2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Daniels, Phillips, Roosevelt & Valley Counties, Montana

Sponsored by

FRANCES MAHON DEACONESS HOSPITAL

2022-1620-02

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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 the four-county service area of Frances Mahon Deaconess Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

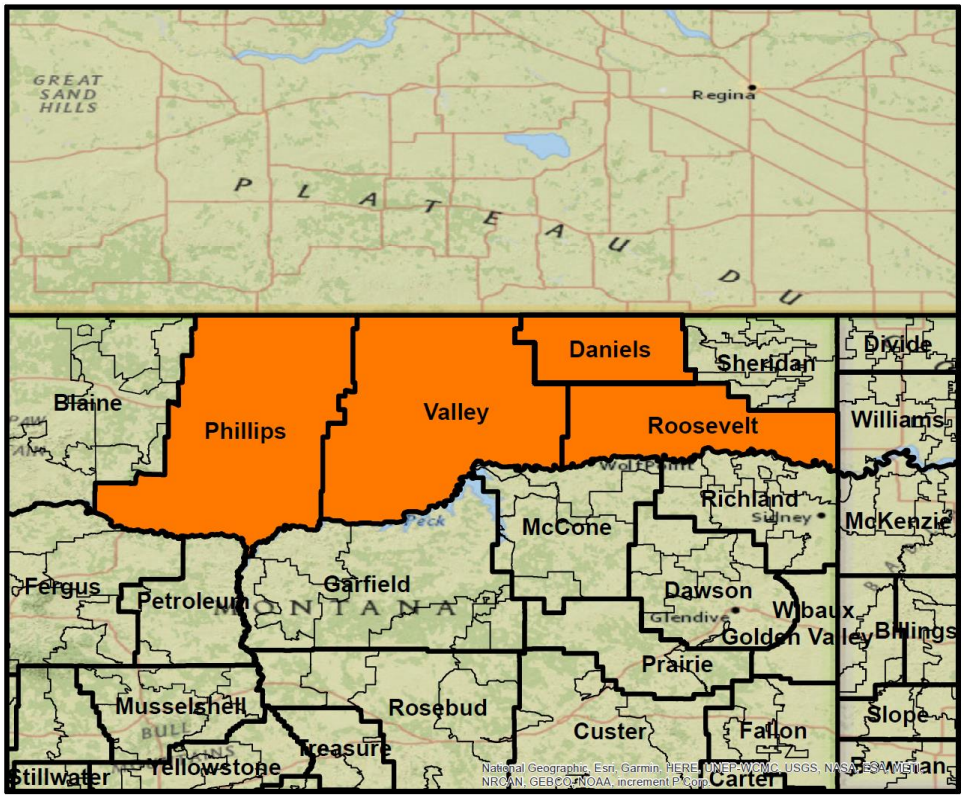
A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

Methodology

Quantitative data input for this assessment includes secondary research (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 stakeholders gathered through an Online Key Informant Survey.

Community Defined for This Assessment

The study area for this effort (referred to as “Total Service Area” in this report) includes four Montana counties: Daniels, Phillips, Roosevelt, and Valley. This community definition, determined based on the areas of residence of most recent patients of Frances Mahon Deaconess Hospital, is illustrated in the following map.



Online Key Informant Survey

To solicit input from community stakeholders (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 Frances Mahon Deaconess Hospital; 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, 43 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Healthcare Leadership	6
Public Health Representatives	8
Other Health Providers	12
Social Services Providers	4
Other Community Leaders	13

Final participation included representatives of the organizations outlined below.

- Casterline Family Chiropractic
- Daniels Memorial Healthcare System
- Eastern Montana Community Mental Health Center
- Frances Mahon Deaconess Hospital
- Frazer Public Schools
- Glasgow Public Schools
- Hinsdale School District
- Milk River
- Nashua Public Schools
- North Central Independent Living Services
- Prairie Ridge Village
- Saco School District
- Scobey School District
- Valley County Health Board Member
- Valley County Health Department
- Valley View Home

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

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.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

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, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Data

Montana 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.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

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 U.S. 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

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

IRS FORM 990, SCHEDULE H COMPLIANCE

For non-profit 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 (2019)	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	20
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	82
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	12
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)	87

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 stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Lack of Health Insurance (Adults 18-64) ▪ Lack of Health Insurance (Children 0-17)
CANCER	▪ Leading Cause of Death ▪ Cancer Incidence – Including Prostate Cancer and Colorectal Cancer
DIABETES	▪ Diabetes Prevalence
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Deaths ▪ Stroke Deaths ▪ High Blood Pressure Prevalence
INFANT HEALTH & FAMILY PLANNING	▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ▪ Violent Crime Rate
MENTAL HEALTH	▪ Mental Health Provider Ratio ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Leisure-Time Physical Activity
ORAL HEALTH	▪ Poor Dental Health
RESPIRATORY DISEASE (INCLUDING COVID-19)	▪ Chronic Lower Respiratory Disease (CLRD) Deaths ▪ Coronavirus/COVID-19 Deaths ▪ Asthma Prevalence

—continued on the following page—

AREAS OF OPPORTUNITY (continued)	
SEXUAL HEALTH	▪ Gonorrhea Incidence ▪ Chlamydia Incidence
SUBSTANCE ABUSE	▪ Key Informants: Substance abuse ranked as a top concern.
TOBACCO USE	▪ Cigarette Smoking Prevalence

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 community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration 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. Substance Abuse
3. Tobacco Use
4. Nutrition, Physical Activity & Weight
5. Cancer
6. Diabetes
7. Infant Health & Family Planning
8. Heart Disease & Stroke
9. Oral Health
10. Sexual Health
11. Access to Healthcare Services
12. Injury & Violence
13. Respiratory Disease (Including COVID-19)

Hospital Implementation Strategy

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

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

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

- In the following tables, four-county Total Service Area results are shown in the larger, gray column.
- 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. Symbols indicate whether the Total Service Area compares favorably (), unfavorably (), or comparably () to these external data.

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

SOCIAL DETERMINANTS	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Population in Poverty (%)	18.7	13.1	13.4	8.0
Children in Poverty (%)	24.1	15.8	18.5	8.0
Housing Exceeds 30% of Income	16.8	27.6	30.9	
No High School Diploma (% Age 25+)	9.1	6.5	12.0	
Linguistically Isolated Population (%)	0.1	0.3	4.3	
		better	similar	worse

OVERALL HEALTH	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
"Fair/Poor" Overall Health (%)	22.0	16.3	18.6	
		better	similar	worse

ACCESS TO HEALTH CARE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Uninsured (% Adults 18-64)	19.0	11.7	12.8	7.9
Uninsured (% Children 0-17)	10.3	6.4	5.6	7.9
Recent Primary Care Visit (%)	72.6	72.2	76.6	
Primary Care Doctors per 100,000	94.9	105.4	101.7	
		better	similar	worse

CANCER	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
		vs. MT	vs. US	vs. HP2030
Cancer (Age-Adjusted Death Rate)	156.3	144.2	149.4	122.7
Prostate Cancer Incidence Rate	133.5	124.2	106.2	
Female Breast Cancer Incidence Rate	134.5	135.4	126.8	
Lung Cancer Incidence Rate	48.7	51.2	57.3	
Colorectal Cancer Incidence Rate	63.4	37.4	38.0	
Cancer Incidence Rate (All Sites)	465.2	462.9	448.6	
Mammogram in Past 2 Years (% Women 50-74)	68.0	70.0	74.8	
		better	similar	worse

DIABETES	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
		vs. MT	vs. US	vs. HP2030
Diabetes Prevalence (%)	12.5	8.5	10.1	
		better	similar	worse

HEART DISEASE & STROKE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Coronary Heart Disease (Age-Adjusted Death Rate)	144.8	88.4	91.5	90.9
Stroke (Age-Adjusted Death Rate)	59.4	31.5	37.6	33.4
High Blood Pressure Prevalence (%)	36.4	30.0	32.6	27.7
		better	similar	worse

INFANT HEALTH & FAMILY PLANNING	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Births to Adolescents Age 15 to 19 (Rate per 1,000)	55.3	22.8	20.9	31.4
		better	similar	worse

INJURY & VIOLENCE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Unintentional Injury (Age-Adjusted Death Rate)	104.6	54.6	50.4	43.2
Violent Crime Rate	834.6	393.7	416.0	
		better	similar	worse

MENTAL HEALTH	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Mental Health Providers per 100,000	43.4	116.1	121.3	
		better	similar	worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Fast Food (Restaurants per 100,000	67.2	75.4	82.2	
Population With Low Food Access (%)	32.8	22.3	22.2	
No Leisure-Time Physical Activity (%)	27.7	19.2	22.0	21.2
Obese (%)	31.6	27.5	27.6	36.0
		better	similar	worse

ORAL HEALTH	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Dentists per 100,000	53.6	36.7	32.8	
Poor Dental Health (%)	19.7	14.2	13.5	
		better	similar	worse

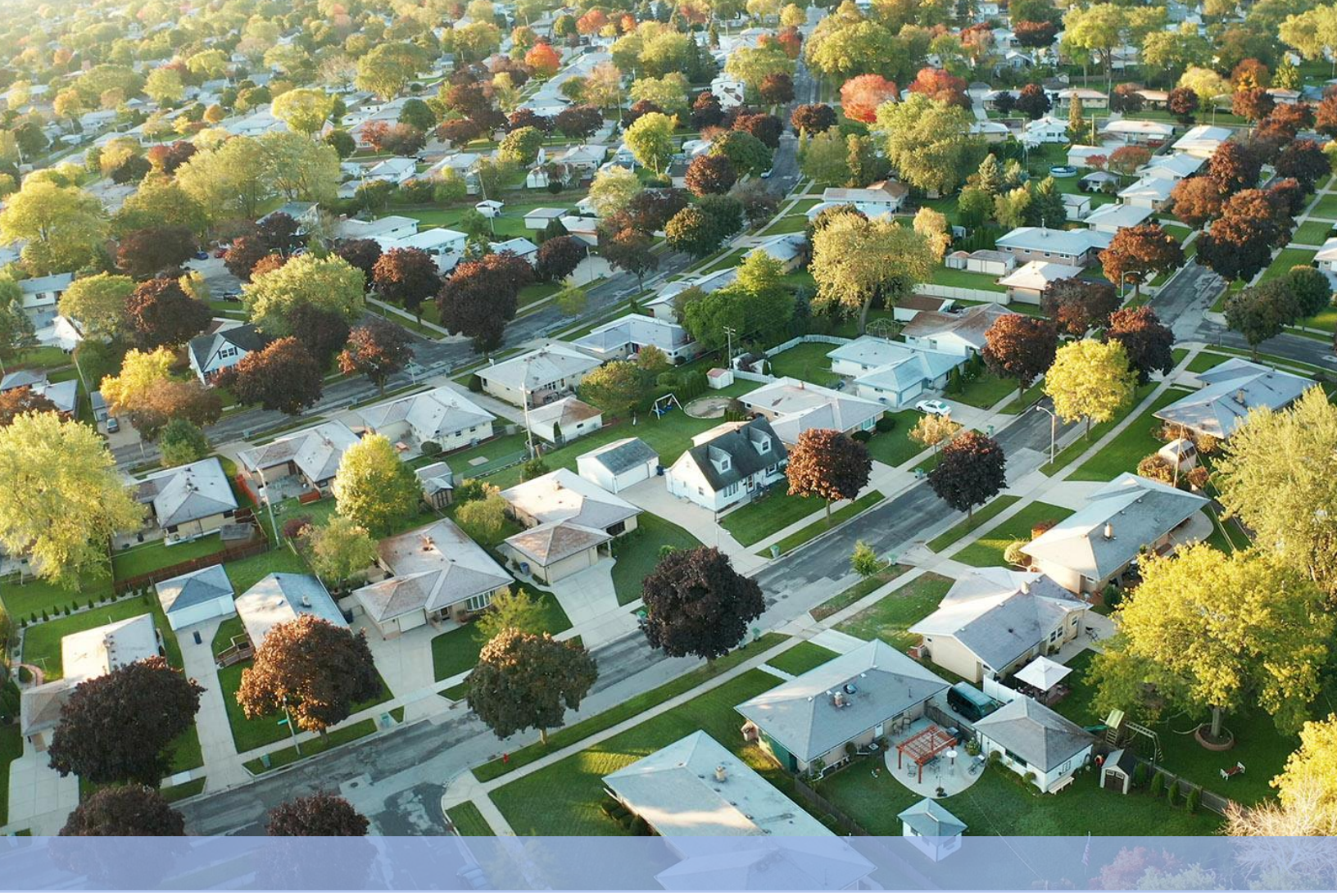
POTENTIALLY DISABLING CONDITIONS	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Disability Prevalence (%)	14.3	13.6	12.6	
		better	similar	worse

