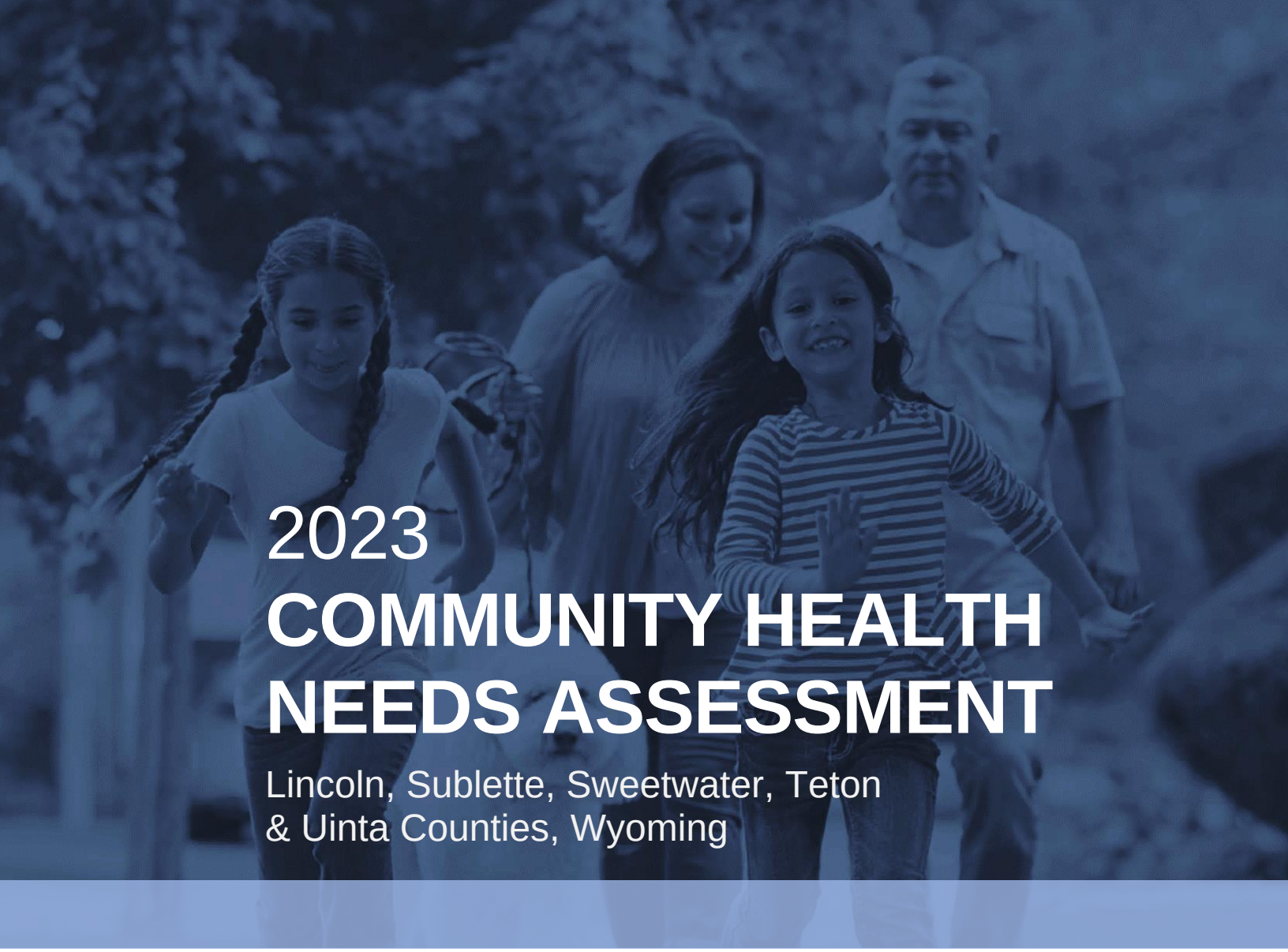

2023 COMMUNITY HEALTH NEEDS ASSESSMENT

Lincoln, Sublette, Sweetwater, Teton & Uinta Counties, Wyoming

Sponsored by

STAR VALLEY HEALTH

2023-0395-02

Prepared by
www.PRCCustomResearch.com

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Star Valley and the surrounding areas, the service area of Star Valley Health. A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

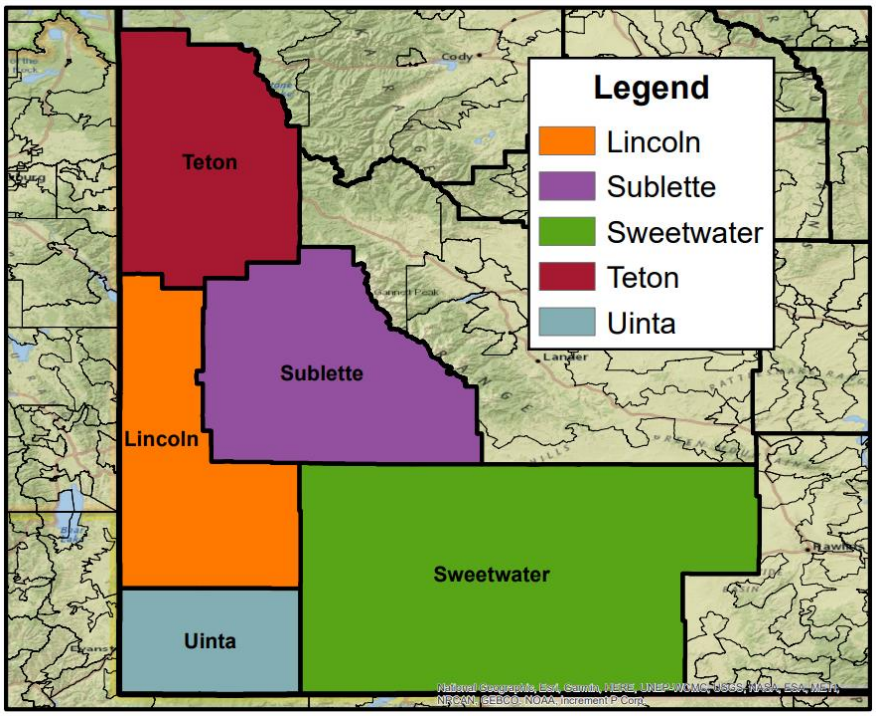
This assessment was conducted on behalf of Star Valley Health by PRC, Inc., a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

Quantitative data input for this assessment includes secondary research (a review of vital statistics and other existing health-related data) that allows for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research among community leaders gathered through an Online Key Informant Survey.

Community Defined for This Assessment

The study area for this effort (referred to as the "Total Service Area" in this report) includes Lincoln County, Sublette County, Sweetwater County, Teton County, and Uinta County in Wyoming. This community definition, determined based on the residences of most recent patients of Star Valley Health, is illustrated in the following map.



Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 41 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	3
Public Health Representatives	2
Other Health Providers	18
Social Services Providers	0
Other Community Leaders	18

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

- Cokeville Clinic/SVH
- Cokeville Hospital
- Evanston High School
- Lincoln County
- Lincoln County School District
- Lincoln County School District #2
- Lyman High School
- Mountain View High School
- Star Valley Health
- Star Valley Middle School
- Sublette County
- Town of Afton
- Town of Alpine
- Town of Cokeville
- Town of Lyman
- Town of Thayne
- Uinta County School District

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

Public Health, Vital Statistics & Other Data

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

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

Note that data are not available for all counties for all measures.

Benchmark Data

Wyoming and National Data

Where possible, state and national data are provided as an additional benchmark against which to compare local findings.

Healthy People 2030

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

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

Determining Significance

For the purpose of this report, “significance” of secondary data indicators (which might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community’s health needs. In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Star Valley Health will use its website as a tool to solicit public comments about this CHNA and ensure that these comments are considered in the development of future CHNAs.

IRS FORM 990, SCHEDULE H COMPLIANCE

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

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	23
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	84
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	11
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	11
Part V Section B Line 3h The process for consulting with persons representing the community's interests	7
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	88

SUMMARY OF FINDINGS

Significant Health Needs of the Community

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

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

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Lack of Health Insurance [Adults & Children] ▪ Access to Primary Care Physicians
CANCER	▪ A Leading Cause of Death ▪ Cancer Mortality (Sweetwater County) ▪ Breast Cancer Screening [Women 50-74] ▪ Prostate Cancer Incidence (Sweetwater County)
HEART DISEASE & STROKE	▪ A Leading Cause of Death ▪ Heart Disease Mortality (Uinta County)
INFANT HEALTH & FAMILY PLANNING	▪ Teen Births (Sweetwater and Uinta Counties)
INJURY & VIOLENCE	▪ Unintentional Injury Deaths (esp. Sweetwater County)
MENTAL HEALTH	▪ Suicide Deaths ▪ Mental Health Provider Ratio ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Obesity (Sweetwater County)
ORAL HEALTH	▪ Access to Dentists
RESPIRATORY DISEASE	▪ Lung Disease Deaths

Community Feedback on Prioritization of Health Needs

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

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

1. Mental Health
2. Cancer
3. Nutrition, Physical Activity & Weight
4. Heart Disease & Stroke
5. Access to Health Care Services
6. Infant Health & Family Planning
7. Injury & Violence
8. Respiratory Disease
9. Oral Health

Hospital Implementation Strategy

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

Summary Tables:
Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Total Service Area, grouped by health topic.

Reading the Summary Tables

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

- In the following tables, Total Service Area results are shown in the larger, gray column.
- The columns to the left of the Total Service Area column provide comparisons among the five counties, identifying differences for each as “better than” (🌞), “worse than” (☠), or “similar to” (☁) the combined opposing areas.
- The columns to the right of the Total Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Total Service Area compares favorably (🌞), unfavorably (☠), or comparably (☁) to these external data.

SOCIAL DETERMINANTS	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	0.6	0.0	1.9	6.7	1.8	2.5	1.0	4.0	
Population in Poverty (Percent)	6.7	8.3	10.5	7.1	8.0	8.5	10.7	12.6	8.0
Children in Poverty (Percent)	5.5	14.1	13.5	8.3	7.5	10.0	12.8	17.1	8.0
No High School Diploma (Age 25+, Percent)	6.5	5.0	7.3	4.0	6.4	6.1	6.3	11.1	
Unemployment Rate (Age 16+, Percent)	3.5	4.3	4.2	2.5	3.8	3.6	3.6	3.3	
Housing Exceeds 30% of Income (Percent)	20.1	15.8	18.3	28.9	13.6	19.9	24.1	30.3	25.5

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

OVERALL HEALTH	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
"Fair/Poor" Overall Health (Percent)	14.3	13.8	14.8	10.5	15.0	13.8	14.6	16.1	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ACCESS TO HEALTH CARE	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Uninsured (Adults 18-64, Percent)	19.5	18.7	17.7	16.8	16.8	17.7	17.0	12.1	7.6
Uninsured (Children 0-18, Percent)	18.5	15.6	10.8	14.9	9.9	13.0	11.5	5.3	7.6
Routine Checkup in Past Year (Percent)	68.1	68.0	70.8	67.4	65.6	68.5	67.9	73.6	
Primary Care Doctors per 100,000	71.5	57.3	42.6	145.7	68.5	74.3	101.2	109.3	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

CANCER	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Cancer Deaths per 100,000 (Age-Adjusted)	112.7	85.9	161.2	93.4	126.9	127.1	138.5	149.4	122.7
Cancer Incidence per 100,000 (Age-Adjusted)	380.3	290.4	421.2	402.5	368.8	388.2	404.3	442.3	
Female Breast Cancer Incidence per 100,000 (Age-Adjusted)	124.3	98.3	84.6	140.0	123.7	111.8	116.0	127.0	
Prostate Cancer Incidence per 100,000 (Age-Adjusted)	100.3	59.3	153.0	106.2	77.5	111.0	113.7	110.5	

CANCER (continued)	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Colorectal Cancer Incidence per 100,000 (Age-Adjusted)	24.9		33.5	32.1	39.5	32.4	34.8	36.5	
Lung Cancer Incidence per 100,000 (Age-Adjusted)	31.6		38.5	19.0	28.4	31.0	40.4	54.0	
Breast Cancer Screening in Past 2 Years (Women 50-74, Percent)	64.6	61.5	61.4	71.8	62.3	64.2	64.7	78.2	80.5
Cervical Cancer Screening in Past 3 Years (Women 21-65, Percent)	81.3	82.0	79.9	84.7	80.5	81.4	80.3	82.8	84.3
Colorectal Cancer Screening (Age 50-75, Percent)	67.7	65.4	65.0	68.4	65.2	66.2	63.9	72.4	74.4

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DIABETES	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Diabetes Prevalence (Percent)	10.2	7.3	8.1	4.6	8.3	7.6	8.6	10.1	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DISABLING CONDITIONS	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Disability Prevalence (Percent)	12.5	15.2	16.1	6.5	15.7	13.4	13.4	12.6	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

HEART DISEASE & STROKE	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Heart Disease Deaths per 100,000 (Age-Adjusted)	160.4	118.1	187.3	71.6	196.5	155.3	154.0	164.8	127.4
Stroke Deaths per 100,000 (Age-Adjusted)	30.0		32.7	17.7	25.7	27.6	30.9	37.6	33.4
High Blood Pressure Prevalence (Percent)	32.1	31.2	30.0	26.4	31.3	30.0	30.7	32.7	42.6
High Blood Cholesterol Prevalence (Percent)	36.6	35.7	33.2	31.8	34.9	34.0	33.8	36.4	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Low Birthweight (Percent of Births)	8.4	8.0	10.1	8.1	9.5	9.2	9.1	8.2	
Teen Births per 1,000 Females 15-19	16.3	14.5	26.7	9.5	26.0	21.5	24.1	19.3	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

INJURY & VIOLENCE	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	69.8	60.0	72.9	44.9	54.6	62.5	59.9	50.4	43.2
Violent Crimes per 100,000	370.5	364.1	378.1	176.5	141.3	294.4	271.9	416.0	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

MENTAL HEALTH	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Suicide Deaths per 100,000 (Age-Adjusted)	26.1		30.6		33.9	30.3	27.4	13.8	12.8
Mental Health Providers per 100,000	25.5	57.3	108.8	192.9	102.7	106.7	152.7	155.8	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Fast Food Restaurants per 100,000	56.2		61.5	68.6	68.5	58.6	59.6	75.9	
Population With Low Food Access (Percent)	17.8	19.8	21.5	17.4	3.4	16.7	29.7	22.2	
No Leisure-Time Physical Activity (Percent)	21.3	18.5	21.4	12.0	23.8	19.5	21.6	22.0	21.8
Obese (Percent)	24.5	20.9	33.8	15.4	28.3	26.1	27.7	29.0	36.0

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ORAL HEALTH	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Dental Visit in Past Year (Percent)	71.4	67.1	66.5	76.7	64.1	69.0	66.8	64.8	45.0
Dentists per 100,000	10.2	22.9	21.3	42.9	39.1	27.1	36.1	37.3	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

RESPIRATORY DISEASE	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Lung Disease Deaths per 100,000 (Age-Adjusted)	43.8		63.3		50.0	55.4	53.3	39.1	
COVID-19 Deaths per 100,000 (Crude Rate)	195.5	285.3	322.9	69.3	211.8	228.2	346.9	337.9	
Asthma Prevalence (Percent)	9.4	8.9	9.5	8.7	9.5	9.3	9.6	9.7	
COPD Prevalence (Percent)	7.3	7.1	6.8	4.9	7.3	6.6	7.1	6.4	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SEXUAL HEALTH	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
HIV Prevalence per 100,000	30.1	0.0	48.5	24.4		33.5	73.0	379.7	
Chlamydia Incidence per 100,000	90.8	122.1	283.4	285.5	197.8	222.1	338.8	481.3	
Gonorrhea Incidence per 100,000	5.0	10.2	26.0	21.3	14.8	18.2	67.7	206.5	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SUBSTANCE ABUSE	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Excessive Drinking (Percent)	20.3	21.8	19.0	21.1	18.2	19.8	19.3	19.0	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

TOBACCO USE	DISPARITY AMONG COUNTIES					Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Lincoln County	Sublette County	Sweetwater County	Teton County	Uinta County		vs. WY	vs. US	vs. HP2030
Cigarette Smoking (Percent)	15.9	15.5	17.9	11.4	16.7	15.8	16.1	13.5	6.1

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

Total Population
(Estimated Population, 2017-2021)

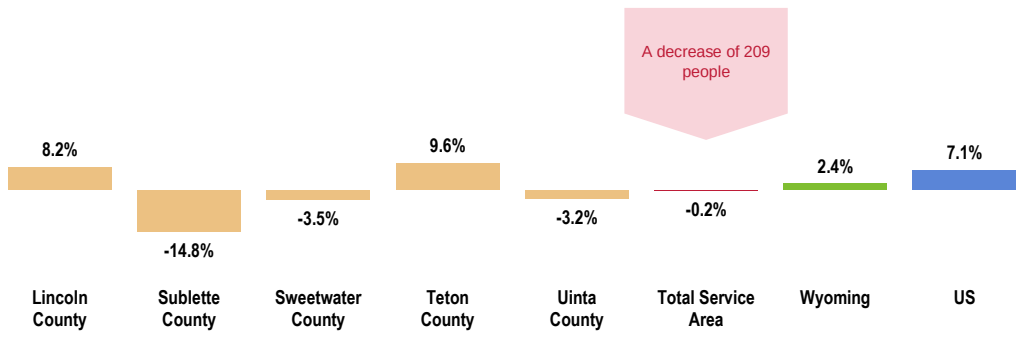
	TOTAL POPULATION	TOTAL LAND AREA (SQUARE MILES)	POPULATION DENSITY (PER SQUARE MILE)
Lincoln County	19,457	4,075.34	5
Sublette County	8,830	4,886.48	2
Sweetwater County	42,459	10,426.98	4
Teton County	23,319	3,996.85	6
Uinta County	20,514	2,081.72	10
Total Service Area	114,579	25,467.37	4
Wyoming	576,641	97,088.75	6
United States	329,725,481	3,533,041.03	93

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

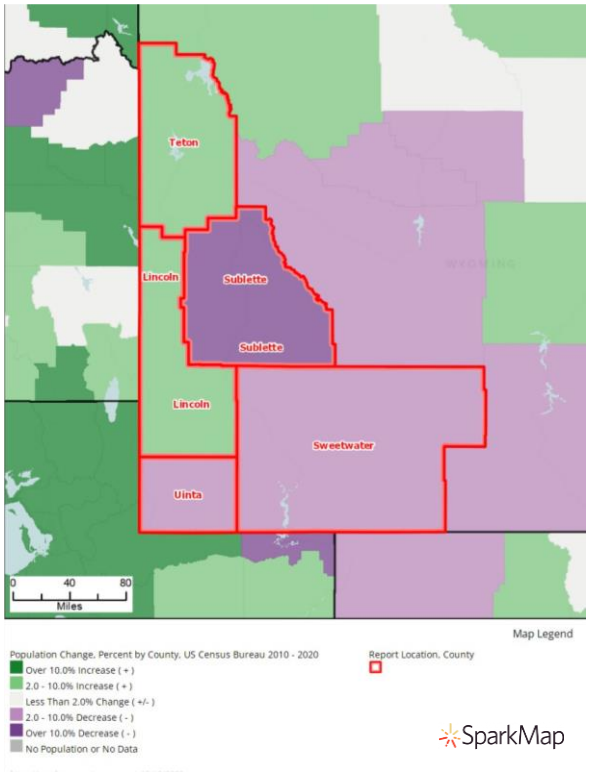
Population Change

A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources. The following chart and map illustrate the changes that have occurred in the Total Service Area between the 2010 and 2020 US Censuses.

