as White, approximately 1% identify as AI/AN, 2.6% identify as API, approximately 5% identify as being of other races/ethnicities, 1.6% identify as being of two or more races/ethnicities, 13.3% identify as Hispanic, and 1.3% identify as Black.

Table 11: Utah Lowest-Ranked Health Indicators[68]

Major Causes of Death[69] (Rate per 100,000)	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Suicide	46.0	15.1	10.2
Health Risk Factors[13]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Eats five or more fruits and vegetables a day (2007–2009)	28.0	23.5	N/A
Preventive Care (Percentage)[70]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Routine checkup in the past 2 years (2008–2010)	48.0	74.4	N/A
Cholesterol screening in the past 5 years (2007–2009)	51.0	70.1	82.1

[68] Ranked among the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands, where data are available and reliable. *Source: 2011 health disparities profiles.*
[69] The estimate is adjusted for all ages unless noted otherwise.
[70] The estimate is adjusted for 18 years of age and older unless noted otherwise.

Health Disparities by Race/Ethnicity

The death rate in Utah attributed to coronary heart disease is particularly low in the state's Hispanic and API populations. In Utah, NHPI have the highest rates of obesity and infant mortality and come in second to AI/ANs in diabetes-related death. Death from diabetes-related causes and unintentional injuries is higher in the Black and AI/AN populations.

The rates of physical inactivity for the Latino population is nearly double that of the White population. The rate of obesity is highest among NHPI population. Rates of dental screening are lower for the Hispanic population. Rates of recent cholesterol screening and health insurance coverage are notably lower for the state's Hispanic and AI/AN populations.

Wyoming Profile

Wyoming has relatively lower rates of death by coronary heart disease and lung cancer but ranks among the states with the highest rates of death by COPD, suicide, unintentional injuries, influenza, and pneumonia in the nation. The state ranks among those with relatively low rates of high blood pressure and obesity. Wyoming ranks among the middle range of states with respect to proportions of residents who have had dental visits and recent cholesterol screenings.

The population in Wyoming is 544,270. Of those people, 91.8% identify as White, approximately 2% identify as AI/AN, 1% identify as API, slightly more than 2% identify as being of other races/ethnicities, 1.8% identify as being of two or more races/ethnicities, 9.5% identify as Hispanic, and 1.5% identify as Black.

Table 12: Wyoming Lowest-Ranked Health Indicators[71]

Major Causes of Death[72] (Rate per 100,000)	**State Rank**	**State Total**	**Healthy People 2020 National Target**
COPD	53.0	165.8	98.5
Suicide	52.0	19.5	10.2
Unintentional injuries	50.0	58.1	36.0
Influenza and pneumonia	48.0	22.2	N/A
Health Risk Factors[13]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Smoking currently (2008–2010)	36.0	19.6	12.0
Preventive Care (Percentage)[73]	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Routine checkup in the past 2 years (2008–2010)	51.0	72.1	N/A
Cholesterol screening in the past 5 years (2007–2009)	37.0	73.1	82.1

[71] Ranked among the 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands, where data are available and reliable. *Source: 2011 health disparities profiles.*
[72] The estimate is adjusted for all ages unless noted otherwise.
[73] The estimate is adjusted for 18 years of age and older unless noted otherwise.

Table 12: Wyoming Lowest-Ranked Health Indicators[71]			
Dental visit within the past year (2008–2010)	34	66.9	N/A
Health Insurance Coverage (Percentage)	**State Rank**	**State Total**	**Healthy People 2020 National Target**
Health Insurance coverage (2008–2010, ages 18–64)	33	80.9	100.0

Health Disparities by Race/Ethnicity

Rates of death from diabetes-related causes and unintentional injuries are more than double for the AI/AN population compared to Whites. The Hispanic population also has a notably high rate of diabetes-related death. The AI/AN population in Wyoming has higher rates of high blood pressure, obesity, physical inactivity, and smoking when compared to all racial/ethnic groups.

Rates of dental visits and recent cholesterol screenings are lower for the state's Hispanic and AI/AN populations. In addition, the state has nearly the lowest overall rate of recent routine checkups, with rates being relatively low across all racial/ethnic groups. Fewer than 60% of Wyoming's Hispanic and AI/AN populations have health insurance.