RESPIRATORY DISEASE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Lung Disease (Age-Adjusted Death Rate)	51.7	49.0	39.1	
Coronavirus/COVID-19 (Crude Death Rate)	596.3	303.4	290.0	
Asthma Prevalence (%)	10.8	9.8	8.9	
		better	similar	worse

SEXUAL HEALTH	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Chlamydia Incidence Rate	717.6	468.1	539.9	
Gonorrhea Incidence Rate	348.5	112.4	179.1	
		better	similar	worse

SUBSTANCE ABUSE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Excessive Drinker (%)	21.7	21.9	19.2	
		better	similar	worse

TOBACCO USE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030
Current Smoker (%)	24.1	17.1	15.3	5.0
		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, 2015-2019)

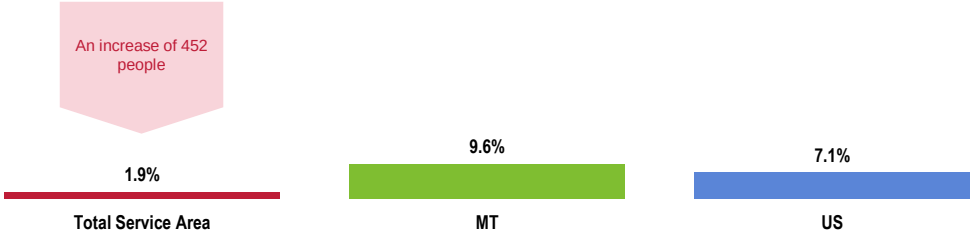
	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Total Service Area	24,453	13,846.91	1.77
Montana	1,050,649	145,546.98	7.22
United States	324,697,795	3,532,068.58	91.93

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Population Change 2010-2020

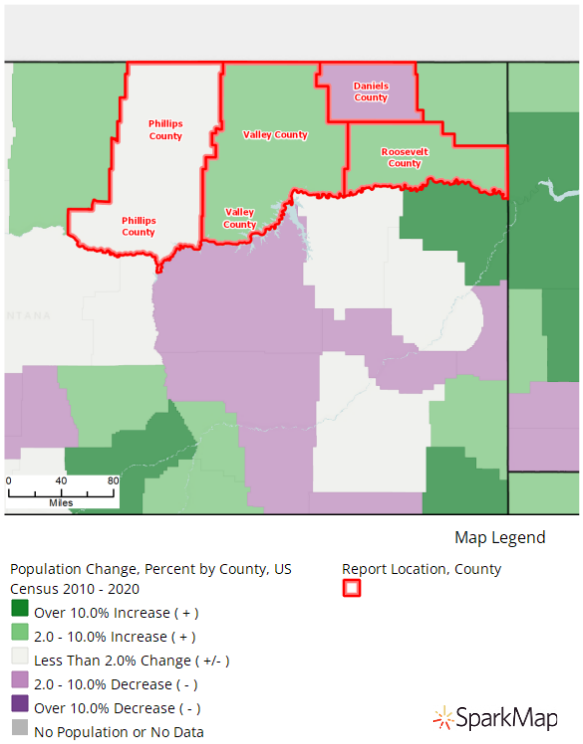
A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources. The following chart and map illustrate the changes that have occurred in the Total Service Area between the 2010 and 2020 US Censuses.

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



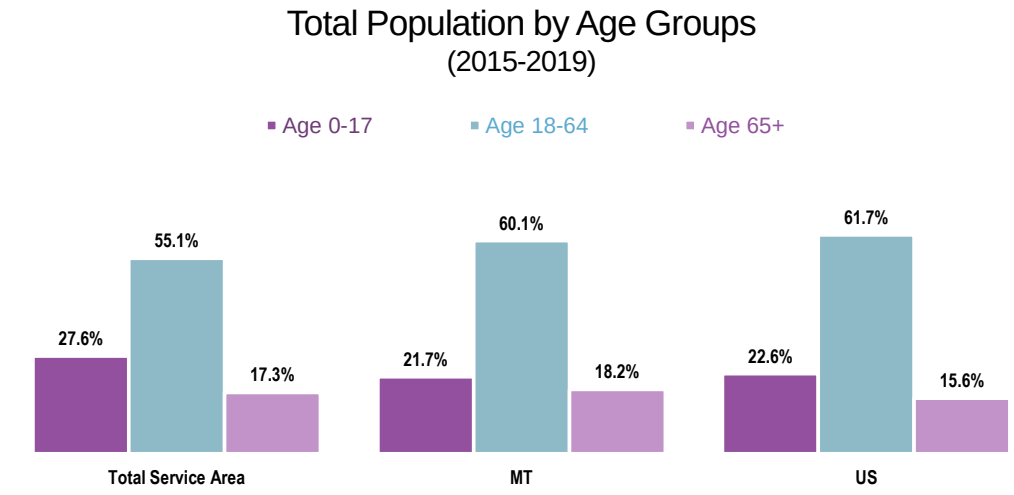
Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Notes:
- A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.



Age

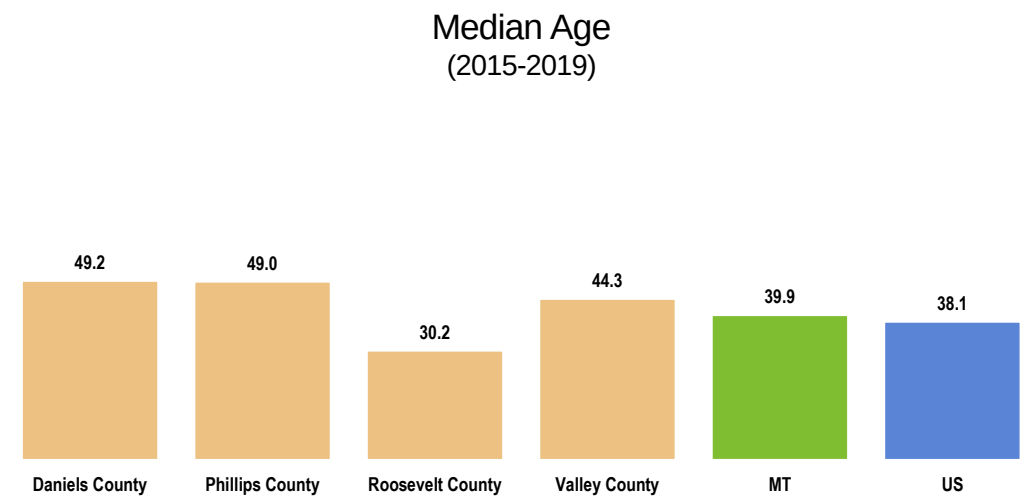
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.



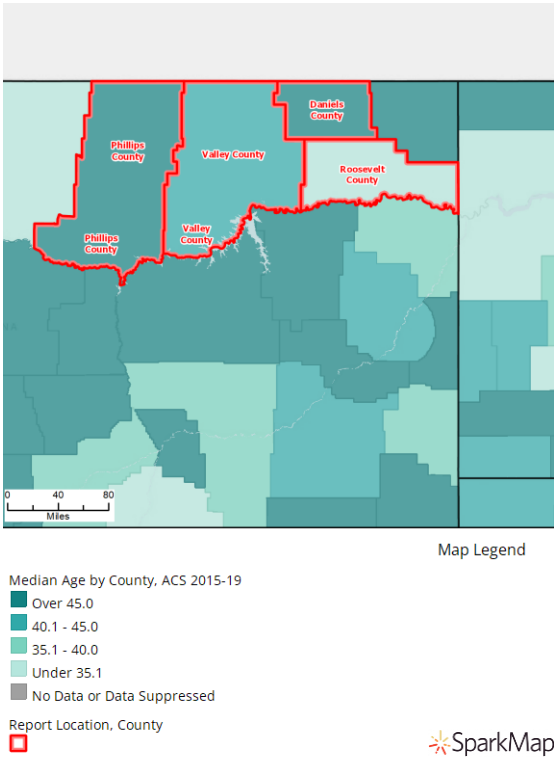
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Median Age

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



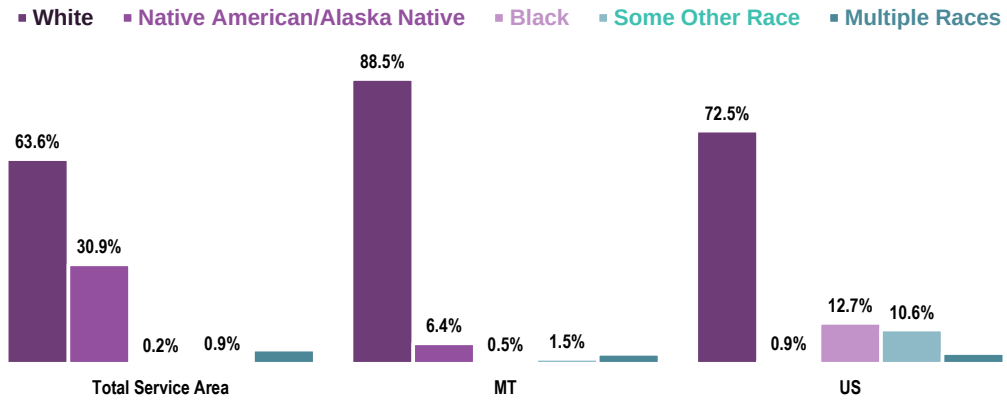
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).