Change in Total Population
(Percentage Change Between 2010 and 2020)

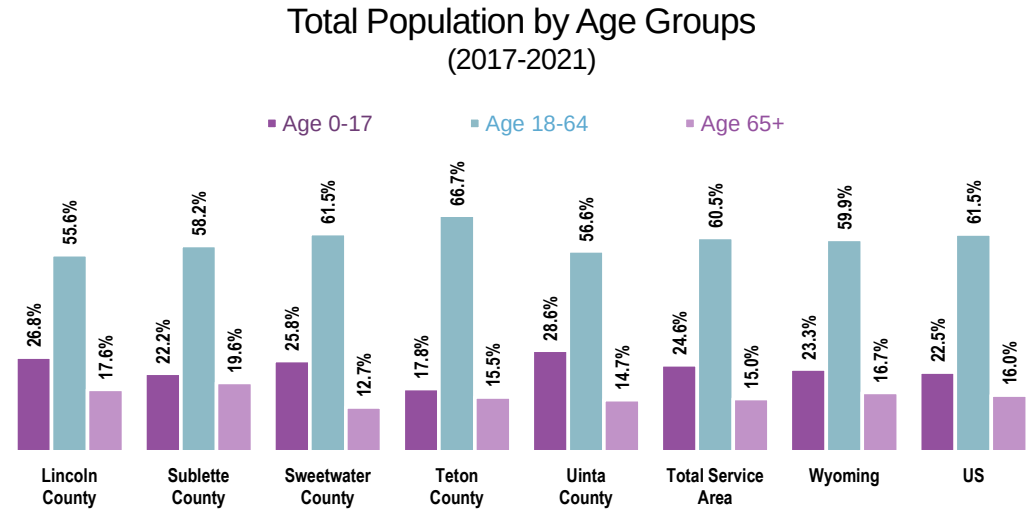


Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).



Age

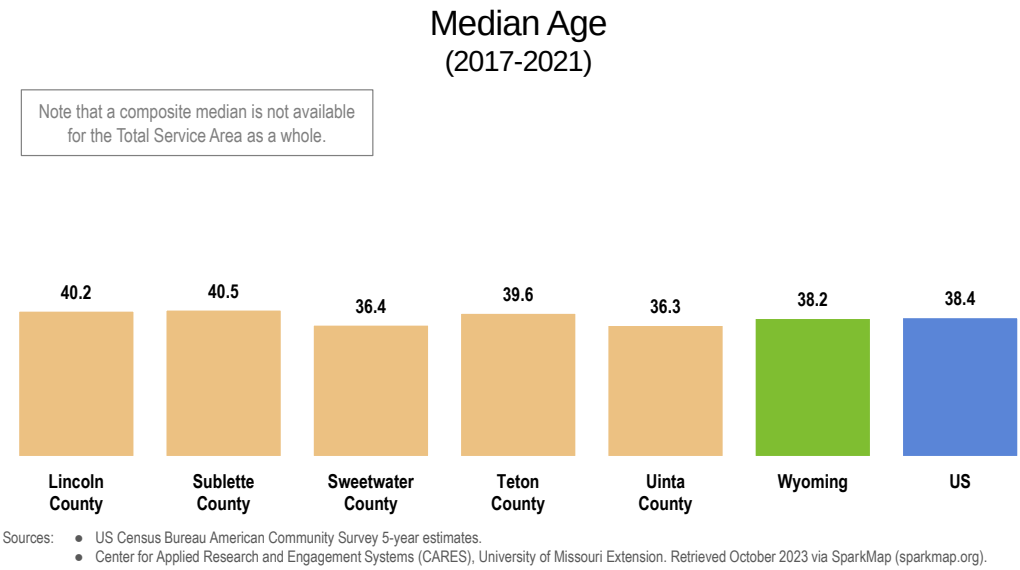
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.



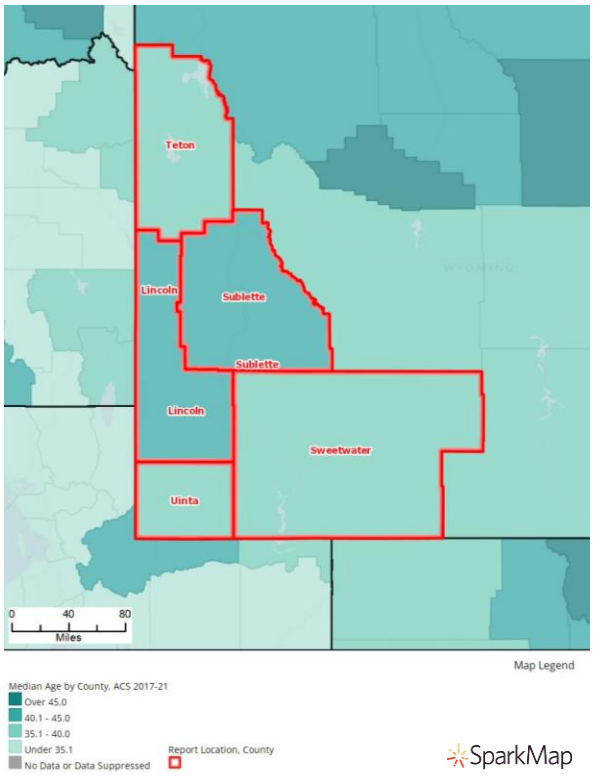
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Median Age

Note the median age of our population, relative to state and national medians.



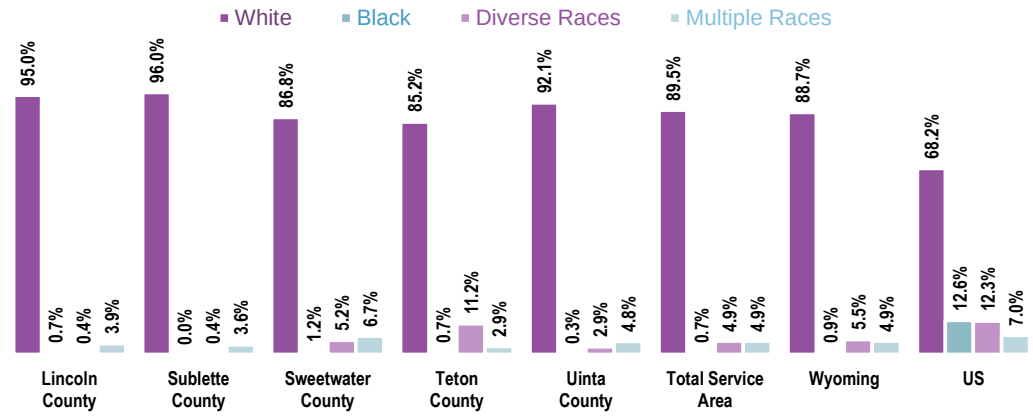
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).



Race & Ethnicity

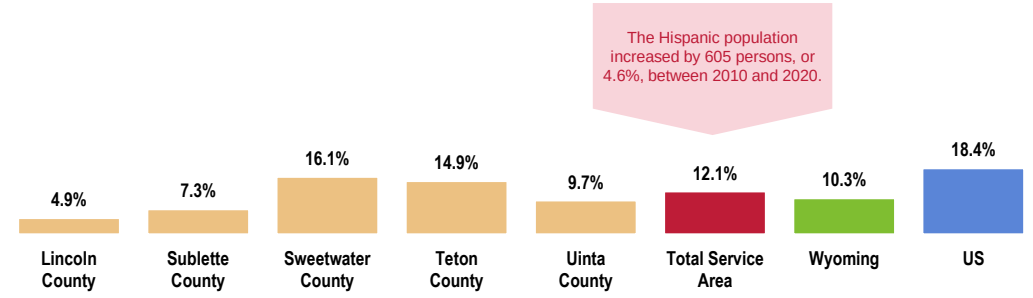
The following charts illustrate the racial and ethnic makeup of our community. “Race Alone” reflects those who identify with a single race category — people who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Total Population by Race Alone
(2017-2021)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Hispanic Population
(2017-2021)



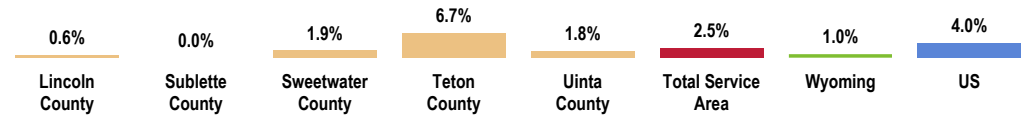
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Linguistic Isolation

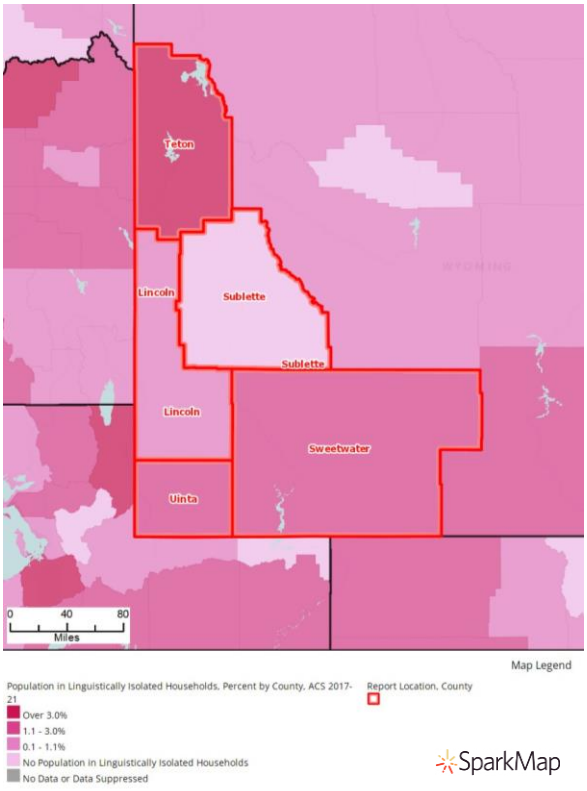
This indicator reports the percentage of the population age 5 years and older who live in a home in which: 1) no person age 14 years or older speaks only English; or 2) no person age 14 years or older speaks a non-English language but also speaks English "very well."

Linguistically Isolated Population
(2017-2021)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English "very well."



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

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

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

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

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

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

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

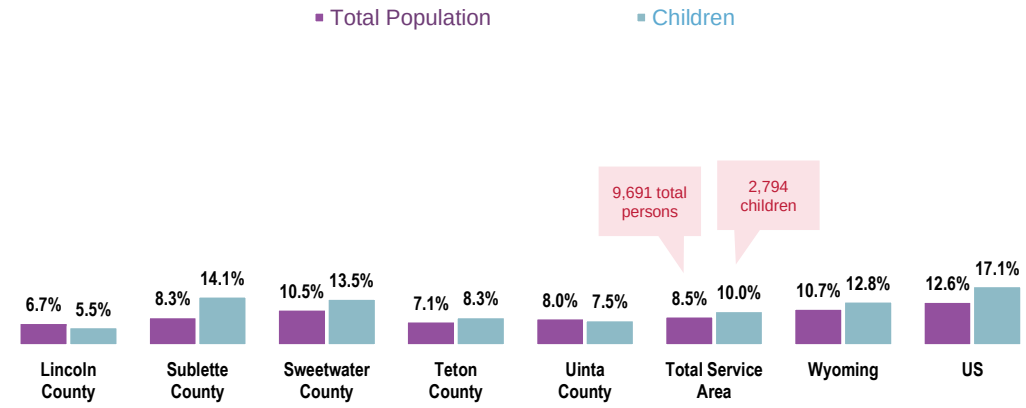
Poverty

Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to accessing health services, healthy food, and other necessities that contribute to health status. The following chart and maps outline the proportion of our population below the federal poverty threshold, as well as the percentage of children in the Total Service Area living in poverty, in comparison to state and national proportions.

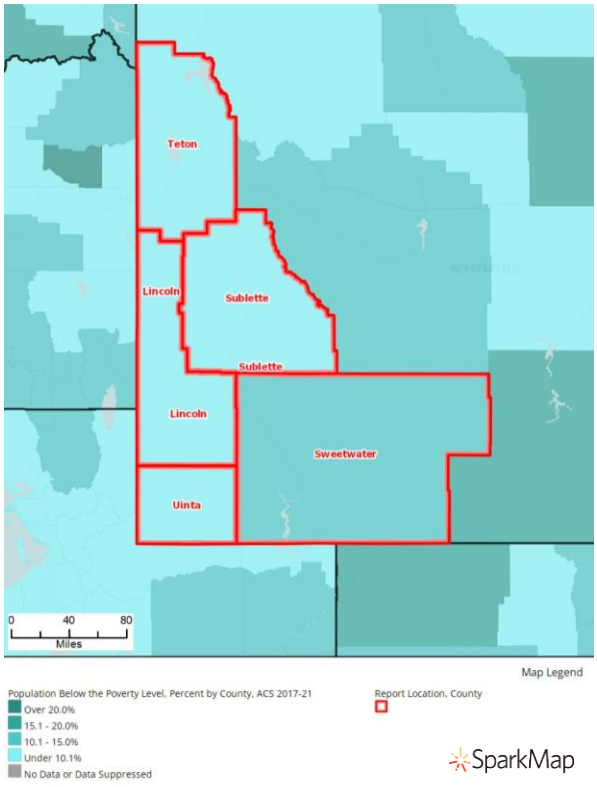
Percent of Population in Poverty

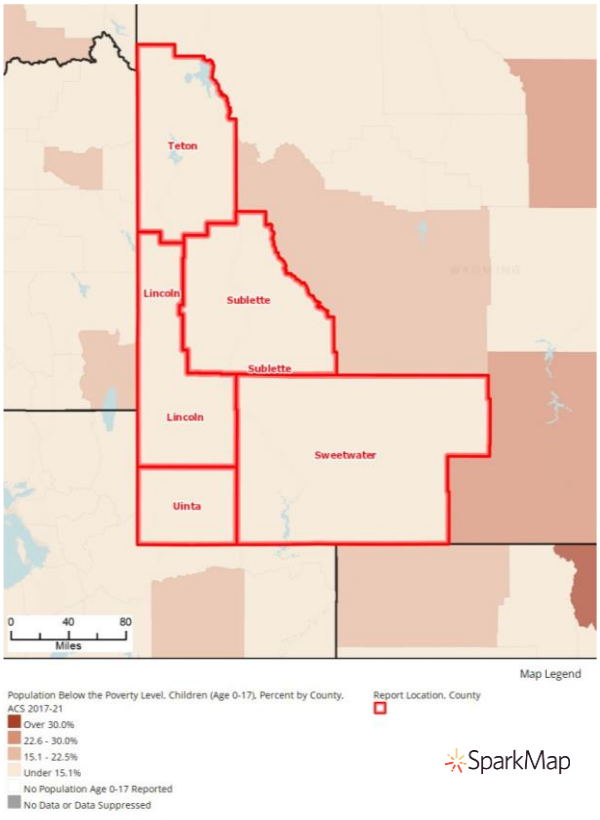
(2017-2021)