Race & Ethnicity

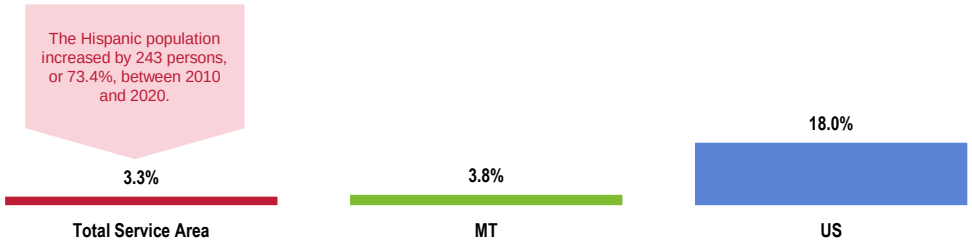
The following charts illustrate the racial and ethnic makeup of our community. Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States — people who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Total Population by Race Alone
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Hispanic Population
(2015-2019)



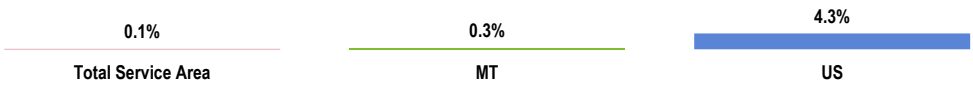
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Linguistic Isolation

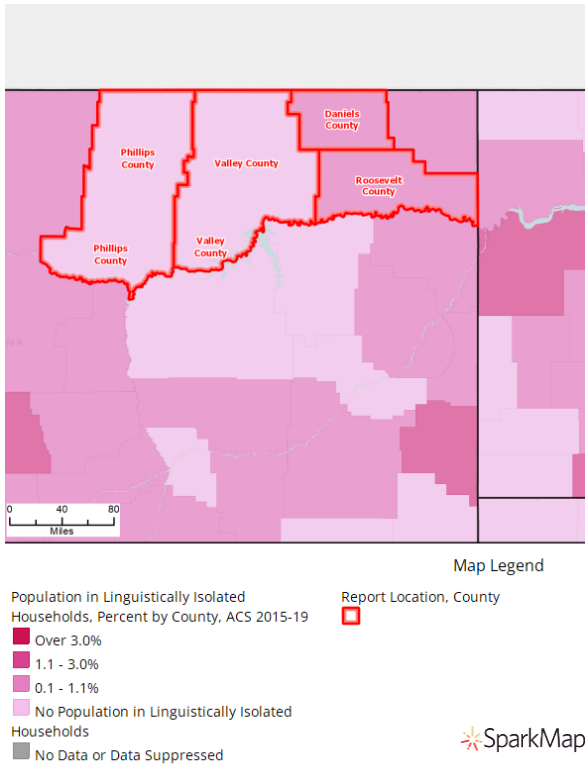
This indicator reports the percentage of the population age 5 years and older who live in a home in which: 1) no person age 14 years or older speaks only English; or 2) no person age 14 years or older speaks a non-English language but also speaks English "very well."

Linguistically Isolated Population
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 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

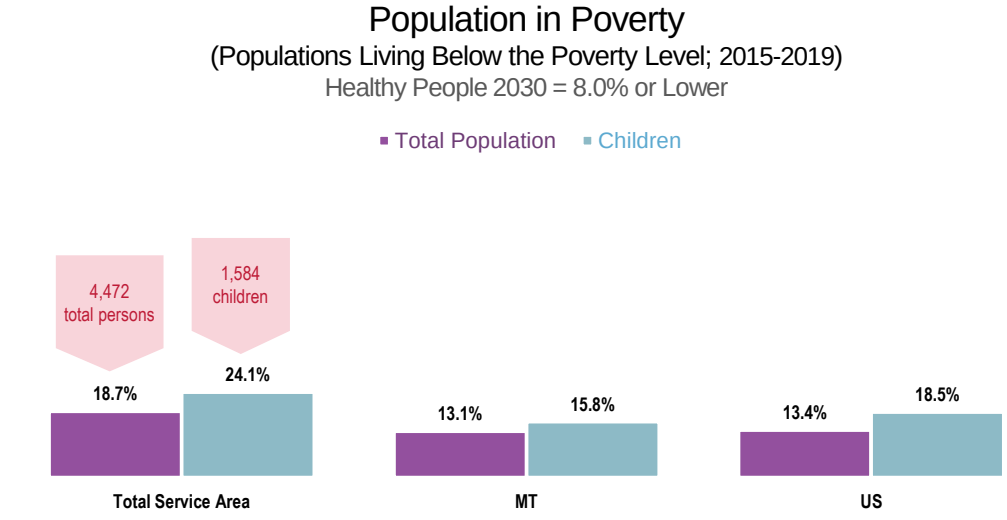
SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy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

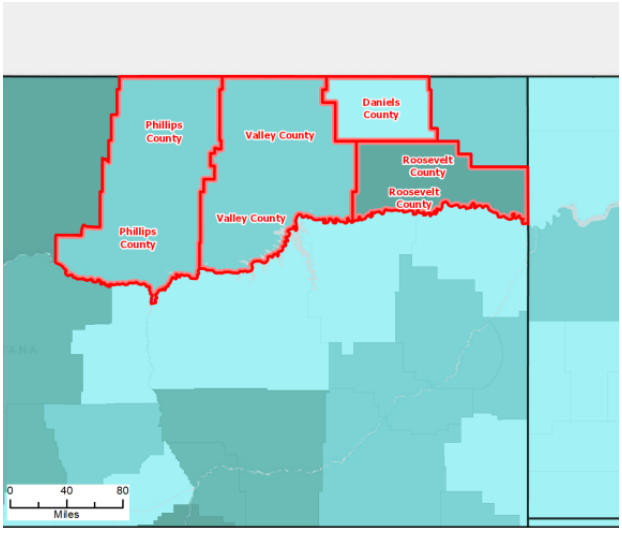
Poverty

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 optimal health. The following chart and maps outline the proportion of our population below the federal poverty threshold, as well the percentage of service area children living in poverty, in comparison to state and national figures.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

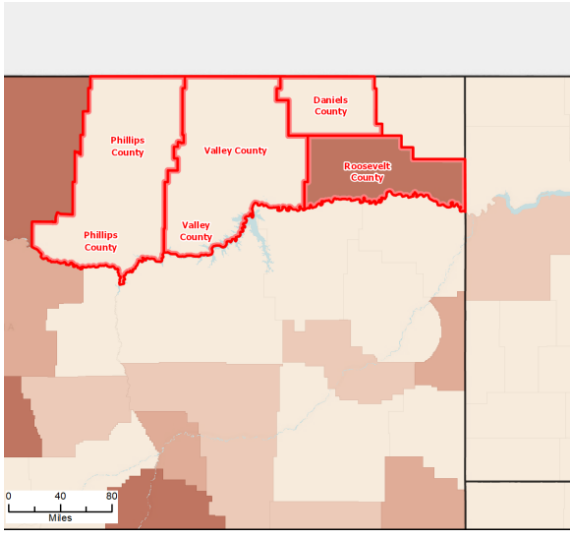


Map Legend

Population Below the Poverty Level, Percent by County, ACS 2015-19
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed

Report Location, County

SparkMap



Map Legend

Population Below the Poverty Level, Children (Age 0-17), Percent by County, ACS 2015-19
- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed

Report Location, County

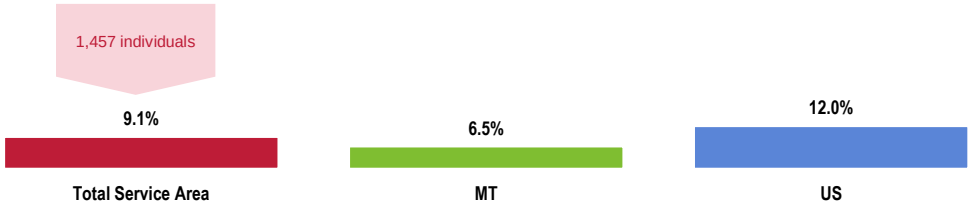
SparkMap

Education

Education levels are reflected in the proportion of our population without a high school diploma.

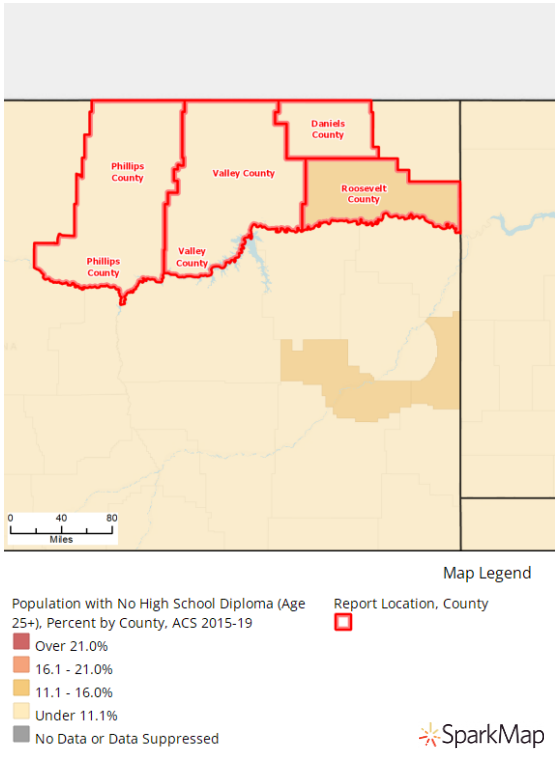
Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

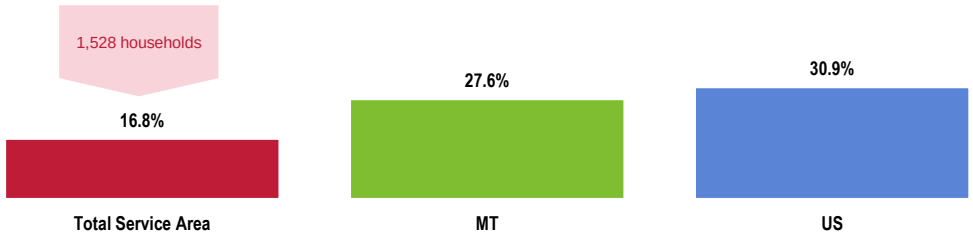


Housing Burden

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

Housing Costs Exceed 30% of Household Income
(2015-2019)



Sources:
- US Census Bureau, American Community Survey.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the households where housing costs exceed 30% of total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers 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.

HEALTH STATUS

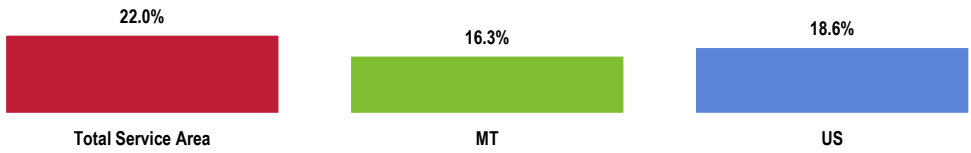
OVERALL HEALTH STATUS

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?"

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.

Adults With "Fair" or "Poor" Overall Health
(2019)



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it is a measure of general poor health status.

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.

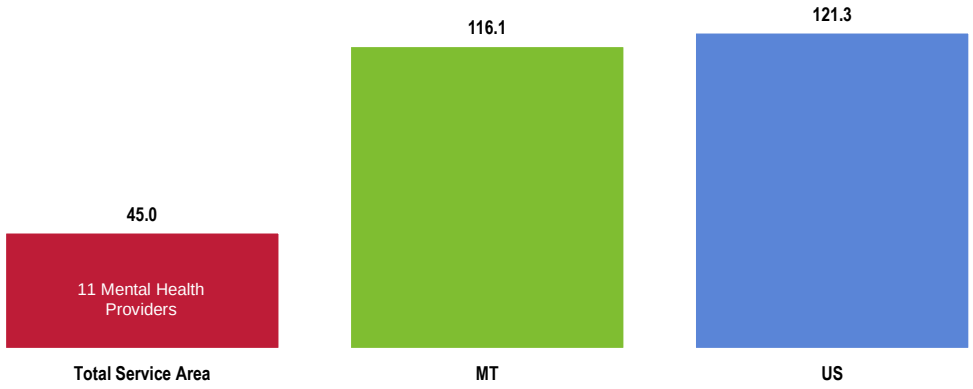
– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Providers

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors 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.

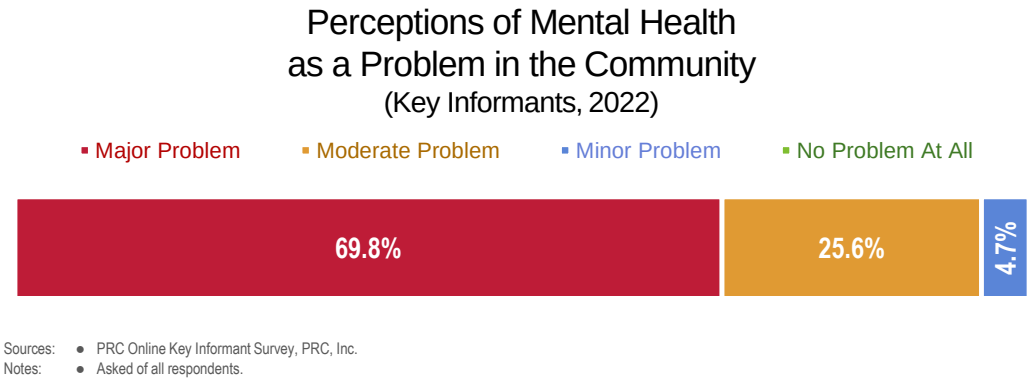


Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

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.

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.



Top Concerns

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

Access to Care/Services

> Finding help. If an individual has mental health issues and needs to be in a facility, there isn't one around. – Community/Business Leader
>
> Limited resources. – Healthcare Provider
>
> Access to qualified professional assistance. – Healthcare Provider
>
> There are not a lot of resources available in this area of the state for one thing. The biggest issue I see is the way that people with mental health issues are treated in our judicial system – like criminals – at least in the couple of people I am aware of that had "breakdowns". Also, I am not sure that locking people up in isolation is a benefit to their mental health. It is hard for mentally ill people to get help as they may be limited by finances and ability to even make those decisions for themselves. I don't know what the answer is. – Healthcare Provider
>
> Lack of resources. – Healthcare Leadership
>
> Access to mental health specialists is difficult to impossible to obtain. – Healthcare Leadership
>
> Lack of caregivers is the primary issue. In the short time that the hospital in Glasgow had a 24-hour call service for emergency help our admissions for mental health crisis decreased dramatically. In the short time that we have not had the service again due to staffing issues with the company, we have had many admissions that could have otherwise went home. We need more counselors in the communities as well as somewhere people in crisis can go to for evaluation and stabilization – Healthcare Provider
>
> We don't have enough people here to provide service to the people who suffer from mental health issues. – Community/Business Leader
>
> There are very few resources in our communities to help people who are struggling with mental health. – Community/Business Leader
>
> The biggest challenge is that we have very little resources and up here in rural Montana, people talk and it's still a taboo thing. – Healthcare Leadership
>
> Services provided to all community members. Perhaps a lack of mental health assistance. – Community/Business Leader

Contributing Factors

> There is a huge lack of resources locally as well as trained professionals to work specifically with elderly dementia + psych patients. Awareness and stigma are an ongoing battle, but we need more physicians who understand elderly pharmacology and especially elderly psychiatric pharmacology. – Healthcare Provider
>
> Access, providers, education, and laws are all huge contributors in the lack of services that are available for all ages in the listed counties. – Community/Business Leader

> There is Limited resources, and an overall lack of community understanding of substance abuse and mental health issues. Those who deal with these issues have difficulty succeeding in our community as people aren't sensitive to their issues and they don't have necessary resources. – Social Service Provider
>
> Stigma, lack of services, very few counselors in the area, services for age less than 18 are extremely limited. Substance and alcohol use and abuse are commonplace and accepted here. – Public Health Representative
>
> Stigma of seeking care, lack of access to mental health providers. – Healthcare Leadership
>
> I believe one of the biggest challenges is reaching out to seek help, there is still a stigma for mental health issues. Many of the physicians are not as well trained to help identify and then treat mental health situations. – Public Health Representative
>
> Stigma and getting a provider that accepts insurance. – Public Health Representative
>
> As a rural community in Montana, I believe the mentality is that we are tough people and will be okay. Additionally, as social media has become more popular, the older generations don't understand what challenges the kids in school now face with comparison issues and bullying that come from social media. Both of those factors combined, I believe, lead to the mentality that mental health isn't really an issue. However, I think because of this, kids either feel they can't reach out for help, shouldn't reach out for help or we, as a community, don't have the resources to help. In the last 6 months, we'd have two suicides by kids 21 years of age or younger. How many more tragedies must happen for us to realize that these kids need help? First issue: what resources are available for those who need mental health help? Second: If I get help, will it truly be confidential? Do we have telehelath options where I don't have to meet with someone locally? – Community/Business Leader

Denial/Stigma

> There is a huge stigma that mental health is "crazy people," that it's not a real ailment, a huge amount of misinformation swirls in regards to mental health and it should be addressed as your entire wellbeing, physical health, etc. It's all a part of it. – Social Service Provider
>
> Stigma around asking for help is number one, recognizing dysfunction, gaps in recognition and accessibility, considering the overlap between substance use issues and mental health. – Public Health Representative
>
> I believe the biggest challenge people with mental health issues face in our community is the stigma this community puts on mental health. Overcoming this stigma is a huge challenge. – Community/Business Leader

Affordable Care/Services

> Access to appropriate, affordable mental health providers. Many people with severe mental illness cannot hold down a job, therefore, have no insurance. On the other hand, when a person does have insurance, the insurance company does not pay for the needed mental health care leading to increased hospitalizations. – Healthcare Provider
>
> Availability of help they can afford. – Public Health Representative

Funding

> Not enough money to take care of the people that need assistance. – Public Health Representative

Incidence/Prevalence

> Many people are suffering from mental health issues. There is a lack of knowledge of mental illness in our area and we still often abide by the "cowboy up" attitude. There is huge lack of help for people suffering from mental illness in our area! – Community/Business Leader

Insurance Issues

> Insurance coverage for those without Medicaid. High deductible to be met before treatment is covered. Because of the nature of the condition causing someone to reach out for help, that out-of-pocket cost and paperwork at times causes more anxiety and depression so the person doesn't follow through with any treatment. In order to be covered by Medicare, the person is required to either be treated by a therapist licensed as SWLC which is one licensed in social work also: there are few who are licensed as such, so many of our elder Medicare clients are billed out of pocket after years of pinching pennies and paying into supplemental insurances that are not accepted by some Behavioral Health facilities. Most don't return as they can't afford that and the cost of keeping up their medical supplemental. – Social Service Provider

Leadership

> The leadership in our community do not even realize some of the substance or mental health issues going on. How can we educate the community when the leadership does not see it as a priority? – Social Service Provider

Lack of Providers

> There are no available mental health specialists in our community other than the school-based health clinic social worker who works primarily with students. – Community/Business Leader

DEATH, DISEASE & CHRONIC CONDITIONS

CARDIOVASCULAR DISEASE

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Montana 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.

Coronary Heart Disease Deaths

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …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.

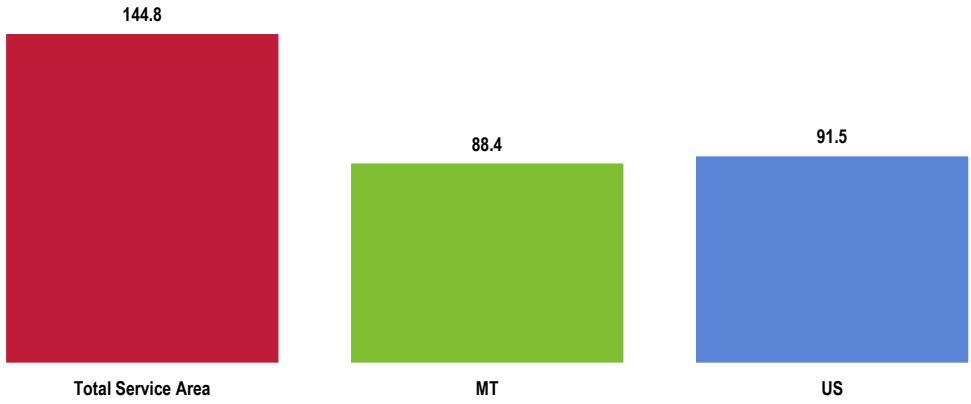
– Healthy People 2030 (https://health.gov/healthypeople)

Coronary 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 Montana and the US.

Coronary Heart Disease: Age-Adjusted Mortality

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

Healthy People 2030 = 90.9 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 February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

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.

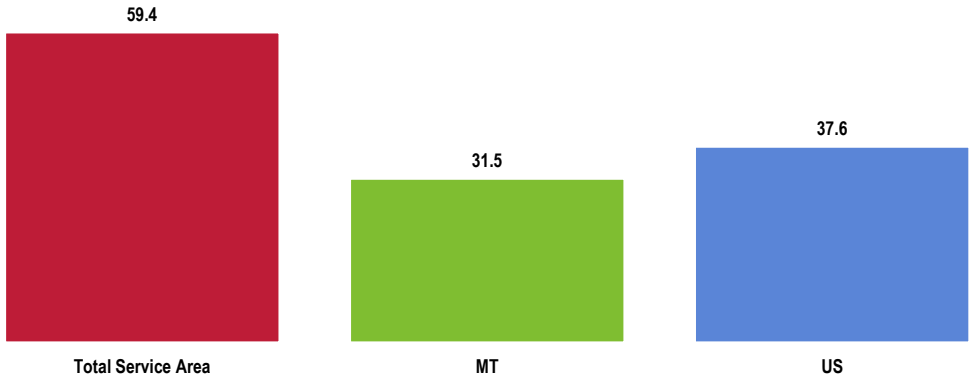
Stroke Deaths

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 February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

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.

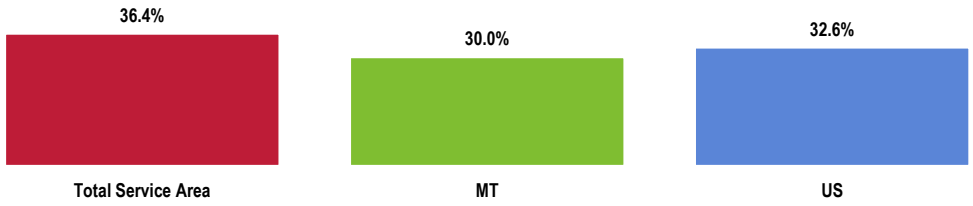
High Blood Pressure

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?"

Uncontrolled high blood pressure (hypertension) can damage the body and lead to disability or heart attack and stroke. As can be seen in the following chart, a significant share of Total Service Area adults have been told by a health professional at some point that their blood pressure was high.