Healthy People 2030 = 8.0% or Lower



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

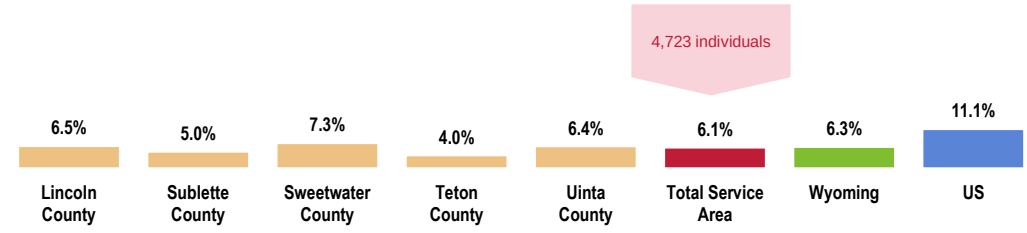




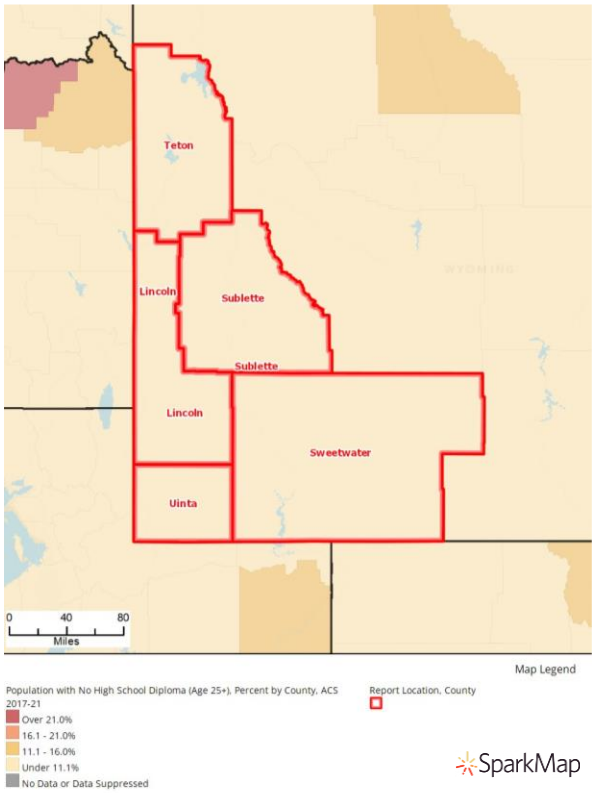
Education

Education levels are reflected in the proportion of our population age 25 and older without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes.

Population With No High School Diploma
(Adults Age 25 and Older, 2017-2021)

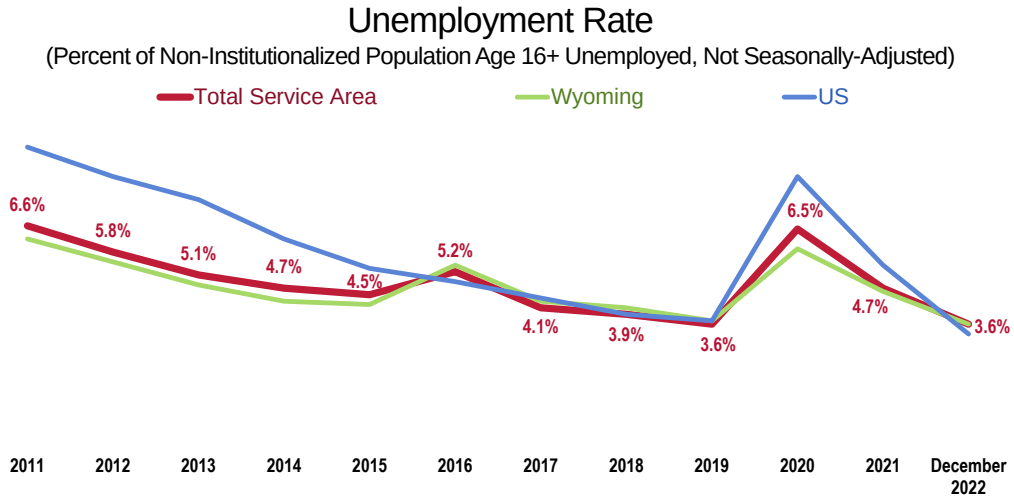


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).



Employment

Changes in unemployment rates in the Total Service Area over the past several years are outlined in the following chart. This indicator is relevant because unemployment creates financial instability and barriers to accessing insurance coverage, health services, healthy food, and other necessities that contribute to health status.



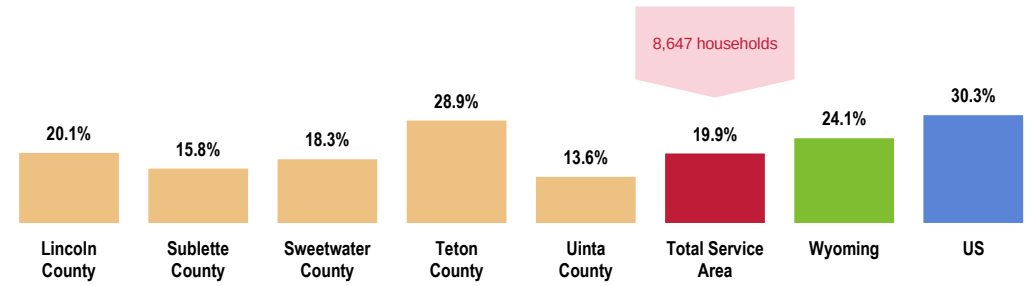
Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Housing Burden

"Housing burden" reports the percentage of the households where housing costs (rent or mortgage costs) exceed 30% of total household income.

The following chart shows the housing burden in the Total Service Area. This serves as a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.

Housing Costs Exceed 30 Percent of Household Income
(Percent of Households; 2017-2021)

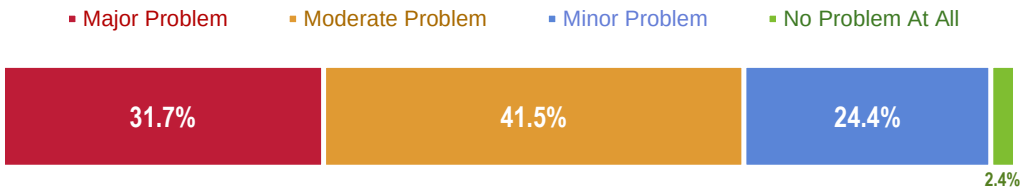


Sources:
- US Census Bureau, American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Key Informant Input: Social Determinants of Health

Key informants' ratings of the severity of *Social Determinants of Health* as a concern in the Total Service Area are outlined below.

Perceptions of Social Determinants of Health as a Problem in the Community
(Key Informants; Total Service Area, 2023)



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Housing

> Out-of-control housing costs, property taxes and income levels in SV are a major factor in health problems. Most families in SV are dual income families working long hours or a couple of jobs to make ends meet, which has adverse effects on addition, education, mental health, engagement with children, etc. – Community Leader

> Housing insecurity is rampant in our area, commute to work equals less time for family, there is no school in Alpine, kids spend too much time on the bus and families have long commutes to be a part of their kid's activities. – Community Leader

> Housing is a basic human need, and we seriously lack affordable housing here. A 1 bedroom 1 bath apartment is typically $1,200 and more, with a three bedroom 2 bath home going for $2,500. This is a ridiculous amount of money and is well over the basic maximum of 30% of income “rule of thumb.” This leaves people with no money for other basic needs. As it is a well-documented fact that stress has a large impact on health, we can be certain that the high housing costs and low comparative income is affecting our community adversely. Families can barely make it on two incomes, leaving parents stressed and unavailable for their kids, while adult children cannot afford to move into their own living spaces, losing the opportunity for growth of confidence through experience of independence. While housing is the largest detriment to the community's health, the environment is also an issue. While beautiful, Star Valley residents endure long winters, and lack of sunshine affects many. – Health Care Provider

> The cost of living in Star Valley, Wyoming, vs. the pay for the jobs available here is astronomical and makes it impossible for families. Especially single mothers. Placing them in potentially dangerous living situations of living with other families, living in campers, unsafe living conditions or with too many people in a household. This can be especially dangerous for vulnerable populations like women and children. Groceries are extremely expensive as well. Many families who do not qualify for income-based benefits because of their pay grade (which should be enough) and STRUGGLING to afford food and housing as well as heat their homes, pay other bills and afford gas. Parents with educations and great jobs are struggling to make ends meet, and where does that leave those who have lesser paying jobs? These effects are detrimental on the mental and physical well-being of people in our community. – Health Care Provider

> We have no affordable housing. Most people live on fixed incomes and can't afford to continue to live here. The wealthy moving in are upping rent and no one can afford the cost of rent in this valley. The income is not the best for the cost of living. We have a growing community, and the schools can't support the kids that live here. Not getting the teaching they deserve because the class sizes are too big. – health care provider

> There is a housing shortage in the Valley with rising prices in homes and rent. Many people cannot afford to buy a home here, or afford rent, and have moved out of the Valley or have chosen jobs elsewhere. There can be bullying to kids that were not born in Star Valley, and adults who were not born in the valley can be left out as well. There is a lot of growth here – some fight against this growth and others fight for it. – Health Care Provider

> There is very limited housing that is affordable. Most people do not make enough money to cover the rent requirements. There are not enough apartment-type housing options, and homes are starting at close to $2,000 a month on the low end. Cost of living is up, but wages are not. – Health Care Provider

Access to Services

> Resources are limited for helping people in our valley. – Community Leader

Environmental Contributors

> Rural issues as previously stated. Discrimination doesn't appear to be an issue to me. However, weather, housing, income, rising costs, rural distanced environment are all issues here. – Health Care Provider

Incidence/Prevalence

> Based on conversations that I've had with clients, friends, people at church and at events. – Health Care Provider

HEALTH STATUS

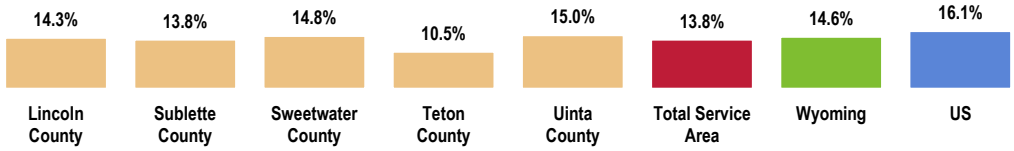
OVERALL HEALTH STATUS

The following indicator provides a relevant measure of overall health status in the Total Service Area, noting the prevalence of residents' "fair" or "poor" health evaluations. While this measure is self-reported and a subjective evaluation, it is an indicator which has proven to be highly predictive of health needs.

The CDC's Behavioral Risk Factor Survey, from which these data are derived, asked respondents:

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

Adults With "Fair" or "Poor" Overall Health
(2021)



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

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

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

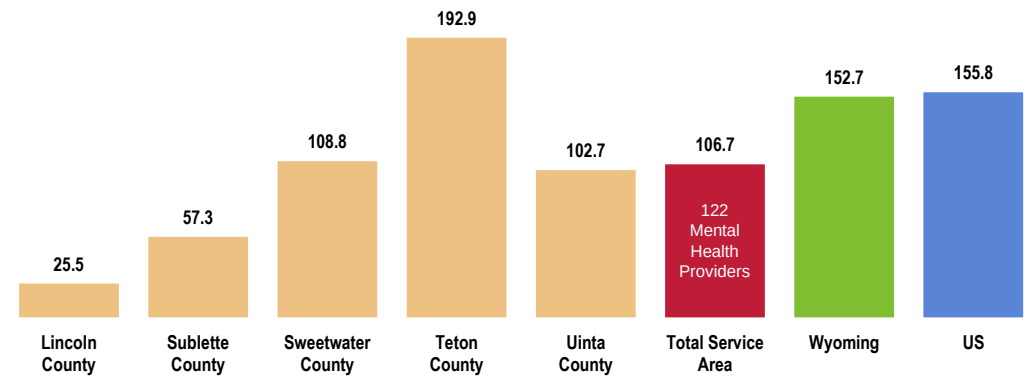
– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Providers

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care.

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

The data below show the number of mental health care providers in the Total Service Area relative to the Total Service Area population size (per 100,000 residents). This is compared to the rates found statewide and nationally.

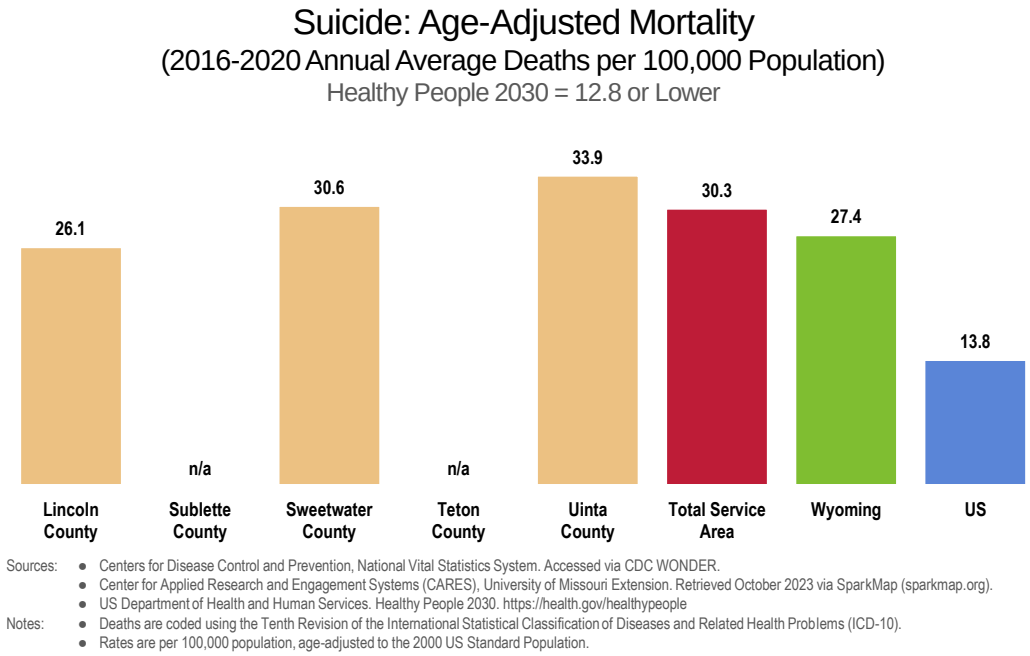


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

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

Suicide

The following reports the rate of death in the Total Service Area due to intentional self-harm (suicide) in comparison to statewide and national rates. Here, these rates are age-adjusted to account for age differences among populations in this comparison. This measure is relevant as an indicator of poor mental health.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

AGE-ADJUSTED DEATH RATES

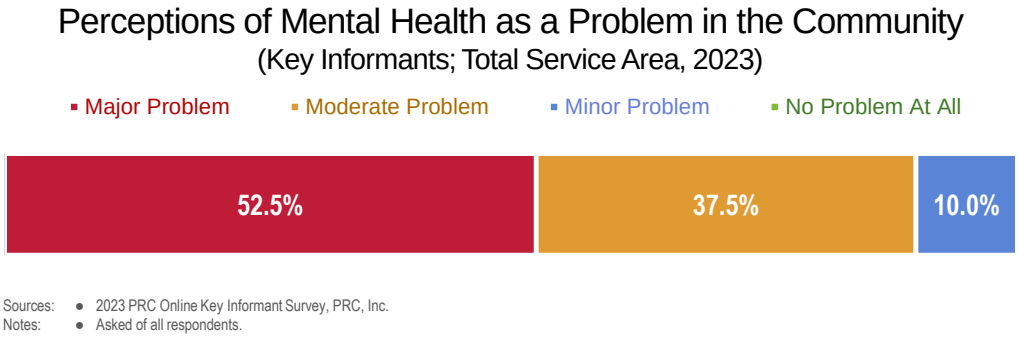
In order to compare mortality in the region with other localities (in this case, Wyoming and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Mental Health

Key informants' ratings of the severity of *Mental Health* as a concern in the Total Service Area are outlined below.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Access to Care/Services