Prevalence of High Blood Pressure
(2019)
Healthy People 2030 = 27.7% or Lower



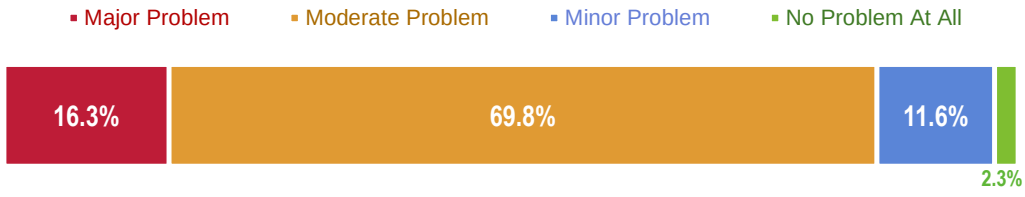
Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- This indicator is relevant because coronary heart disease is a leading cause of death in the US and is also related to high blood pressure, high cholesterol, and heart attacks.

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.

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2022)



Sources:
- 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

> It seems many people are affected by heart disease and stroke. Sometimes it is difficult to diagnose prior to having a problem. – Public Health Representative
>
> Look at the statistics and treatment/prevention facilities and efforts in this community. Very limited. – Public Health Representative
>
> The number of people experiencing these diseases. – Healthcare Provider
>
> (1) Due to our rural environment, most of the golden hour (or 90 minutes if you use that) is consumed by ambulance response and flight time. I've never seen county-by-county survivability rates, but I would assume counties in NE Montana are lower than many other counties in the nation. – Healthcare Leadership

Education/Awareness

> I would say that lack of a healthy diet and exercise are major contributors to heart disease and stroke in our area. We need better education and intervention to help people maintain a healthy diet and weight. – Healthcare Provider

Aging Population

> Aging population. Lifestyle. – Healthcare Leadership

CANCER

ABOUT CANCER

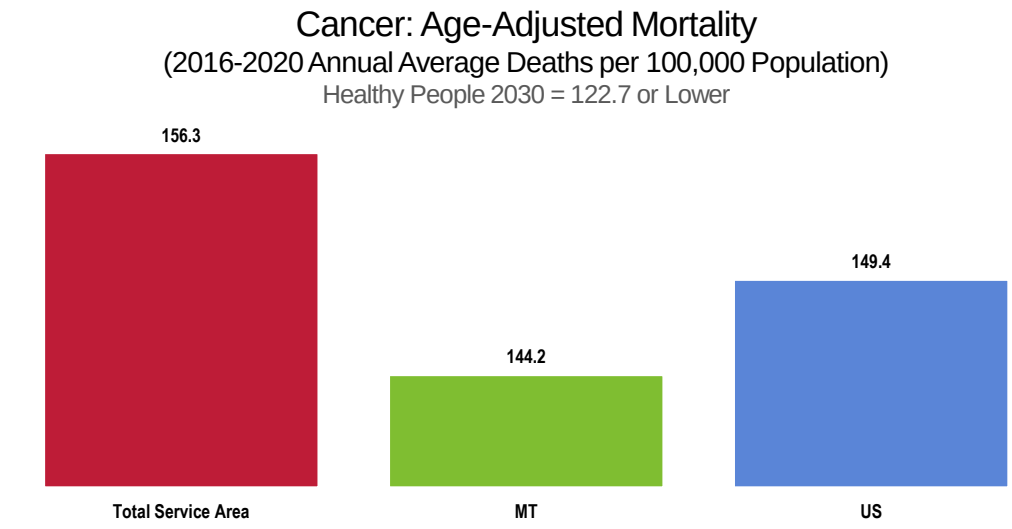
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are 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 February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

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.

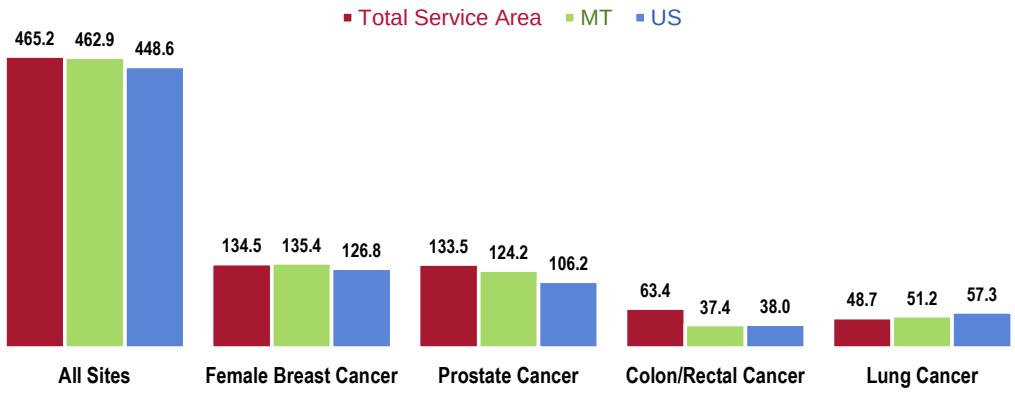
Cancer Incidence

"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, including female breast cancer, lung cancer, prostate cancer, and colon/rectum cancer.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2014-2018)



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 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). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Mammograms

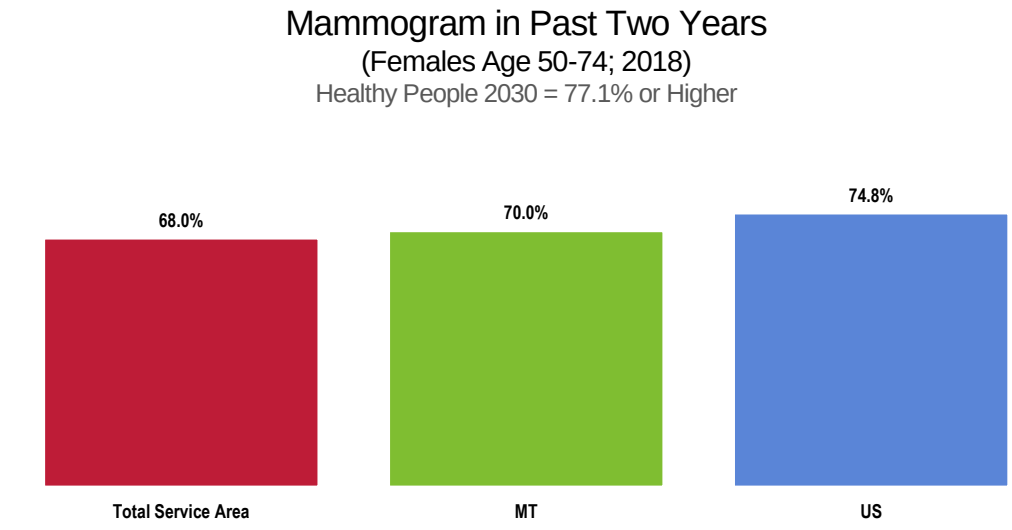
FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 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 indicator outlines the percentage of women age 50–74 who have received a mammogram in the past two years. Mammography is important as a preventive behavior 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.

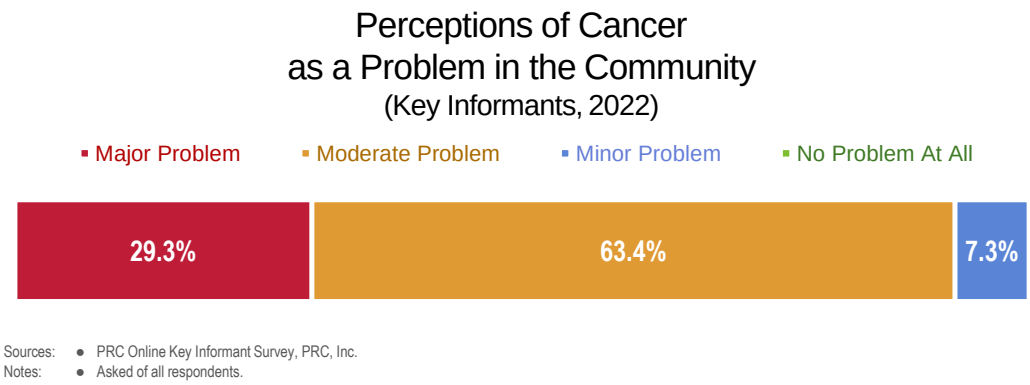


Sources:
- Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems.

Key Informant Input: Cancer

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



Sources: • 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

> Many people in our community have been diagnosed with cancer. Treatment options in our area are limited and people often have to leave their jobs/families to travel long distances for treatment. – Community/Business Leader
>
> Maybe it's because I live in a smaller community where word gets around, but I feel like I hear of somebody dealing with cancer every day. – Community/Business Leader
>
> Cancer is a major problem everywhere in the world. In a small community where you know everyone, it tends to feel like there's a large population of patients with cancer. – Healthcare Provider
>
> Many people in the community are dealing with cancer. Rates have increased in the past several decades. May be a particular problem in our area due to history of chemical use in agriculture. – Healthcare Leadership
>
> We seem to have above average cancer issues up here, for whatever reason. Not sure if there's a way for better pre-screening or more convenient services for the patient. – Healthcare Leadership

Contributing Factors

> Cancer is a major problem due to (1) ubiquity, (2) recurrence after remission, (3) distance to receive treatment. – Healthcare Leadership
>
> Aging population. Lifestyle, obesity, smoking, diet. – Healthcare Leadership
>
> Agricultural and industrial chemicals, both firsthand contact and residual in foods, cultural tobacco use acceptance, both cigarettes and chewing tobacco, high cost of health insurance, so suspect conditions go unchecked for early detection. – Social Service Provider
>
> Rates of cancer are high and much of the treatment is done hours away, which means that the cancer patient is alone in another city/town and family is at home without their loved one. Plus, the expense of being away is a huge burden on the family. – Public Health Representative
>
> We are an agricultural community that heavily relies upon pesticides and herbicides to manage our crops and lands. I believe that the improper use and disposal of these products have negatively affected our water resources and that this has had a negative impact on individuals overall health and as increased our risk of certain types of cancer. – Healthcare Provider

Nutrition

> I feel disease is heavily related to your overall health and diet and nutrition play a direct role in fueling your body or feeding disease. – Social Service 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.

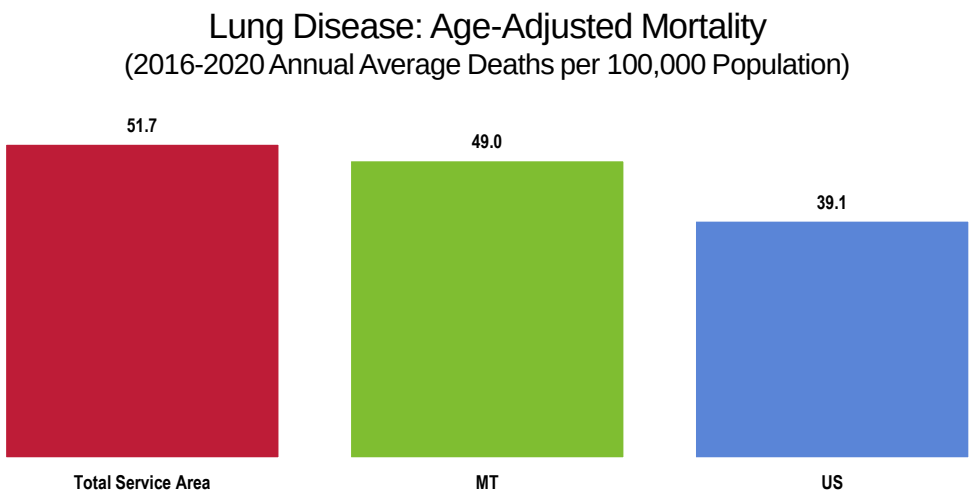
Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

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

Lung Disease Deaths

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

The mortality rate for lung disease (chronic lower respiratory disease) in the Total Service Area is summarized below, in comparison with Montana 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 February 2022 via SparkMap (sparkmap.org).