> Mental health is a concern, as the PA is the only available resource in the community to treat mental health conditions. People have to travel out of town for therapy. – Community Leader
>
> Limited access to counseling services throughout the Valley, and resources for community members in need of a therapist or counselor with in-person visits. – Health Care Provider
>
> Mental health is a huge problem in our community. We have no facilities and limited counseling that does not fit the need in the valley. Mental health is not affordable for most of the community members. The closest mental health inpatient facilities are hours and hours away, and to get them into a facility in another state can be difficult. Suicide is high in this valley and not enough support groups for mental health. – Health Care Provider
>
> There is a lack of access to mental health counselors and more advanced psychiatric providers. Only the poorest who qualify for the sliding scales (where provided) or the wealthy can afford to see providers who can provide mental health resources, diagnoses, and guidance. When a person with mental health issues is taken to the ER, the hospital lacks the ability to care for those who are in a mental health crisis, releasing them back into the same environments that cause the crisis in the first place, unless they can afford to be placed in a mental health facility and can find one who will accept the patient. Additionally there remains a stigma for people who suffer with mental health. In the west, we are supposed to just "man up" and never show weakness, and where weakness is shown, the assumption is that the person is weak, so people often suffer in silence till they have a crisis. – Health Care Provider
>
> There are very few and very limited options for mental health care. – Health Care Provider
>
> High need, limited resources and access to mental health care. Another barrier for many is not wanting to access mental health care in a small community where privacy issues are a concern. – Health Care Provider

Lack of Providers

> Not enough counselors. – Community Leader
>
> Finding someone to go talk to and be treated. – Health Care Provider
>
> We don't have enough mental health practitioners to help those who suffer with mental health. The wait time to see a mental health professional is too long, and the need is too high. – Health Care Provider
>
> Lack of providers, lack of time and availability of when the providers could see clients. The client is not comfortable seeing local providers. – Public Health Representative

Affordable Care/Services

> Lack of affordable mental health services for those without health insurance. – Physician
>
> Most people are unable to get the help they need for mental health due to financial limitations, resources, and lack of education. – Health Care Provider

Access to Care for Uninsured/Underinsured

> Access to those who are underinsured and the inabilty of insurance/noninsured people able to keep paying for continued mental health counseling/medication/inpatient stays. Acute psych is also a problem, nowhere for them to go. No preventative measures like other health problems – Health Care Provider

Comorbidities

> Mental health paired with drug use is a huge problem countrywide. Wyoming has very limited access to help for these individuals. Patients who are titled for their protection at SVH are unable by law to cross state lines to a mental health facility. If we cannot find placement in state (which often we cannot), those patients are taken and held at the county jail for their own protection. There are no high-level mental health providers in our area, such as psychiatry or psychology. Out-of-state providers are impossible to get into in a reasonable timeframe. In my opinion, this is one of the greatest problems we have in our community, and we desperately need more resources. – Health Care Provider

Denial/Stigma

> People in Star Valley have a hard time identifying their mental health needs, as it is a stigma in the community. Mental health counseling can be expensive for individuals who do not have insurance. At least 50% of the individuals in counseling stop attending before all the therapy is completed. Transportation or computer (Zoom) knowledge can be difficult for various populations, and people do not know how to obtain knowledge of resources to help them. If they do go to therapy, they have a hard time (or do not know) what services are offered if they are not thoroughly explained. There are not enough mental health counselors that live in Star Valley, and it is hard for them to move here as the prices of living are very high; therefore, we have burned-out counselors (doctors, nurses, etc.) trying to provide their best services, but cannot. – Health Care Provider

Follow Up/Support

> Support during and through their counseling, outside of the counselor or medical facility. – Community Leader

Lack of Confidentiality/Privacy

> Confidentiality concerns from local providers in a rural setting. Two-hour drive for most mental health resources. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

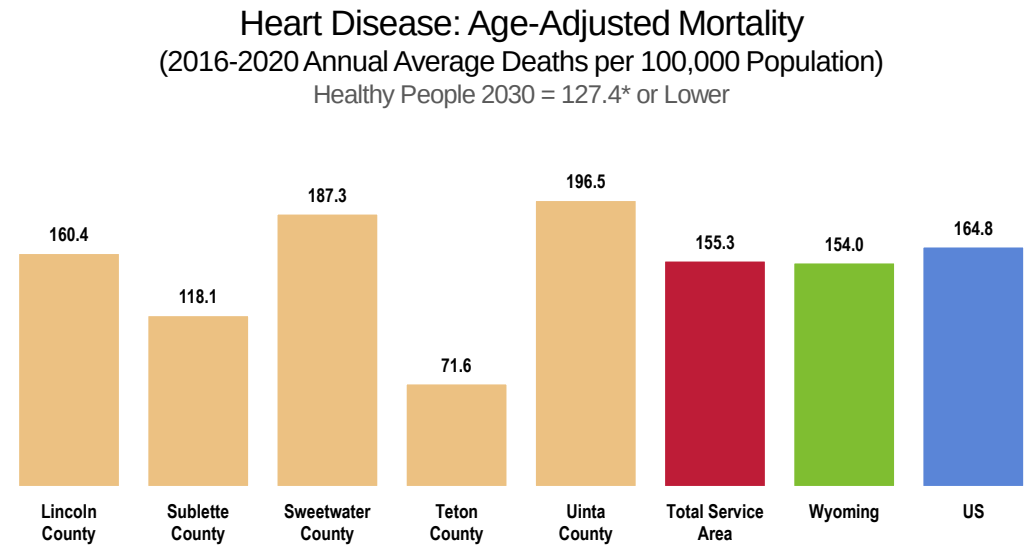
Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

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

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

Heart Disease Deaths

Heart disease is a leading cause of death in the Total Service Area and throughout the United States. The chart that follows illustrates how our (age-adjusted) mortality rate compares to rates in Wyoming and the US.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- *The Healthy People 2030 objective for coronary heart disease has been adjusted here to account for all diseases of the heart.

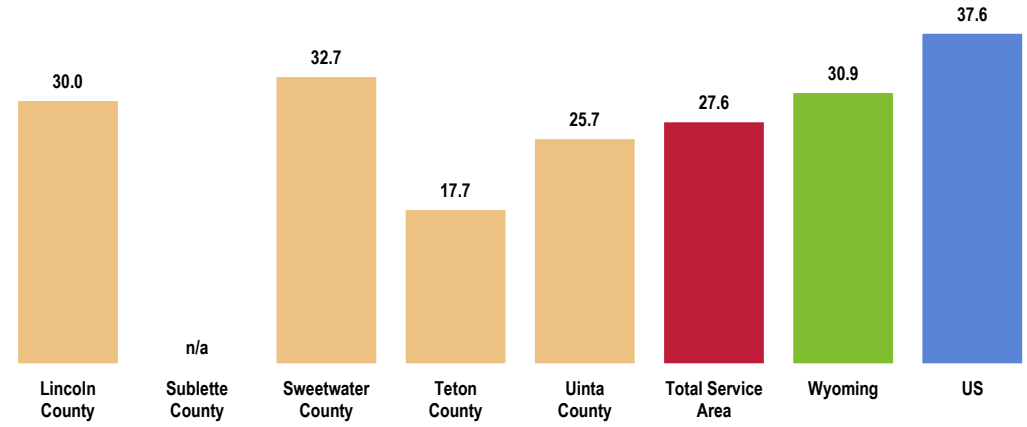
Stroke Deaths

Stroke, a leading cause of death in the Total Service Area and throughout the nation, shares many of the same risk factors as heart disease. Outlined in the following chart is a comparison of stroke mortality locally, statewide, and nationally.

Stroke: Age-Adjusted Mortality

(2016-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Blood Pressure & Cholesterol

The following chart illustrates the percentages of Total Service Area adults who have been told that they have high blood pressure or high cholesterol, known risk factors for cardiovascular disease.

The CDC's Behavioral Risk Factor Survey asked:

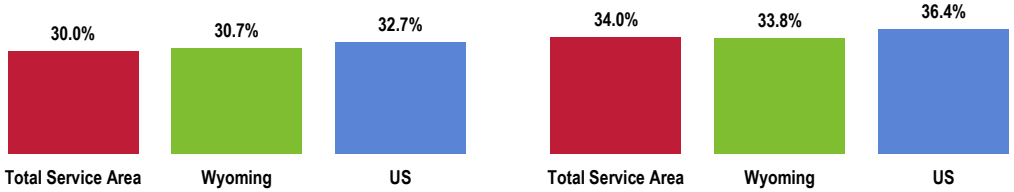
"Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?"

"Have you ever been told by a doctor, nurse, or other health professional that your cholesterol is high?"

Prevalence of High Blood Pressure (2021)

Healthy People 2030 = 42.6% or Lower

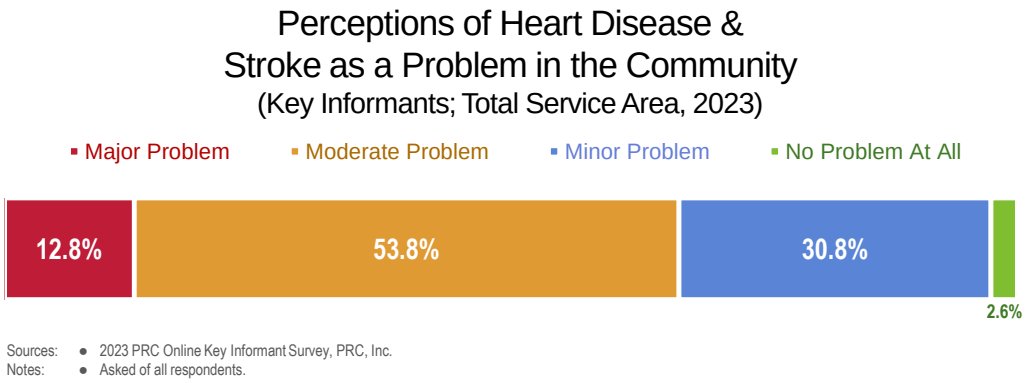
Prevalence of High Blood Cholesterol (2021)



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Heart Disease & Stroke

Outlined below are key informants' levels of concern for *Heart Disease & Stroke* as an issue in the Total Service Area.



Top Concerns

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

Lifestyle

> Diet and lifestyle play a big role. Also, our snowbird community coming from sea level to 6,000 feet each spring. – Community Leader
>
> A lot of people, including myself, don't pay attention to nutrition and what they are eating, leading to heart disease. This can impact other health problems, including mental health. – Health Care Provider

Aging Population

> Because of our large senior/elderly population. – Physician

Incidence/Prevalence

> Heart disease and stroke are prevalent in every community, and our community is no exception. Nowhere to exercise in the community right now exists, so it is hard for people to exercise during the winter months and too cold and too dangerous with the ice and snow, especially for the elderly population. – Community Leader

CANCER

ABOUT CANCER

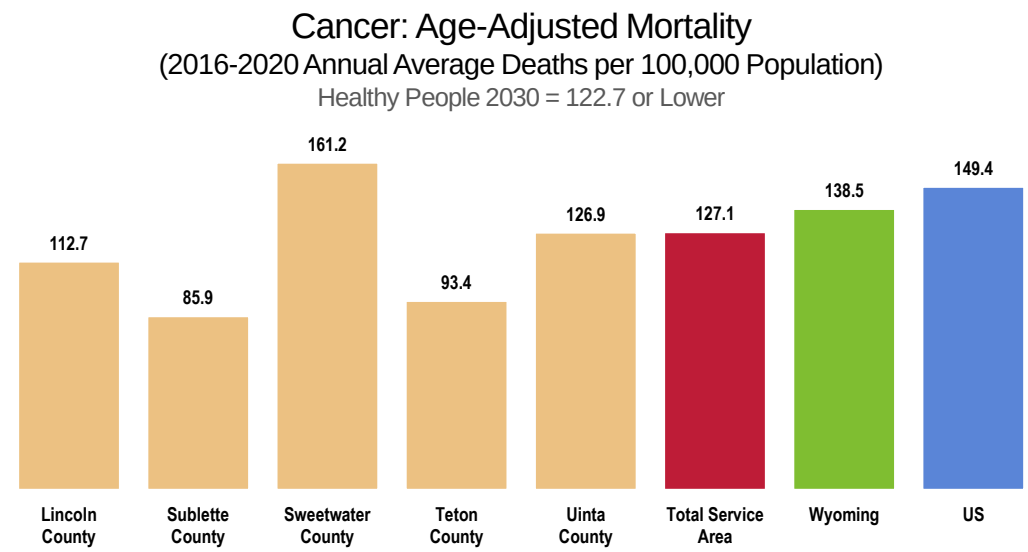
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are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

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

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

Age-Adjusted Cancer Deaths

Cancer is a leading cause of death in the Total Service Area and throughout the United States. Age-adjusted cancer mortality rates are outlined below.



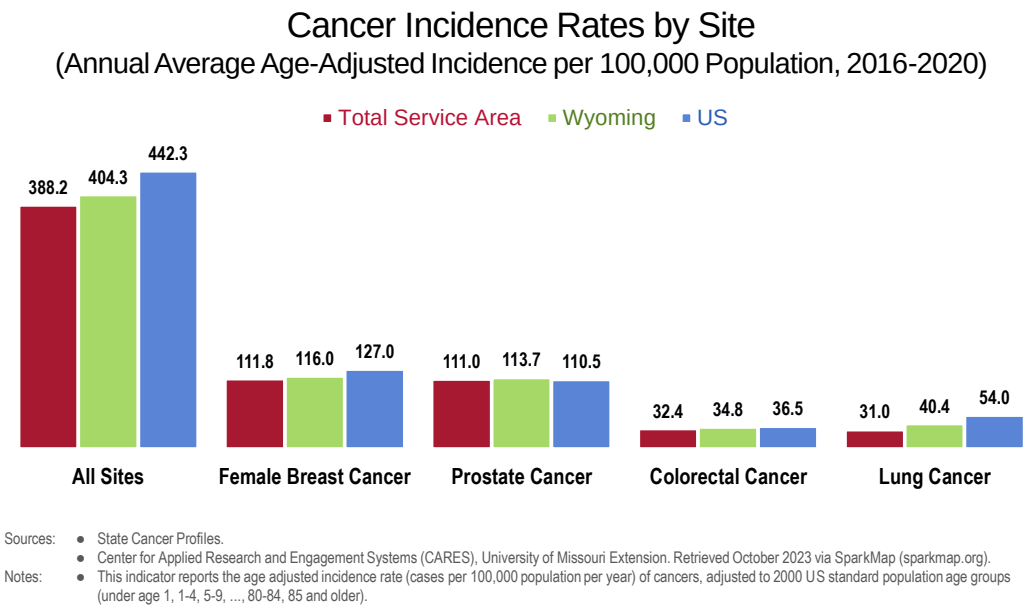
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer Incidence

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

It is important to identify leading cancers by site in order to better address them through targeted intervention. The following chart illustrates the Total Service Area incidence rates for leading cancer sites.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older).

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

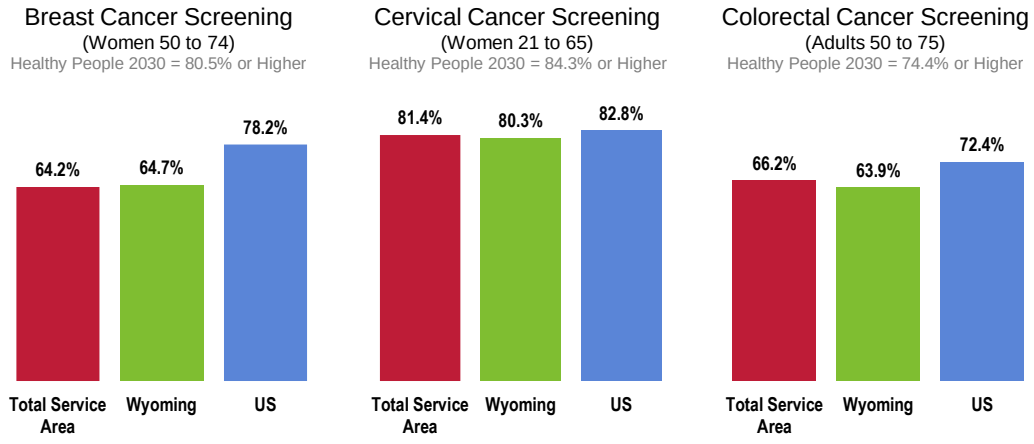
COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

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

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

The following outlines the percentages of residents receiving these age-appropriate cancer screenings. These are important preventive behaviors for early detection and treatment of health problems. Low screening levels can highlight a lack of access to preventive care, a lack of health knowledge, or other barriers.

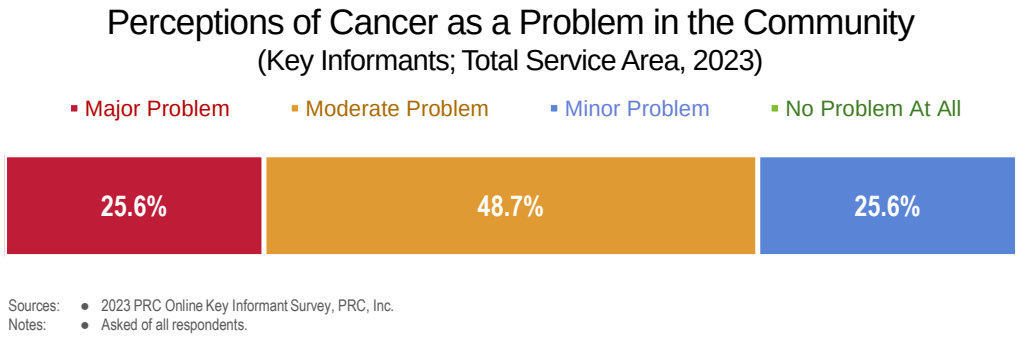


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the age group specified. Breast cancer screenings are mammograms among females age 50-74 in the past 2 years. Cervical cancer screenings are Pap smears among women 21-65 in the past 3 years. Colorectal cancer screenings include the percentage of population age 50-75 years who report having had 1) a fecal occult blood test (FOBT) within the past year, 2) a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or 3) a colonoscopy within the past 10 years.