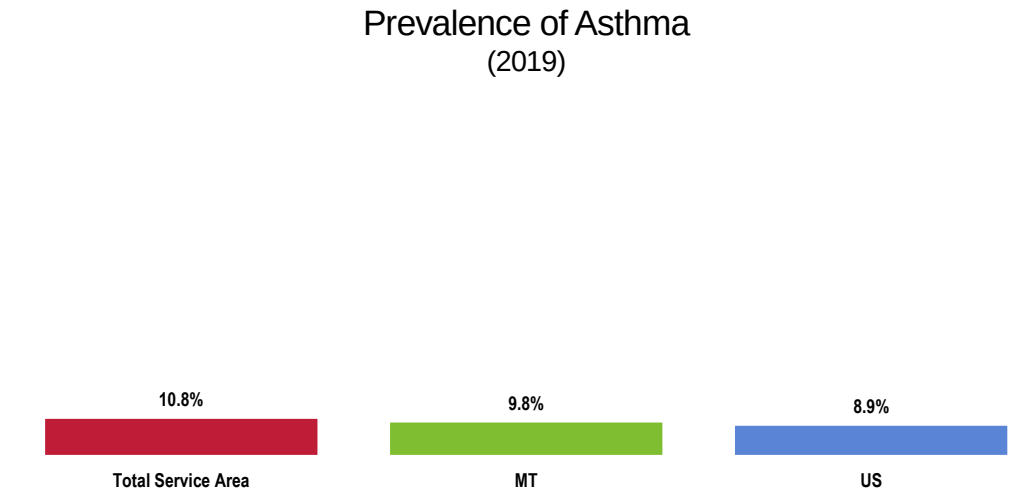
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- This indicator is relevant because lung disease is a leading cause of death in the United States.

Asthma Prevalence

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

The CDC Behavioral Risk Factor Survey asked respondents:

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

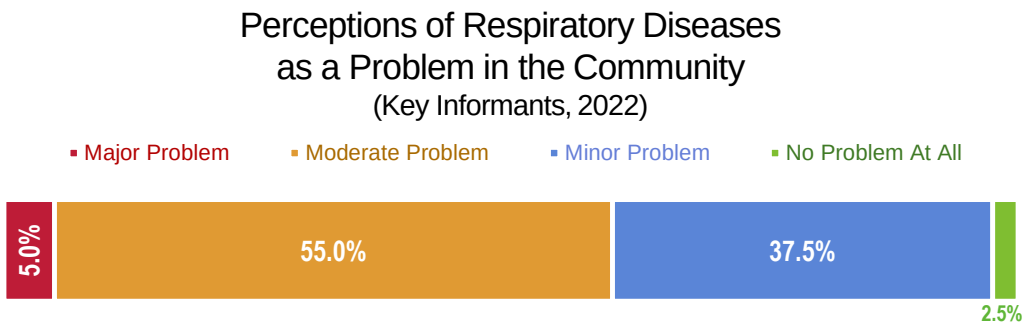


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

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

Key Informant Input: Respiratory Disease

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



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

Notes:
- Asked of all respondents.

Top Concerns

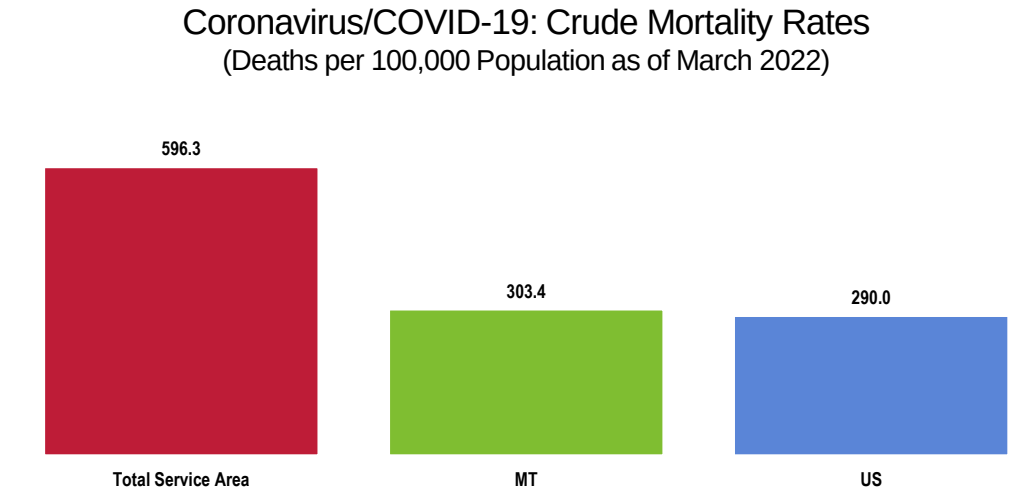
Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Poor management of asthma, COPD and high percentage of the population are smokers. – Healthcare Provider

Coronavirus Disease/COVID-19 Deaths

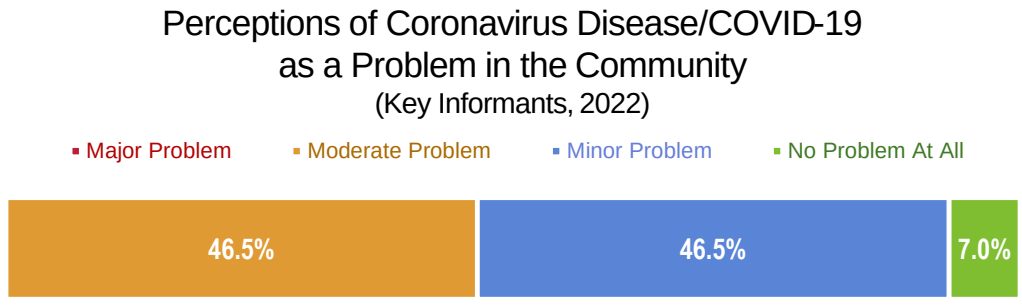
The mortality rate for coronavirus/COVID-19 deaths in the Total Service Area as of March 2022 is illustrated below, in comparison with state and US figures.



Sources: ● Johns Hopkins University. Accessed via ESRI. Additional data analysis by CARES, 2022; University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).
Notes: ● Rates are crude deaths per 100,000 population as of March 2022.

Key Informant Input: Coronavirus Disease/COVID-19

Key informants' levels of concern about *Coronavirus Disease/COVID-19* in the Total Service Area is outlined below.



Sources: ● 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:

Polarization

> COVID pandemic caused a lot of polarization in Valley County. I'm concerned that regular public health issues such as vaccinations of our children will be affected negatively by the vaccine hesitancy towards the COVID vaccine. Also, that public health has become a "dirty" word instead of remembering all the good things they bring to our community. I think there needs to be continued cooperation and support between the medical community, county elected officials and public health so that we have a strong Public Health Department. – Public Health Representative

Depression

> Depression. Never seen depression at such a high level in community. Due to Covid, isolating, meth use, marijuana use. The cost of living, etc. – Public Health Representative

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.

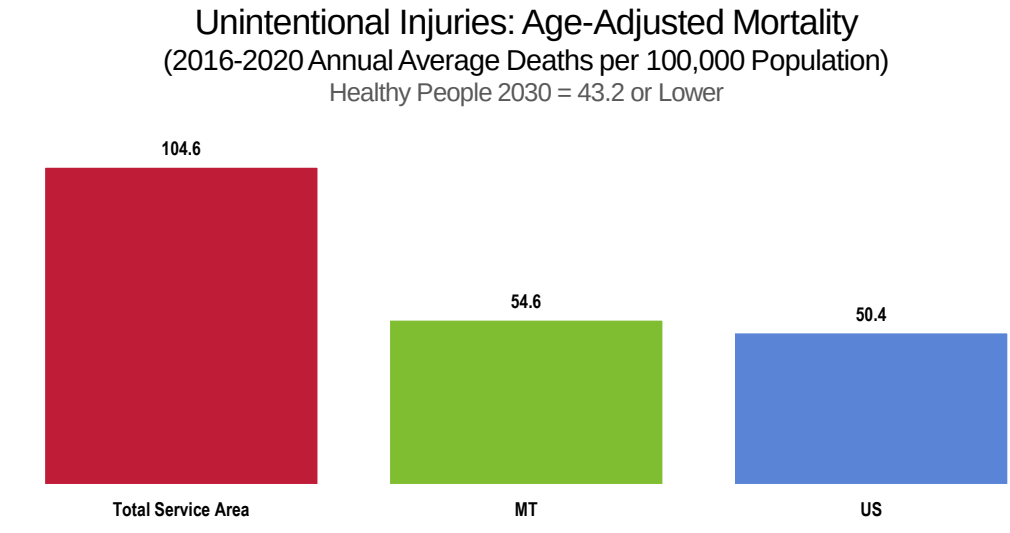
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– 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, Montana, 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 February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

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.

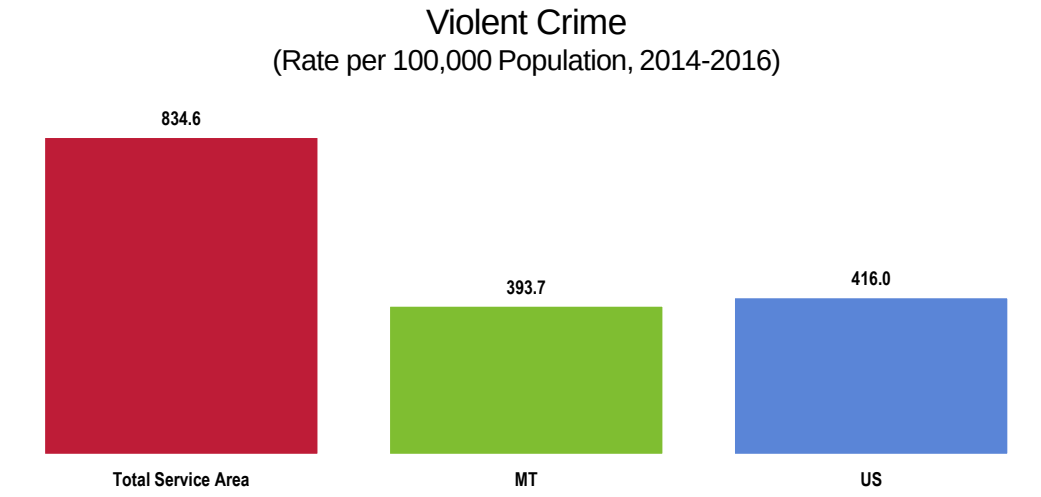
Intentional Injury (Violence)

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, Montana, and the US.