Key Informant Input: Cancer

Key informants' perceptions of *Cancer* as a local health concern are outlined below.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Incidence/Prevalence

> I can think of many cases of cancer in the community. It seems like a high level. – Health Care Provider
>
> In the population that I am familiar with, we have a high prevalence of cancer. I don't know the exact number of residents who have cancer to compare it to the national averages, but it does seem like we have a lot. – Health Care Provider
>
> It seems that proportionally, we have higher rates of cancer. I would like to see the data that addresses this. My beliefs are completely from personal observation. – Community Leader
>
> It seems the number and severity of cancer cases, including death from cancer, are high for such a small community. Services for cancer treatment requires travel to a larger community. – Community Leader
>
> It's an issue of concern I hear often from our community. I don't know how we compare in cases to other communities our size. However, I would guess that everyone knows or has someone close who is fighting or recovering from cancer. – Community Leader

Distance to Care

> If you have a cancer diagnosis, most people will have to travel out of town to see their oncologist, and most will travel out of town for treatments. It's costly for cancer treatment in our community. – Public Health Representative
>
> We have a lot of community members that are being dx with cancer and just not a lot of resources available here. We can do infusions, but we do not have medical professionals for cancer patients. The patients have to drive hours away for medical care. We do not have a lot of resources for in-home help. – Health Care Provider
>
> Star Valley residents must travel out of state, a minimum of 90 minutes, to reach a cancer specialist. Often farther. (Salt Lake is roughly four hours away.) They are also often directed to go out of state for biopsies. Like all communities, cancer is a large issue here. – Health Care Provider

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

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

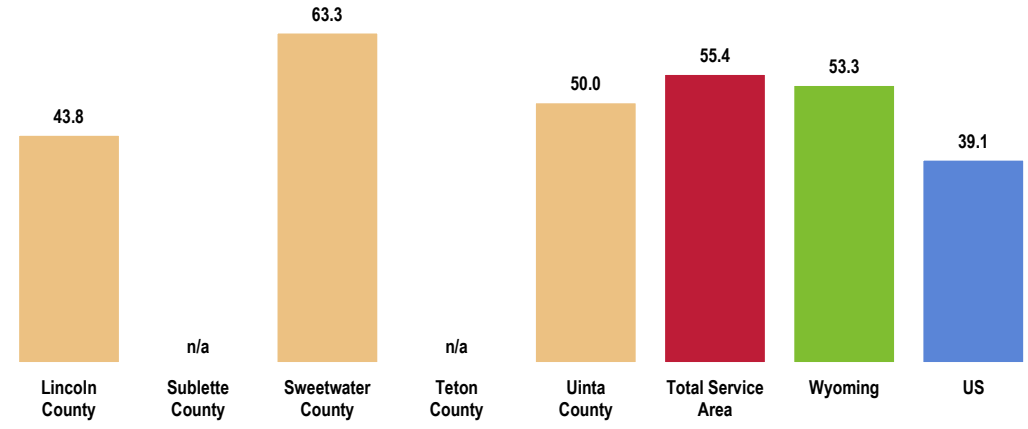
– Healthy People 2030 (https://health.gov/healthypeople)

Note that this section also includes data relative to COVID-19 (coronavirus disease).

Lung Disease Deaths

Note: Here, lung disease reflects chronic lower respiratory disease deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

The mortality rate for lung disease in the Total Service Area is summarized below, in comparison with Wyoming and national rates.

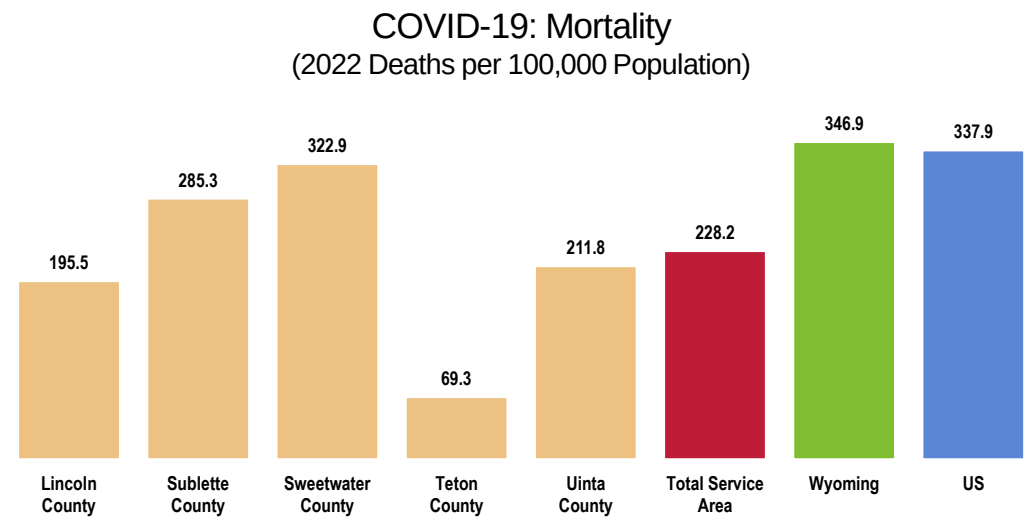


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

COVID-19 (Coronavirus Disease) Deaths

The mortality rate for COVID-19 in the Total Service Area is summarized below, in comparison with Wyoming and national rates.



Sources:
- Johns Hopkins University. Accessed via ESRI. Additional data analysis by CARES. 2022.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

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

Asthma Prevalence

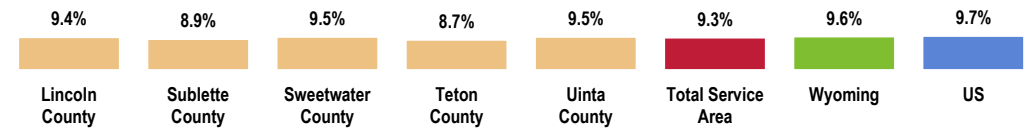
The following chart shows the prevalence of asthma among Total Service Area adults.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had asthma?"

"Do you still have asthma?"

Prevalence includes those responding "yes" to both.



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

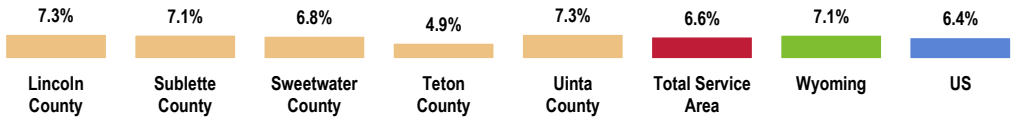
COPD Prevalence

The following chart shows the prevalence of chronic obstructive pulmonary disease (COPD) among Total Service Area adults.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had COPD (chronic obstructive pulmonary disease), emphysema, or chronic bronchitis?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)
(2021)



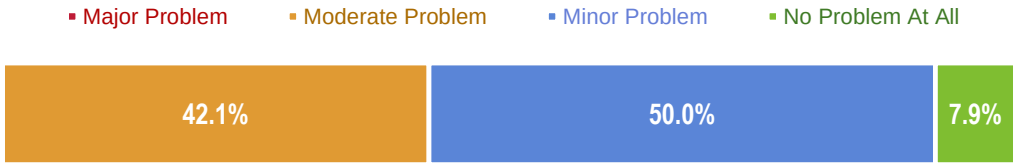
Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- Includes those who have ever been diagnosed with chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis.

Key Informant Input: Respiratory Disease

The following outlines key informants' perceptions of *Respiratory Disease* in our community.

Perceptions of Respiratory Disease as a Problem in the Community
(Key Informants; Total Service Area, 2023)



Sources:
- 2023 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

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

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

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

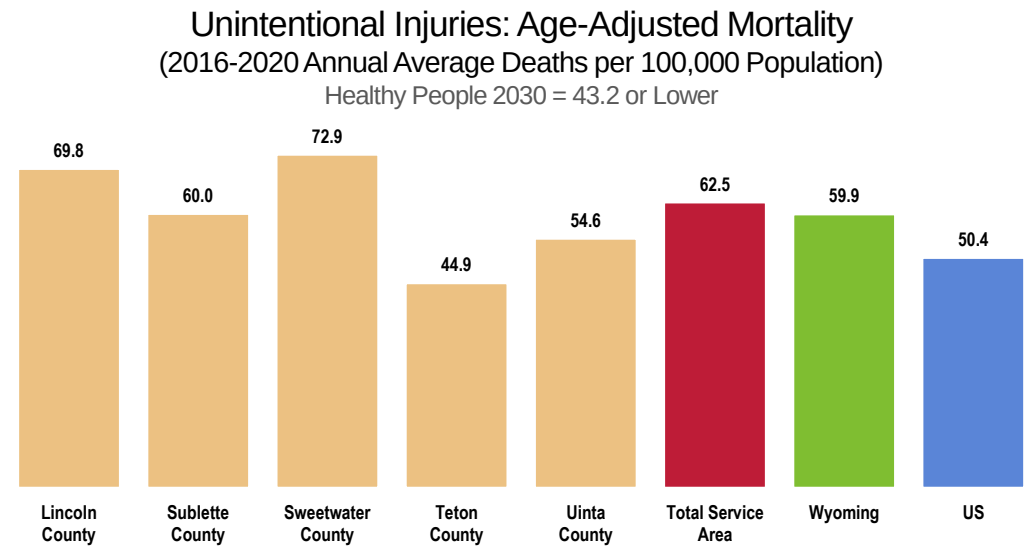
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Unintentional injury is a leading cause of death. The chart that follows illustrates unintentional injury death rates for the Total Service Area, Wyoming, and the US.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

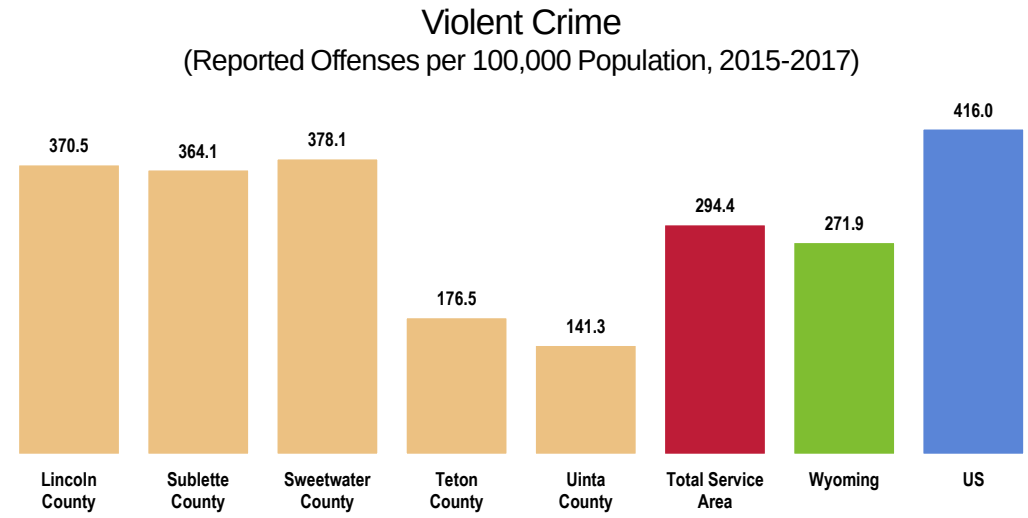
Intentional Injury (Violence)

Violent Crime Rate

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

The following chart shows the rate of violent crime per 100,000 population in the Total Service Area, Wyoming, and the US.

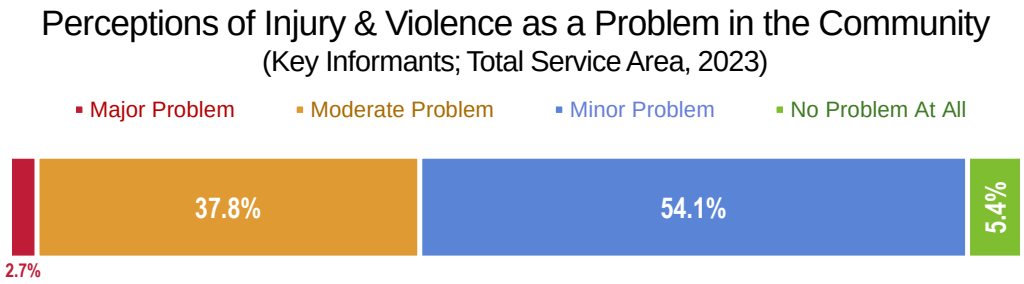


Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, forcible rape, robbery, and aggravated assault.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Key Informant Input: Injury & Violence

Key informants' perceptions of *Injury & Violence* in our community:



Sources:
- 2023 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Domestic/Family Violence

> Our police officers are called out to more and more incidents in homes, and other places, due to violence, and some include injuries. I have been on the suicide and drug coalition, and the number of times officers are called out have been calculated. – Health Care Provider

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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

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

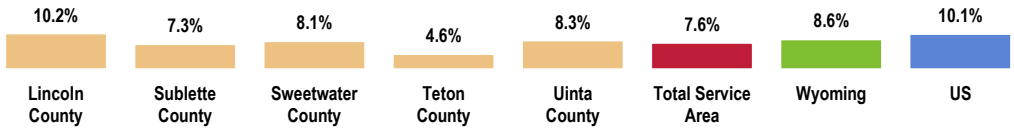
Prevalence of Diabetes

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had diabetes?"

Diabetes is a prevalent and long-lasting (chronic) health condition with a number of adverse health effects, and it may indicate an unhealthy lifestyle. The prevalence of diabetes among Total Service Area adults age 20 and older is outlined below, compared to state and national prevalence levels.

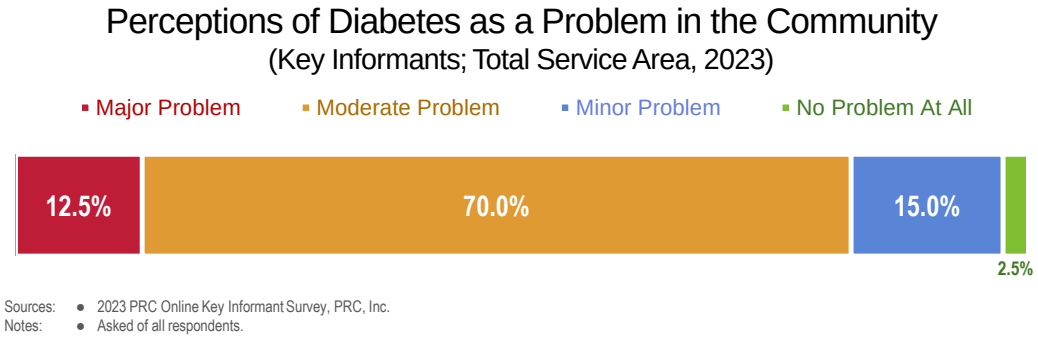
Prevalence of Diabetes
(Adults Age 20 and Older; 2019)



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Key Informant Input: Diabetes

The following are key informants' ratings of *Diabetes* as a health concern in the Total Service Area.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Access to Care/Services

> Appropriate services. – Community Leader
>
> No registered dietician available to do diet counseling. No registered nurse in the clinic to do diabetic education. – Community Leader
>
> As a parent of a type 1 diabetic, we have to travel to Idaho Falls regularly to receive care. With type 1 numbers on the rise, it would be a service to the community to have a specialist in the valley. – Community Leader

Awareness/Education

> Education, access to daily testing materials, affordable prescriptions, and affordable healthy foods. – Health Care Provider

Lack of Providers

> No local providers. – Community Leader

Nutrition & Physical Activity

> Proper nutrition and regular exercise. – Community Leader

DISABLING CONDITIONS

ABOUT DISABILITY & HEALTH

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

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

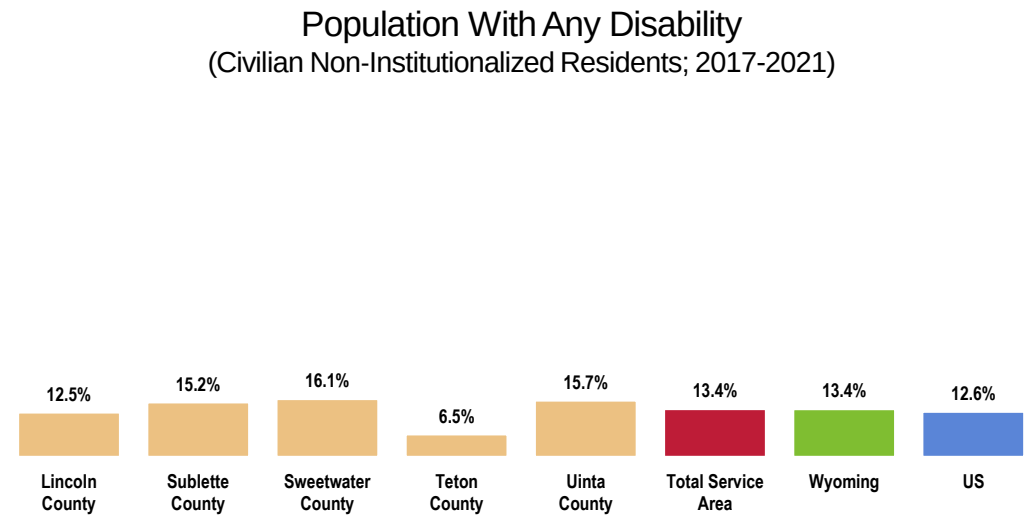
– Healthy People 2030 (https://health.gov/healthypeople)

Disability

Disability data come from the US Census Bureau's American Community Survey (ACS), Survey of Income and Program Participation (SIPP), and Current Population Survey (CPS). All three surveys ask about six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent-living difficulty.

Respondents who report any one of the six disability types are considered to have a disability.

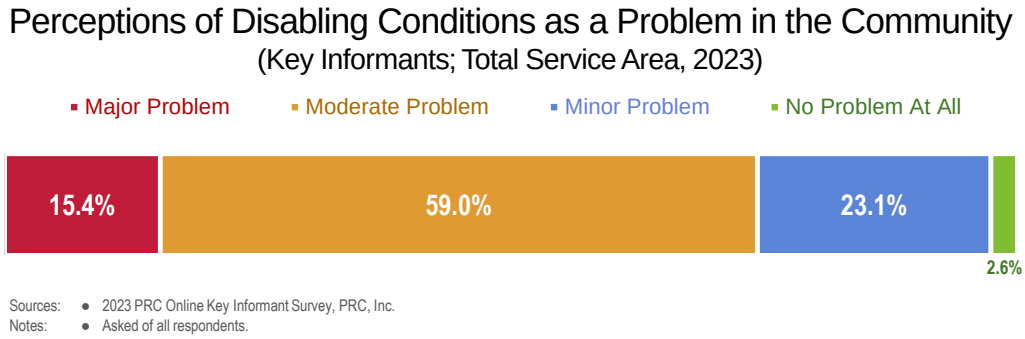
The following represents the percentage of the total civilian, non-institutionalized population in the Total Service Area with a disability. This indicator is relevant because disabled individuals may comprise a vulnerable population that requires targeted services and outreach.



Sources:
- US Census Bureau, American Community Survey.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Key Informant Input: Disabling Conditions

Key informants' perceptions of *Disabling Conditions* are outlined below.



Top Concerns

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

Access to Care/Services

> We don't have the ability to care for advanced dementia/Alzheimer's. These people need a lockdown unit; we don't have the ability to do this. Some disabling conditions require more advanced care and specialists, and they have to travel out of town for care. Loss of vision – most travel out of town for injections, or for cataract surgery. – Public Health Representative
>
> We do not have many resources for in-home help. All resources that we have are just short-term and private pay. A lot of the community members are on fixed incomes and can't afford the private care. We have no dementia facilities or resources. We do not have 24/7 care for people who have disabling conditions. – Health Care Provider
>
> Limited access to resources and information. – Health Care Provider

Aging Population

> The community is an older community with a lot of elderly people. – Community Leader
>
> Our community has a large population that is older than the age of 65 years old, so the prevalence of disabling conditions, like activity limitations, dementia, loss of vision/hearing and chronic pain, are also increasing. – Physician

Housing

> Rural living; lack of housing, very limited accessible housing for disabilities, rising costs and taxes, limited resources, and great distances for people to get to accommodations, including stores/providers. Weather in the winter is also very limiting for those that don't have great mobility. – Health Care Provider

BIRTHS

BIRTH OUTCOMES & RISKS

ABOUT INFANT HEALTH

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

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

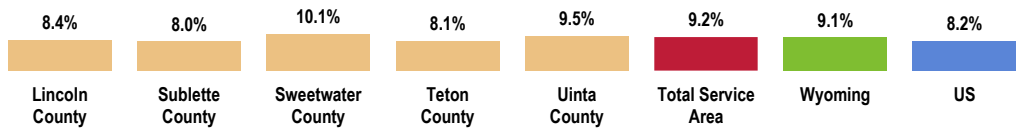
– Healthy People 2030 (https://health.gov/healthypeople)

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. The following chart illustrates the percent of total births that are low birth weight.

Low-Weight Births
(Percent of Live Births, 2014-2020)



Sources: ● University of Wisconsin Population Health Institute, County Health Rankings.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g).

FAMILY PLANNING

ABOUT FAMILY PLANNING

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

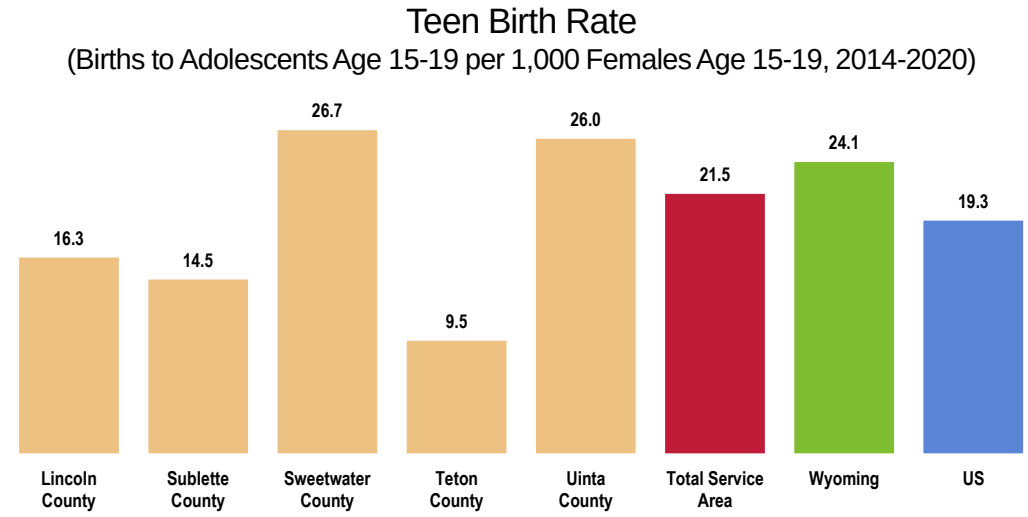
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

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

Births to Adolescent Mothers

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

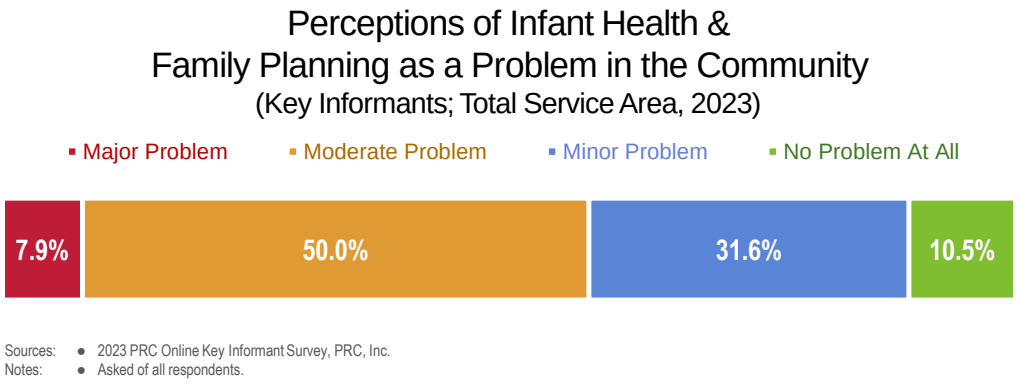
The following chart outlines the teen birth rate in the Total Service Area, compared to rates statewide and nationally. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Key Informant Input: Infant Health & Family Planning

Key informants' perceptions of *Infant Health & Family Planning* as a community health issue are outlined below.



Top Concerns

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

Lack of Providers

> I don't think that infant health and family planning are a major problem in the community. They can have some challenges due to no pediatrician in the community. – Community Leader

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

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

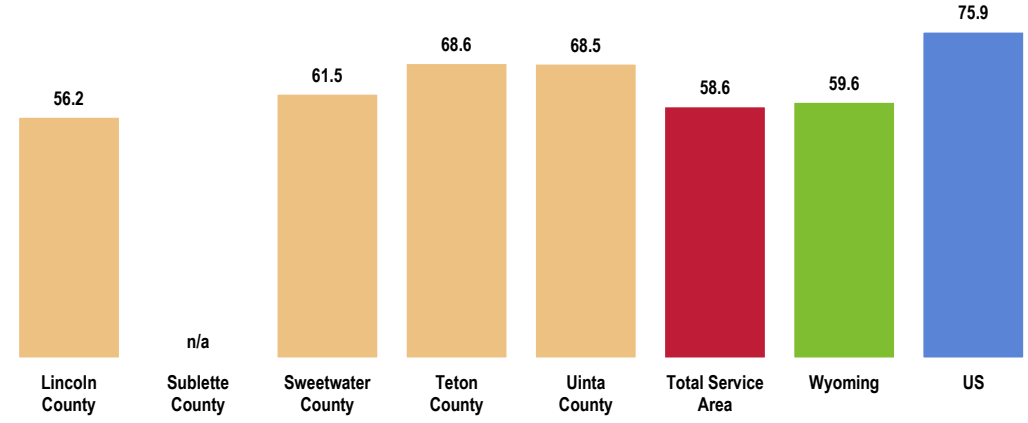
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

Food Environment: Fast Food

Here, fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating.

The following shows the number of fast food restaurants in the Total Service Area, expressed as a rate per 100,000 residents. This indicator provides a measure of healthy food access and environmental influences on dietary behavior.



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

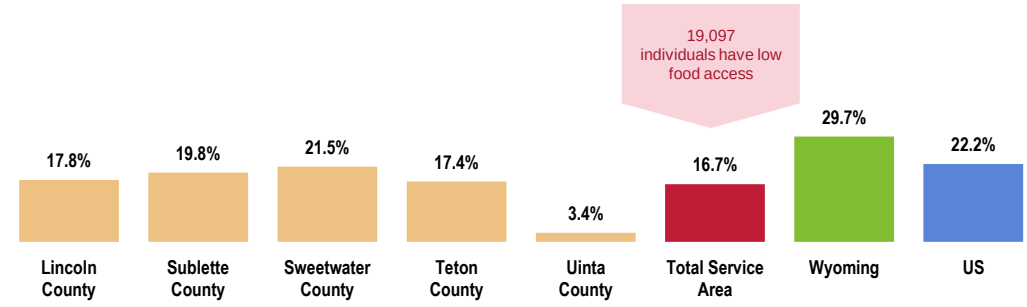
Low Food Access

Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store (or 10 miles in rural areas).

The following chart shows US Department of Agriculture data determining the percentage of Total Service Area residents found to have low food access, meaning that they do not live near a supermarket or large grocery store.

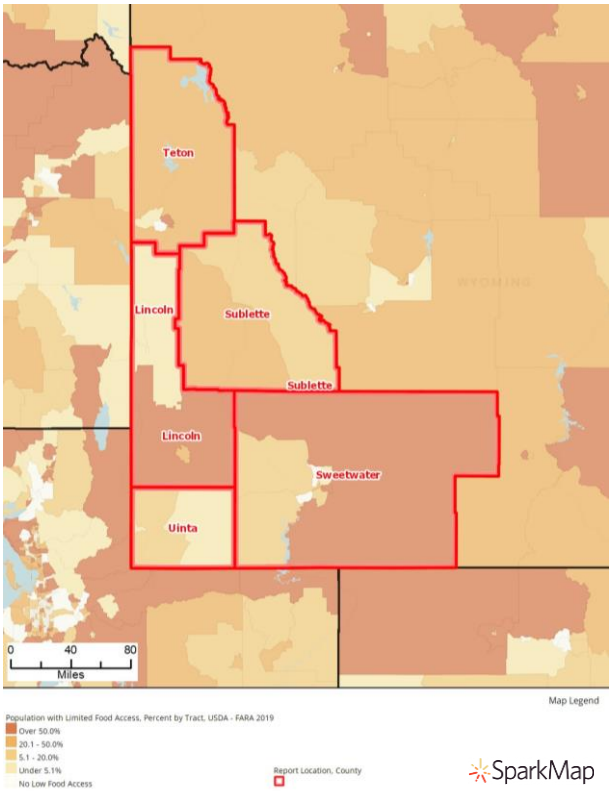
Population With Low Food Access

(Percent of Population Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.



PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

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

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

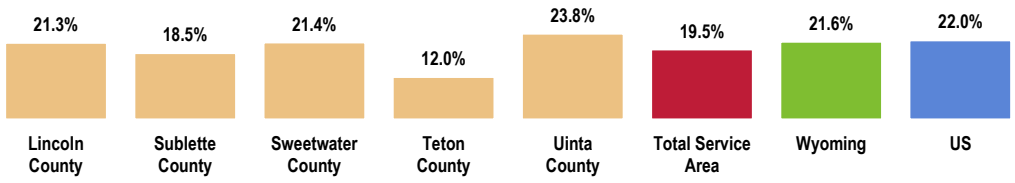
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

Below is the percentage of Total Service Area adults age 20 and older who report no leisure-time physical activity in the past month. This measure is important as an indicator of risk for significant health issues such as obesity or poor cardiovascular health.

No Leisure-Time Physical Activity in the Past Month
(Adults Age 20 and Older, 2019)
Healthy People 2030 = 21.8% or Lower



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

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

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

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

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

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

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

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

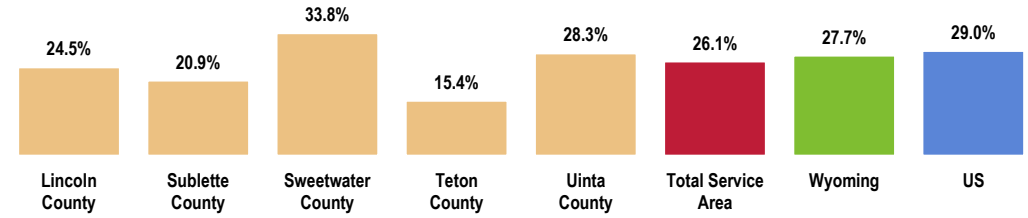
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

Obesity

"Obese" includes respondents with a BMI value ≥30.0.

Outlined below is the percentage of Total Service Area adults age 20 and older who are obese, indicating that they might lead an unhealthy lifestyle and be at risk for adverse health issues.

Prevalence of Obesity
(Adults Age 20 and Older With a Body Mass Index ≥ 30.0, 2019)
Healthy People 2030 = 36.0% or Lower



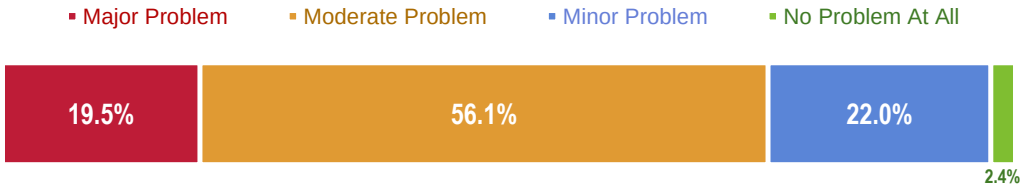
Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Key Informant Input: Nutrition, Physical Activity & Weight

Key informants' ratings of *Nutrition, Physical Activity & Weight* as a community health issue are illustrated below.

Perceptions of Nutrition,
Physical Activity & Weight as a Problem in the Community
(Key Informants; Total Service Area, 2023)



Sources:
- 2023 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Lifestyle

> The abundance of high-calorie, low-nutrient fast foods that are marketed to youth and adults. We need a recreation center with a swimming pool to increase access to physical activity. – Physician
>
> People become overweight due to a host of problems, including inactivity, poor nutrition, physical health problems, mental health issues, etc. They don't know how to follow through with programs that are good for them, or follow through with goals due to the products that are available to them. Some residents do not have sufficient money to deal with these challenges or thwart their progress in various ways. There is also a lack of support groups. – Health Care Provider

Environmental Contributors

> Because of the long, cold winters, I feel that the community could use a free or very low-cost recreational center with an indoor pool. – Health Care Provider
>
> Weather, winters are long and hard, physical activity is limited for such a long period of time. – Community Leader

Awareness/Education

> Education. – Health Care Provider

Poverty

> I believe I underestimated the degree that the social determinants of health, particularly poverty and limited access to healthy food, contributes to poor health in our community. – Physician

Recreation Center

> I feel that the community, due to its long, cold winters, needs an indoor, free or no-cost recreation center that includes a swimming pool. – Community Leader

Social Norms/Community Attitude

> Culture of poor health is a normalcy. Access and desire to have healthier food is not wanted nor sought after. Meat and potatoes in a cheap form and is the norm for individuals and businesses. – Community Leader

SUBSTANCE USE

ABOUT DRUG & ALCOHOL USE

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

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

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

Excessive Alcohol Use

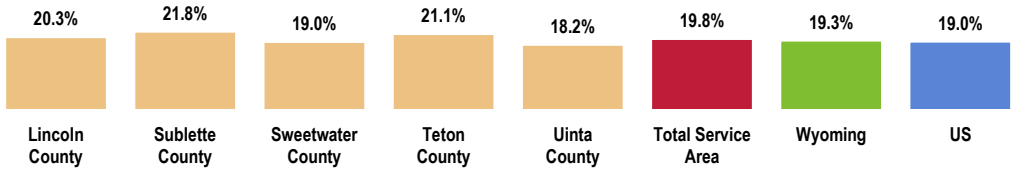
Excessive drinking includes heavy and/or binge drinking:

HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.

BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

The following illustrates the prevalence of excessive drinking in the Total Service Area, as well as statewide and nationally. Excessive drinking is linked to significant health issues, such as cirrhosis, certain cancers, and untreated mental/behavioral health issues.

Engage in Excessive Drinking
(2020)

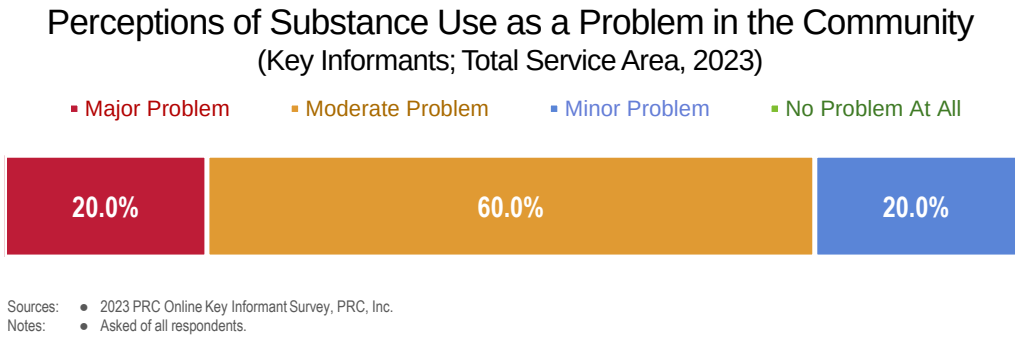


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period.

Key Informant Input: Substance Use

Note the following perceptions regarding *Substance Use* in the community among key informants taking part in an online survey.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Access to Care/Services

> Rural setting, two-hour drive to access most treatment programs. – Community Leader
>
> There is a lack of access to substance abuse counselors. Drug and alcohol use is a big problem in Star Valley, just ask the police. When a person with a substance abuse issue needs detox, there is nowhere to turn, unless the substance is alcohol. The hospital can help an alcoholic detox and then release them, but if the substance is drug-related, the hospital will tell them that there is nothing they can do. Where are those people to turn? Additionally, a person with a substance abuse problem is a person with an underlying mental health problem, which has been touched on in an earlier question. – Health Care Provider
>
> We have no facilities or doctors that specialize in substance abuse. The closest help is hours away, and it is not affordable for non-insured residents. These patients are not getting the help they need because we have no resources available. – Health Care Provider
>
> There is only one agency that offers full substance abuse/mental health services. Most of the time there is a waiting list to get services, and some patients will not stay for services if they don't get right in. Star Valley Health does not advertise substance use/mental health services in the community. Many people cannot obtain them if they do not have insurance. The cost is too high. A lot of clients who need services deny that they do, and do not seek services. – Health Care Provider

Incidence/Prevalence

> I see many people in the emergency room who are smokers, drinkers, and drug users. I also see vehicle accidents caused by people who are under the influence. – Health Care Provider

Most Problematic Substances

Note below which substances key informants (who rated this as a “major problem”) identified as causing the most problems in the Total Service Area.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Use as a “Major Problem”)	
ALCOHOL	38.9%
HEROIN OR OTHER OPIOIDS	22.2%
METHAMPHETAMINE OR OTHER AMPHETAMINES	16.7%
PRESCRIPTION MEDICATIONS	11.1%
MARIJUANA	11.1%

TOBACCO USE

ABOUT TOBACCO USE

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

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

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

Cigarette Smoking Prevalence

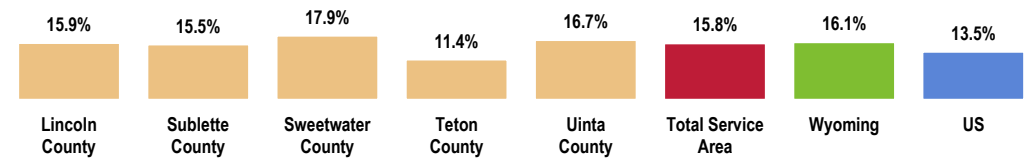
Tobacco use is linked to the two major leading causes of death: cancer and cardiovascular disease. Note below the prevalence of cigarette smoking in our community.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Have you smoked at least 100 cigarettes in your entire life?"

"Do you now smoke cigarettes every day, some days, or not at all?"

Cigarette smoking prevalence includes those who report having smoked at least 100 cigarettes in their lifetime and who currently smoke every day or on some days.

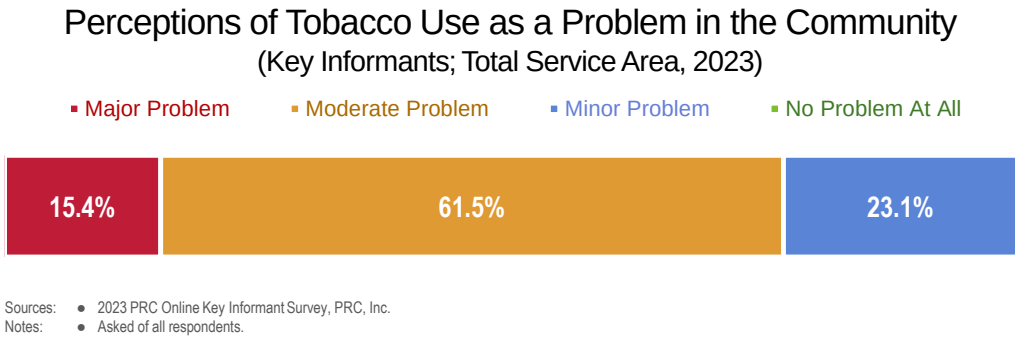


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Includes those who report having smoked at least 100 cigarettes in their lifetime and currently smoke cigarettes every day or on some days.

Key Informant Input: Tobacco Use

Below are key informants' ratings of *Tobacco Use* as a community health concern.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Addiction

> It's highly addictive, and people have a very difficult time stopping once started, even with help. – Health Care Provider

Incidence/Prevalence

> There are still a lot of smokers. – Health Care Provider

Teen/Young Adult Usage

> I thought we had turned a corner with teen tobacco use, then vaping jumped in to fill that void. It would be nice to attack the dangers of vaping aggressively with our youth. – Community Leader

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

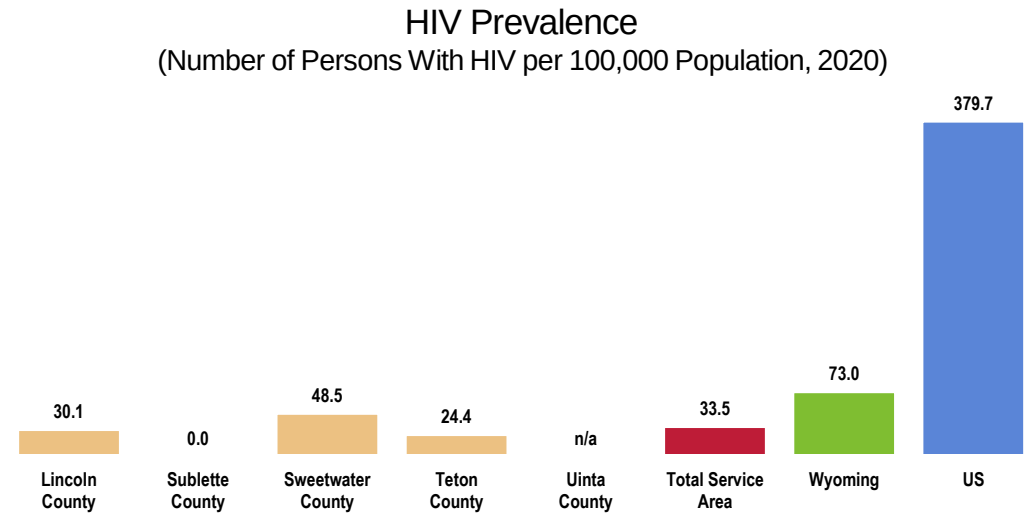
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

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

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

HIV

The following chart outlines the prevalence of HIV in our community, expressed as a rate per 100,000 population. This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

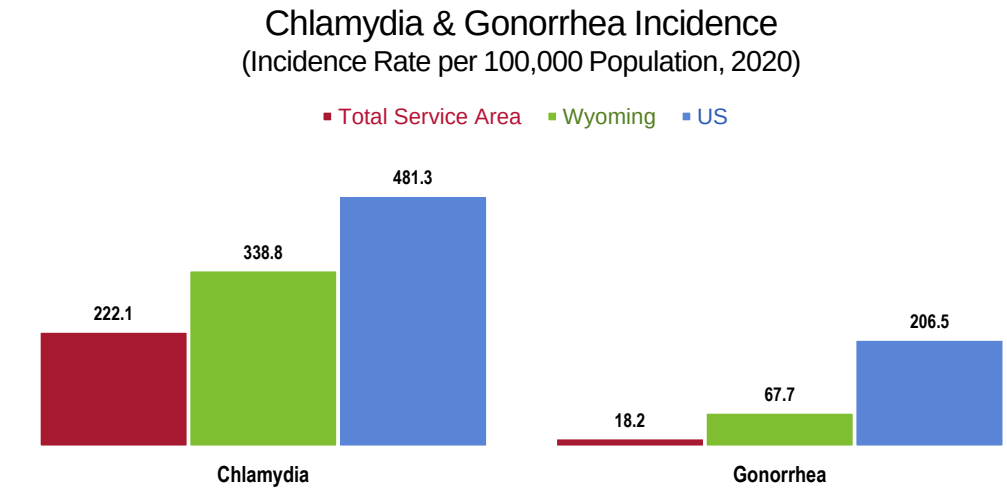


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

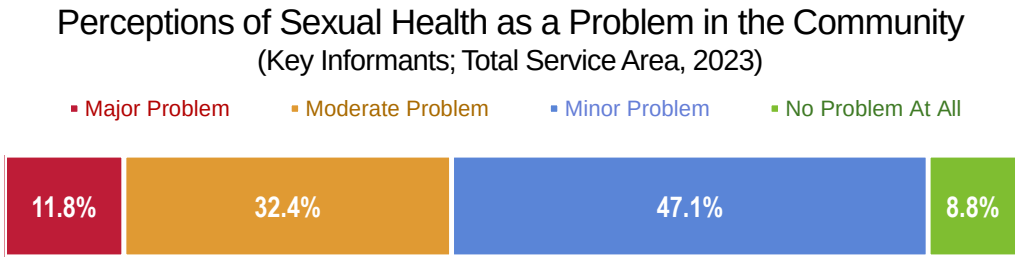
Chlamydia and gonorrhea are reportable health conditions that might indicate unsafe sexual practices in the community. Incidence rates for these sexually transmitted diseases are shown in the following chart.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

Key informants' ratings of *Sexual Health* as a community health concern are shown in the following chart.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Culture/Social Norms

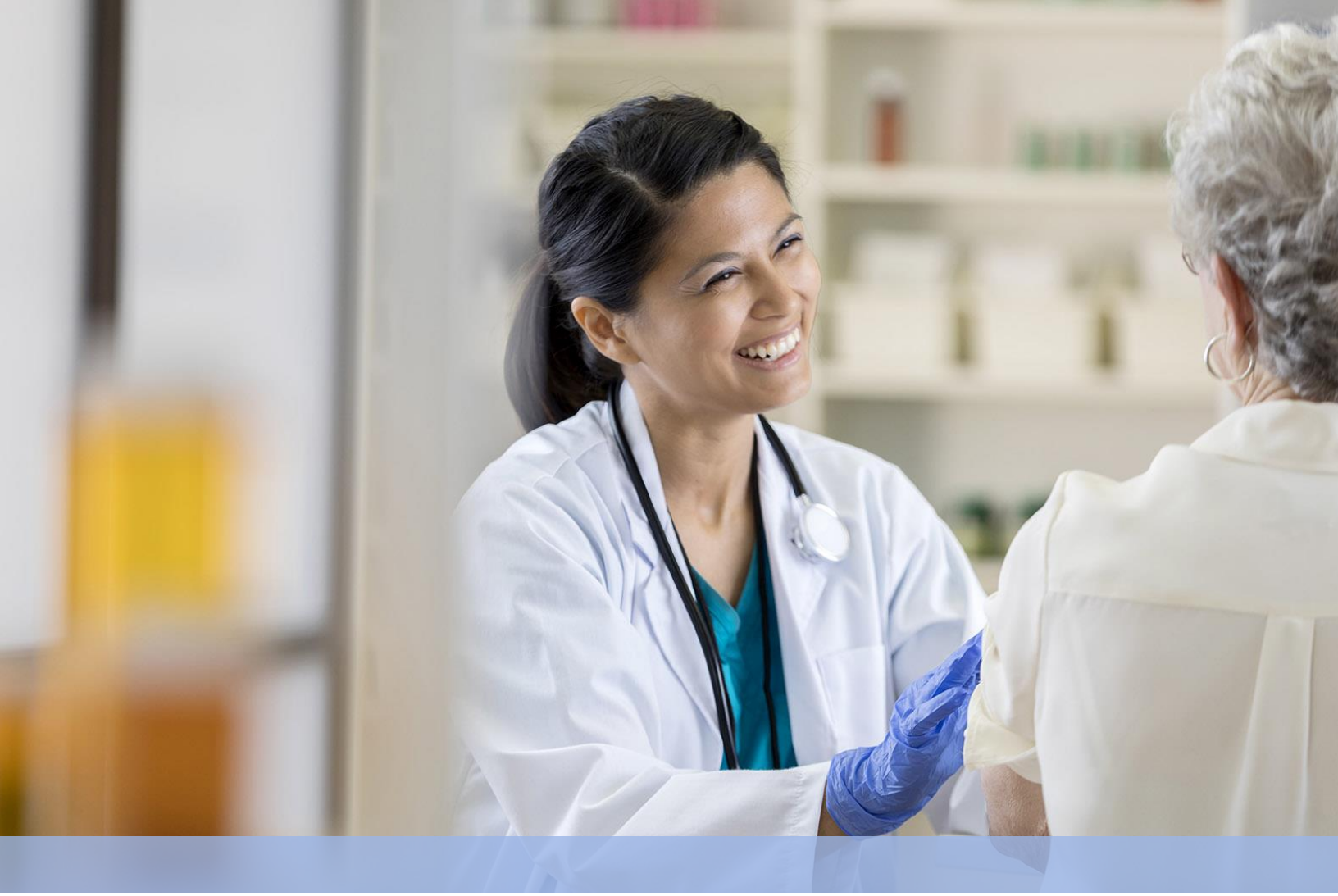
> 1. There are many people who do not believe they need to go to the doctor to take care of their overall health, especially sexual health. Therefore, they are neglected. When I go into a medical chart, I see what tests are needed, and over half represent sexual health. Prevention is not a priority. 2. There is a culture of people within Star Valley who have sex with different people, using no protection, increasing risks of HIV, STDs. This is not just one group of people; it is more than one. – Health Care Provider

Incidence/Prevalence

> Data shows that we have a high incidence of STIs. – Health Care Provider

Lack of Confidentiality/Privacy

> The limit for sexual health in a small community is a concern for privacy. That is the main feedback that I have gotten. – Health Care Provider



ACCESS TO HEALTH CARE

BARRIERS TO HEALTH CARE ACCESS

ABOUT HEALTH CARE ACCESS

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

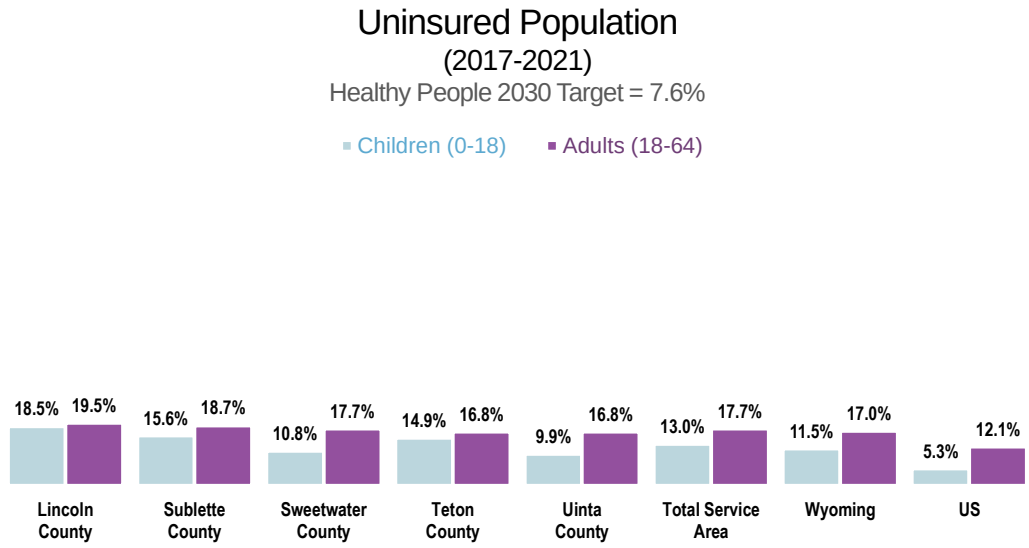
Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication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

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

Lack of Health Insurance Coverage

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

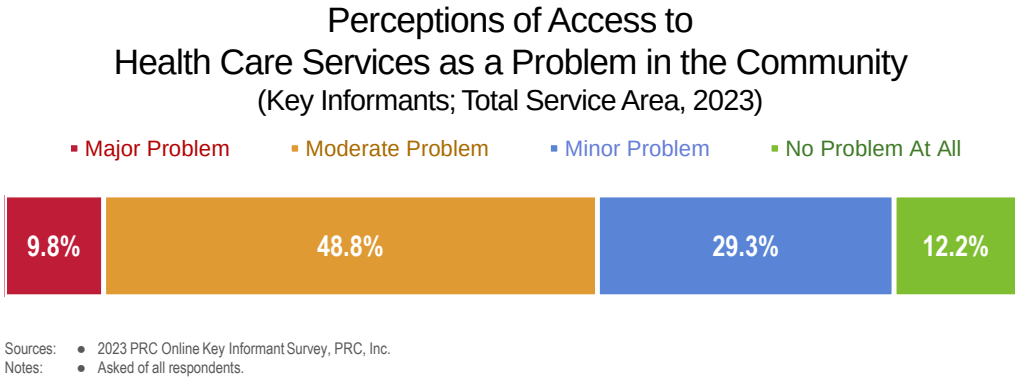
Health insurance coverage is a critical component of health care access and a key driver of health status. The following chart shows the latest figures for the prevalence of uninsured adults (age 18 to 64 years) and of uninsured children (under the age of 19) in the Total Service Area.