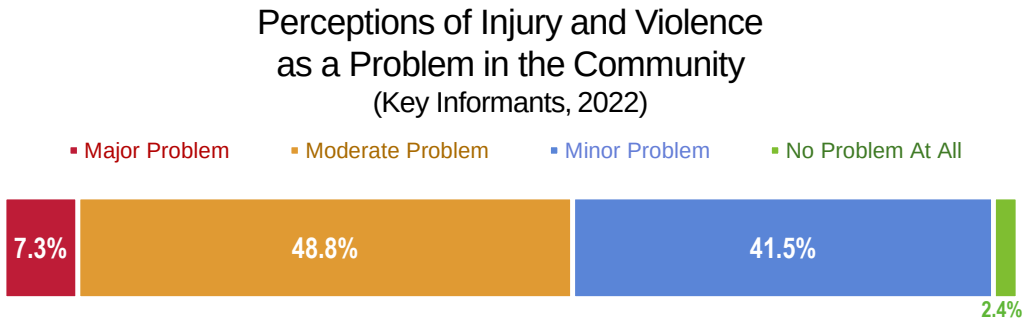


Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

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, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- 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:
- 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:

Alcohol/Drug Use

> Substance and alcohol use and abuse are major problems, thus any injury or violence related to these problems are a major problem. I believe that injuries related to domestic violence and/or abuse are not reported. – Public Health Representative
>
> The drug use is high, which leads to the injury and violence. – Community/Business Leader
>
> Overabundant use of alcohol. – Healthcare Provider

DIABETES

ABOUT DIABETES

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

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

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

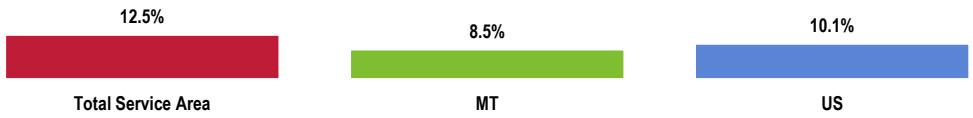
Prevalence of Diabetes

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.

The CDC Behavioral Risk Factor Survey asked respondents:

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

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

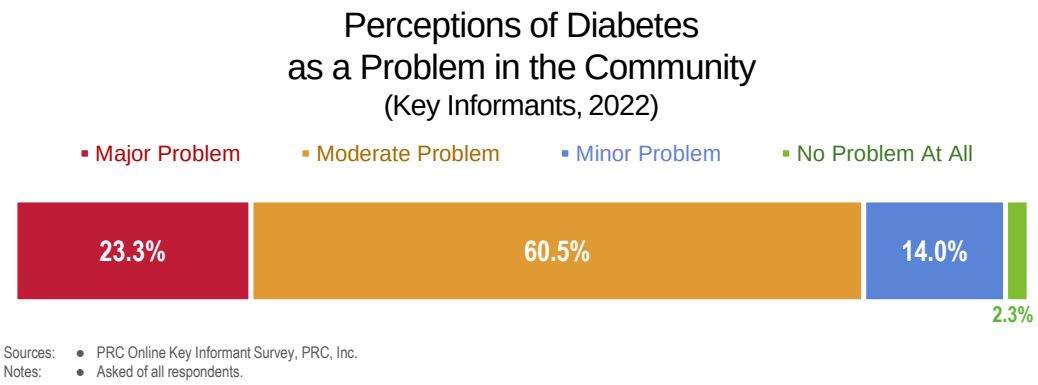


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because diabetes is a prevalent problem in the US; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Key Informant Input: Diabetes

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



Sources: • 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:

Contributing Factors

> High cost of insurance to detect onset of type 2, high cost of insulin, lack of education about the prevention of type 2 diabetes. – Social Service Provider
>
> Affordable medications and lack of dialysis if needed. Have to travel at least 70+ miles to the nearest facility. – Social Service Provider
>
> Obesity, diet, and lifestyle. – Healthcare Leadership
>
> Access to healthy food and knowledge about how diet interacts with chronic diseases like diabetes. – Healthcare Leadership

Awareness/Education

> Recognizing it is a problem, so probably proper education, and screening/testing. – Public Health Representative
>
> Diabetes awareness information and suggestions regarding proper diets, etc. – Community/Business Leader

Access to Care/Services

> They have to travel so far for dialysis. – Public Health Representative

Follow-Up/Support

> Maybe support groups for maintaining a healthy lifestyle. There are resources for education through the Glasgow Clinic and FMDH, but ongoing support may help folks stay focused in establishing and maintaining a healthy lifestyle. – Healthcare Provider

Lack of Providers

> Lack of diabetes specialists available locally, including diabetes educators, classes. – Healthcare Provider

KIDNEY DISEASE

ABOUT KIDNEY DISEASE

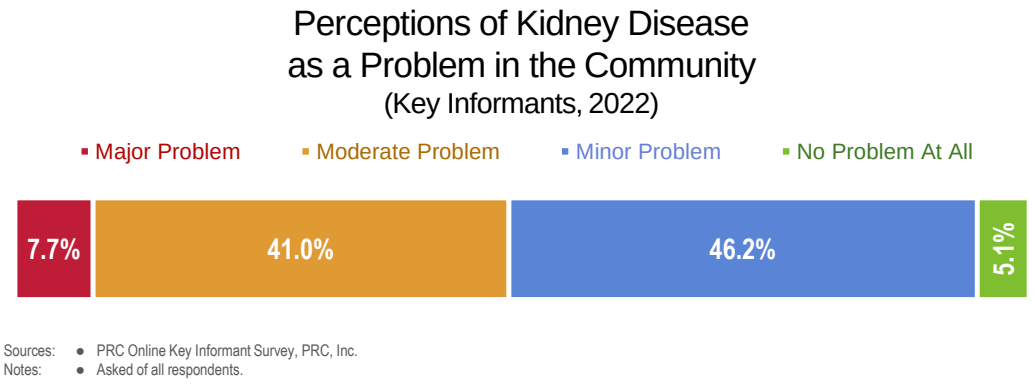
More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

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

Key Informant Input: Kidney Disease

The following are the perceptions of *Kidney Disease* as a community health issue among key informants taking part in an online survey.



Sources: 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:

Co-Occurrences

> Most likely connected to the high level of diabetics. – Social Service Provider

Obesity

> Many individuals in our community are overweight and do not lead a healthy lifestyle. – Healthcare Provider

Vulnerable Populations

> I work with the dietitians at FMDH and they work with dialysis at Poplar. I believe there is an issue with kidney disease on the reservation, so maintaining those services would be important for them. – Healthcare Provider

POTENTIALLY DISABLING CONDITIONS

Disability

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.

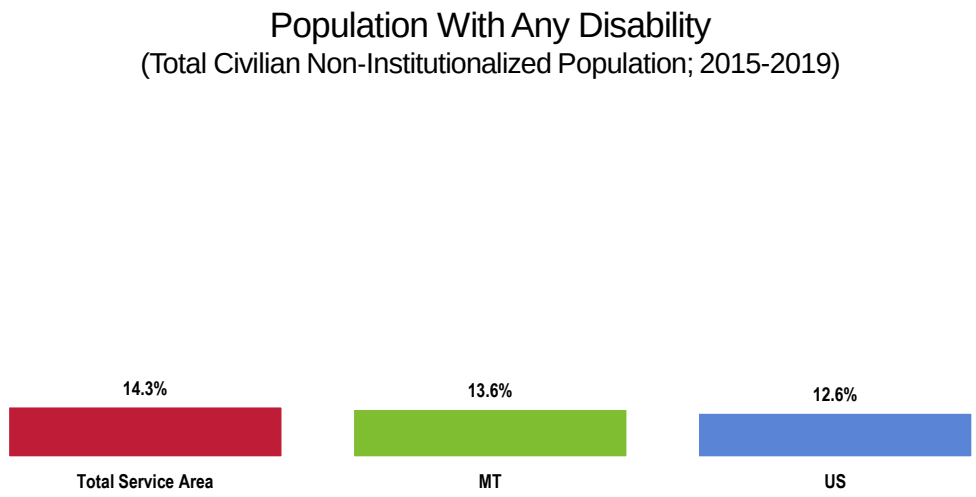
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life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

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

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.

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.

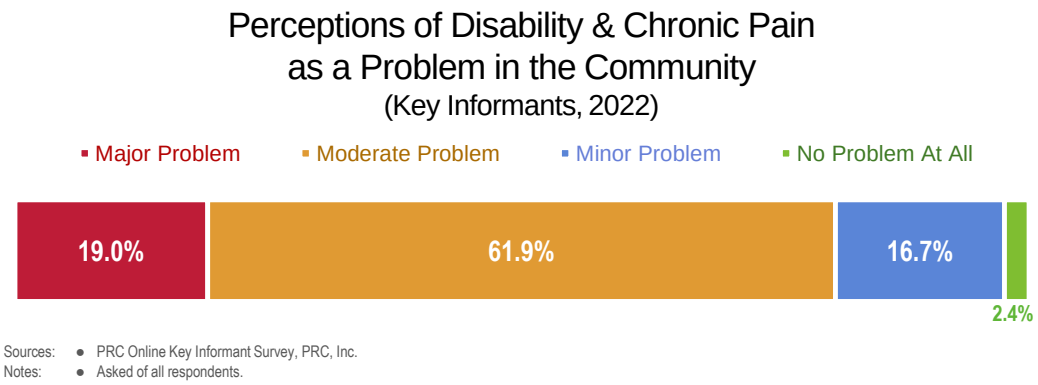


Sources:
- US Census Bureau, American Community Survey.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because disabled individuals comprise a vulnerable population that requires targeted services and outreach by providers.

Key Informant Input: Disability & Chronic Pain

Key informants' perceptions of *Disability & Chronic Pain* are outlined below.



Top Concerns

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

Vision Care

> Vision care that accepts insurance of BNSF, a major employer in this community. – Public Health Representative
> Vision support for blindness. Currently, I don't know of any support for patients in this area. – Community/Business Leader

Access to Care/Services

> Rehab services are nearly non-existent. Local outpatient physical therapy is the only treatment available. Fragmented health care options. – Public Health Representative

Aging Population

> We have a primarily senior population and with that, disability and chronic pain comes with the territory. – Public Health Representative

Diagnosis/Treatment

> Many people are on daily pain medications or anti-inflammatory drugs without being pointed in the direction of fixing the cause of their pain first. – Healthcare Provider

Disease Management

> Our clinicians do not have the expertise to manage and treat chronic pain/disability. – Healthcare Provider

Insurance Issues

> For the legitimate condition, insurance costs with high deductibles keep injured workers from seeking early treatment or time off work to let the injury repair. The problem of drug-seeking by claiming disability and chronic pain, is what I see as the largest cause of those with legitimate injury and disability not receiving the justified treatment and compensation. Paring away those who are not truly incapacitated by putting in place the same protocol and investigations that Workman's Comp have in place, I believe that would alleviate much of the false claims that are resulting in misappropriation of our Social Security and Medicare benefits to those who didn't work for nor are willing to contribute to by paying taxes for these benefits. – Social Service Provider

Aging Population

> Judging by the US Census Bureau, Valley County, like most counties in Montana, will have a dramatic shift in the overall average age increase over our elderly population. HBCC, assisted living care and long term nursing care will not be able to support the geriatric care required in the very near future. – Healthcare Provider

Services for Developmentally Disabled

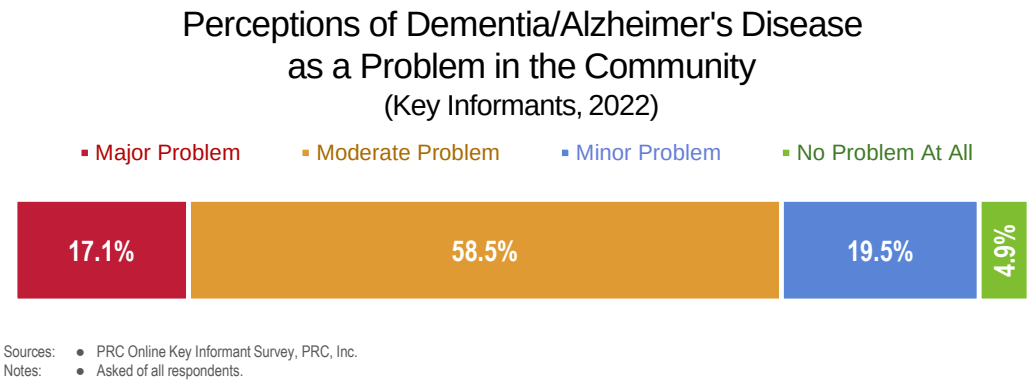
> Services for developmentally disabled. – Community/Business Leader

Work Related

> The livelihood of our communities is hard on workers' bodies. – Community/Business Leader

Key Informant Input: Dementia/Alzheimer's Disease

The following represents key informants' ratings of *Dementia/Alzheimer's Disease* as a community health concern.