Sources:
- US Census Bureau, Small Area Health Insurance Estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Access to Health Care Services

Key informants' ratings of *Access to Health Care Services* as a problem in the Total Service Area is outlined below.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Lack of Providers

> Not having a provider in the clinic consistently. It is frustrating to go into the clinic and expect to see the provider, only to learn that you have to wait for him to come back to the clinic, as he is at home or he is off for the day. – Community Leader
>
> Cost of health care and access to general practitioners. – Community Leader
>
> Typical rural health issues, including medical providers being overwhelmed with high patient loads, and lacking services. – Health Care Provider

Access to Pediatric Care

> Access to pediatric care in all aspects of health. There is no pediatrician at all in our valley. Family practice physicians are wonderful, but many children would benefit from seeing a pediatrician or require a higher level of primary care they must travel out of our valley for. – Health Care Provider
>
> While I feel our providers do their best to meet the needs of all their patients, there are a large number of families with children with special health needs that travel outside of SV for care. While living in Utah, I chose to take my children to a pediatrician, and the experience was far better and more specific to the needs of children than what I've ever received from our PCP at SVH. Overwhelmingly, this is the specialist I hear wanted most at SVH. – Health Care Provider

Distance to Care

> Rural setting results in a two-hour drive for accessing most health care services. – Community Leader

Access to Primary Health Care

> Access to primary health care is a major concern. It shouldn't take patients four to six weeks to schedule an appointment with their primary health care provider. – Community Leader

Geriatric Resources

> Geriatric resources. – Health Care Provider

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

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

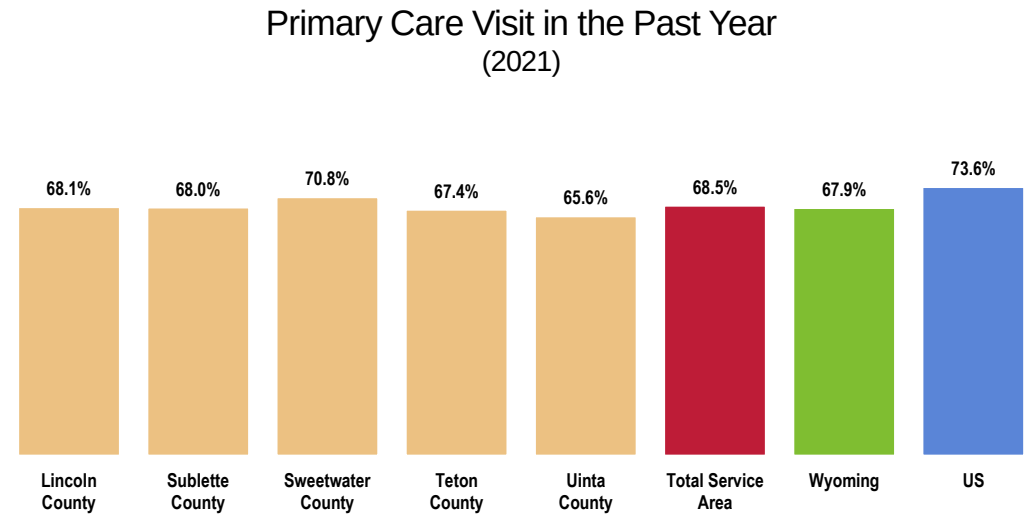
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't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

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

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

Primary Care Visits

The following chart reports the percentage of Total Service Area adults who visited a doctor for a routine checkup in the past year.



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

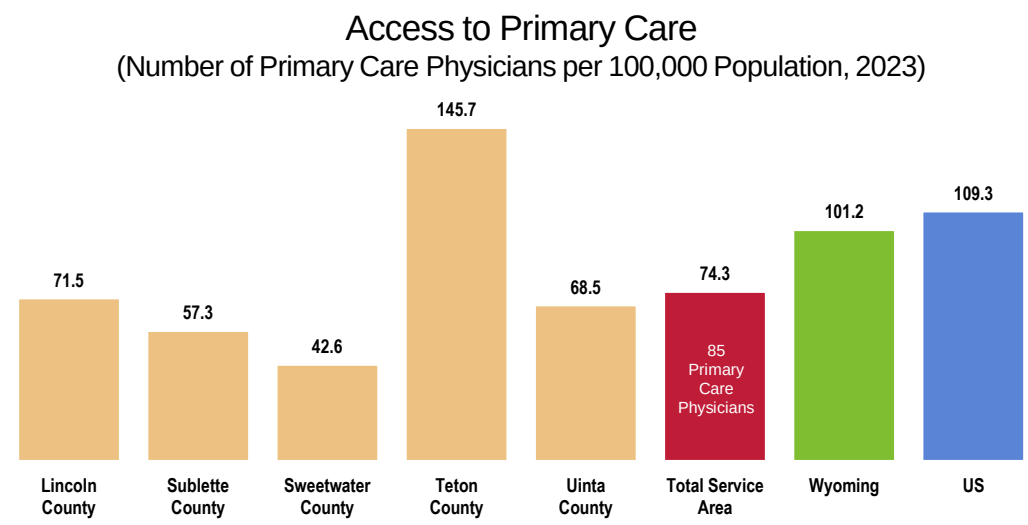
Notes:
- This indicator reports the number and percentage of adults age 18 and older with one or more visits to a doctor for routine checkup within the past one year.

Access to Primary Care

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

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

The following indicator outlines the number of primary care physicians per 100,000 population in the Total Service Area. Having adequate primary care practitioners contributes to access to preventive care.



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

ORAL HEALTH

ABOUT ORAL HEALTH

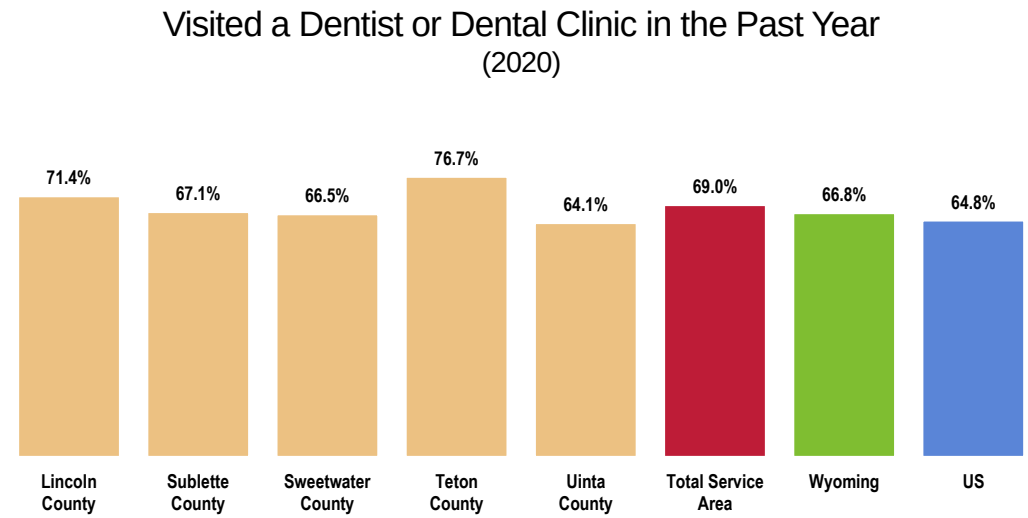
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems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

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

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

Dental Visits

The following chart shows the percentage of Total Service Area adults age 18 and older who have visited a dentist or dental clinic in the past year.

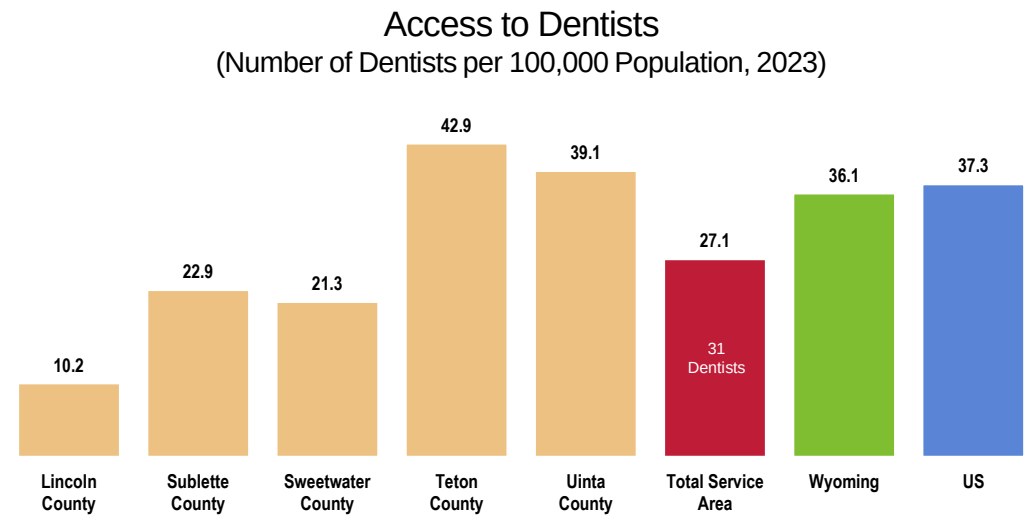


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Access to Dentists

This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD), who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

The following chart outlines the number of dentists for every 100,000 residents in the Total Service Area.

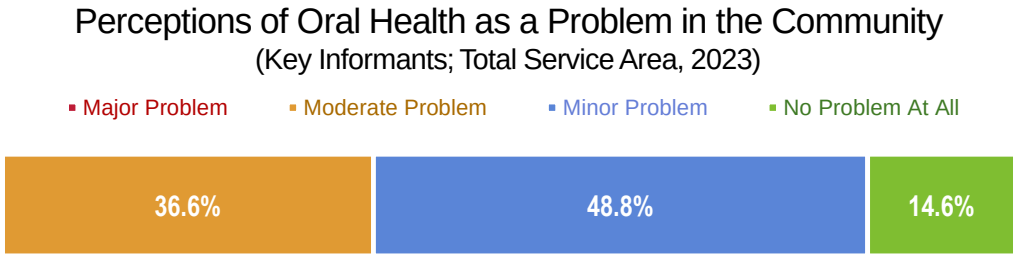


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2023 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the number of dentists per 100,000 population. This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD) — who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

Key Informant Input: Oral Health

Key informants' perceptions of *Oral Health* are outlined below.



Sources:
- 2023 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

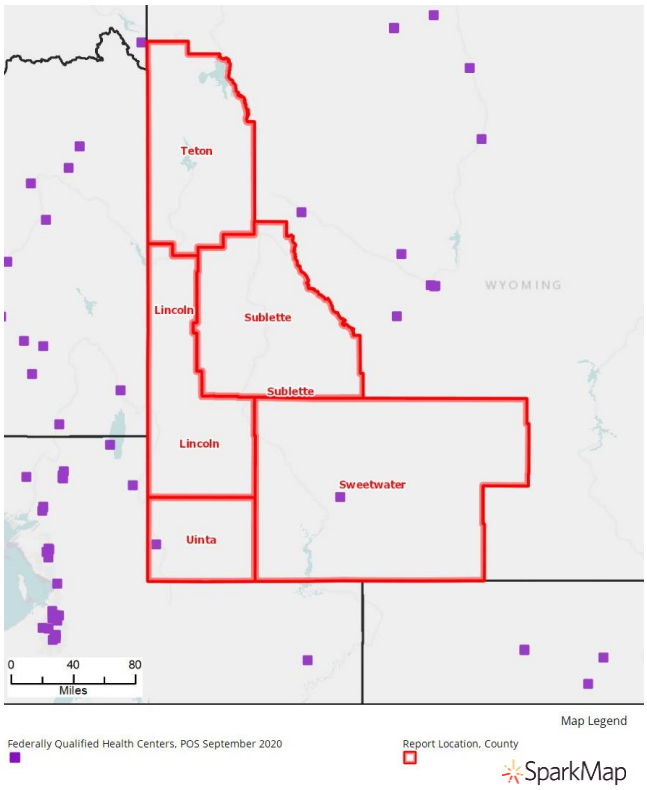
LOCAL RESOURCES

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

FQHCs are community assets that provide health care to vulnerable populations; they receive federal funding to promote access to ambulatory care in areas designated as medically underserved.

The following map details Federally Qualified Health Centers (FQHCs) within the Total Service Area.



Resources Available to Address Significant Health Needs

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

Access to Health Care Services

- Department of Family Services
- Doctors' Offices
- High Country Behavioral Health
- Lincoln County School District #2
- Online Resources
- Star Valley Health
- Urgent Care

Cancer

- Easter Idaho Regional Medical Center
- Home Health Agencies
- Huntsman Cancer Center
- IHC Hospital
- LDS Hospital
- Lyman Clinic
- Mountain View Clinic
- St. John Hospital
- Star Valley Health
- University of Utah Medical Center
- Urgent Care
- Wyoming Cancer Program

Diabetes

- Evanston Regional Hospital
- Hospitals
- IHC Hospital
- LDS Hospital
- Nutrition Services
- Parks and Recreation
- School System
- Star Valley Health
- University of Utah Medical Center

Disabling Conditions

- Department of Family Services
- Doctors' Offices
- Home Health Agencies
- Lincoln County School District #2
- Physical Therapy Offices
- Senior Citizen Center
- Star Valley Health
- Star Valley Medical Supply
- Vision - Voss

Heart Disease & Stroke

- Department of Family Services
- Doctors' Offices
- Easter Idaho Regional Medical Center
- Hospitals
- Radiology Services
- Senior Citizen Center
- Simply Cent$ible Nutrition
- St. John Hospital
- Star Valley Health
- WIC

Infant Health & Family Planning

- Doctors' Offices

Injury & Violence

- High Country Behavioral Health
- Star Valley Health
- Town of Afton Police Department
- Women's Shelter

Mental Health

- Afton Clinic
- Churches
- Community Case Manager
- Counseling Services
- Doctors' Offices
- Frontier Counseling
- Health Department
- High Country Behavioral Health
- Pioneer Counseling
- Private Practice Therapists

- School System
- Star Valley Health
- Therapists
- Uinta Counseling
- Uinta County Prevention
- Wyoming State Hospital

Nutrition, Physical Activity & Weight

- Evanston Recreation Center
- Evanston Regional Hospital
- Fitness Centers/Gyms
- Grocery Stores
- Hospitals
- Local Farms
- Online Resources
- Parks and Recreation
- Peak Fitness
- Physical Therapy Offices
- School System
- Simply Cent$ible Nutrition
- Star Valley Health

Sexual Health

- Azar House
- Health Department
- Lyman Clinic
- Mountain View Clinic
- Public Health
- Star Valley Health
- Urgent Care

Social Determinants of Health

- Afton Food Bank
- Alpine Food Bank
- Bus
- Child Development Centers
- City Council
- CLIMB Wyoming
- Department of Family Services
- EBT
- High Country Behavioral Health
- School System
- Star Valley Health
- Subsidized Units
- Thayne Food Bank

Substance Use

- AA/NA
- Churches
- Counseling Services
- High Country Behavioral Health
- Lincoln County Courts
- Probation and Parole
- Star Valley Health
- Town of Afton Police Department

Tobacco Use

- Government
- Health Department
- Online Resources
- Quit Now
- Religious Organizations
- School System
- Star Valley Health

APPENDIX

EVALUATION OF PAST ACTIVITIES

As the first Community Health Needs Assessment completed pursuant to IRS regulations, Star Valley Health will evaluate actions taken to address the needs identified in this assessment from this point forward