Sources: • 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

> I believe there isn't help for family if a family member has dementia or Alzheimer's. – Community/Business Leader
>
> Finding services for those suffering from dementia/Alzheimer's disease is a problem. The Nursing Home in Glasgow is stressed for employees to provide services for their patients, including dementia/Alzheimer's patients. – Healthcare Provider

Aging Population

> Aging population. – Healthcare Leadership
>
> A lot of our community are in their elder years, there's a high percent of them that have dementia/Alzheimer's. Our facility handles them, but it's not set up as it could be. Most of that is due to staff shortages. – Healthcare Leadership

Awareness/Education

> It appears that dementia/Alzheimer disease doesn't get a voice in our community. We need more education for family members to learn how to deal with it. More people might want to keep a loved one at home and sometimes the caretaker needs a break and the services to assist is far and in between. – Public Health Representative

Contributing Factors

> Shortage of facilities for assisted care. Shortage of family support and information. Day help for caregivers. – Community/Business Leader

Diagnosis/Treatment

> There are no good programs or resources for early detection in our community. Many of our seniors do not have good family support to get them the early help they need. – Healthcare Provider

BIRTHS

FAMILY PLANNING

ABOUT FAMILY PLANNING

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

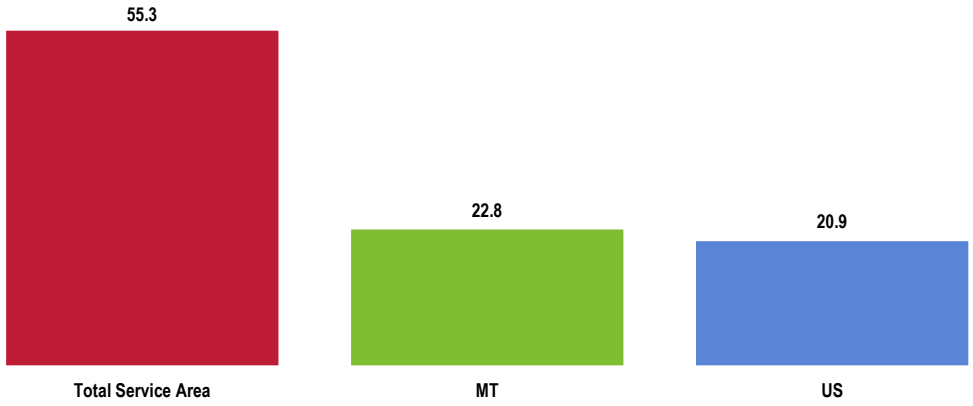
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

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

Births to Adolescent Mothers

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.

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.

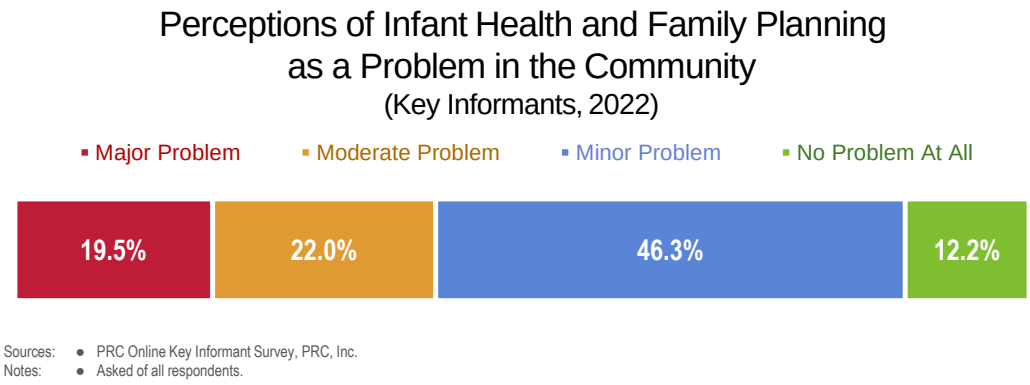


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

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



Sources: 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:

Awareness/Education

> The services are at the Health Department. Needs more advertising. – Public Health Representative
>
> More so in regards to family planning rather than infant planning, the perceived comfort with discussing or accessing family planning resources is lower than might be ideal. – Public Health Representative
>
> Lack of basic education in families and schools. – Healthcare Leadership
>
> I don't believe a lot of people have sound information for infant health and family planning, what it entails, how to parent, classes to support learning parenting skills, etc. – Social Service Provider

Access to Care/Services

> Lack of resources and low income are major contributors for poor infant health and family planning in our community. – Healthcare Provider
>
> Well child checks and any family planning have to be done out of town. It would be nice if somehow it could be done in house or have travelers that could provide some of that. – Healthcare Leadership

Vulnerable Populations

> Pregnancy by addicted women, birth control should be made more affordable and made more visible on social media. – Social Service Provider

Parenting Education

> Parenting support is an area that would help to limit health issues of children and ease the stress of young parents. – Public Health Representative

Low Income/Poverty

> Limited to zero options and support for low-income groups. – Public Health Representative

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.

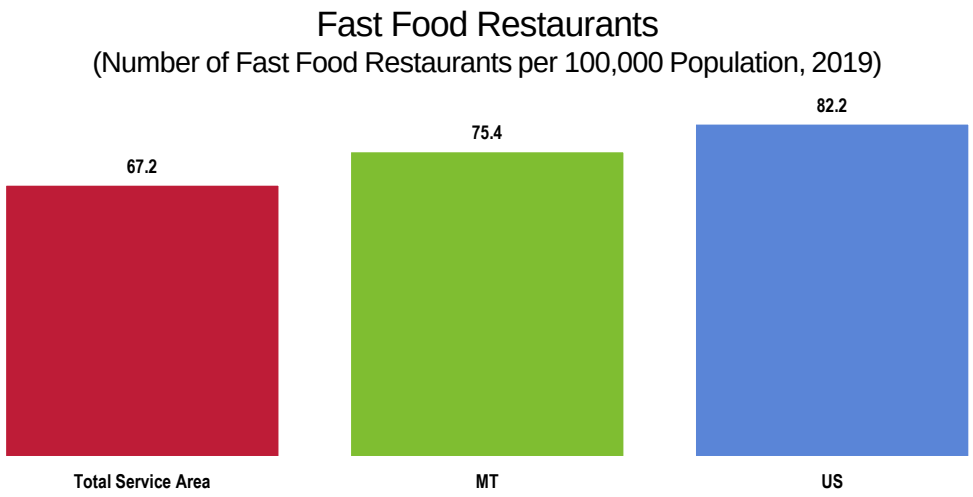
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– 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 nutrition.



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 February 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

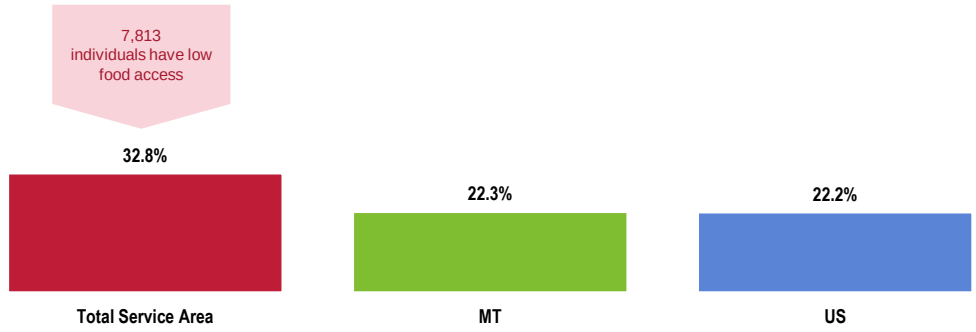
Access to Healthful Food

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

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.

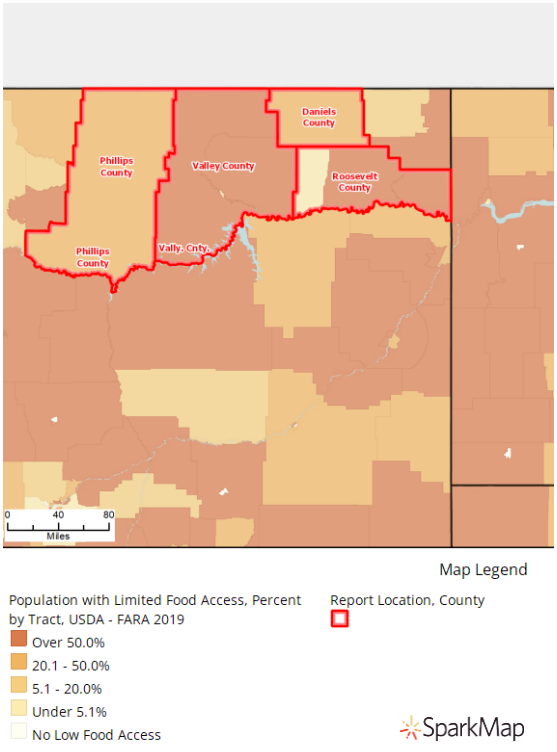
Population With Low Food Access

(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 February 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.



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.

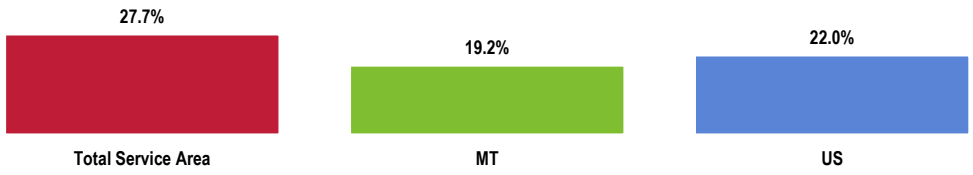
– Healthy People 2030 (https://health.gov/healthypeople)

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+, 2019)
Healthy People 2030 = 21.2% or Lower



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

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
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

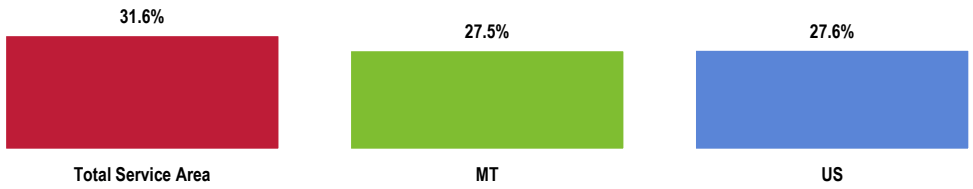
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 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+ With a Body Mass Index ≥ 30.0, 2019)
Healthy People 2030 = 36.0% or Lower



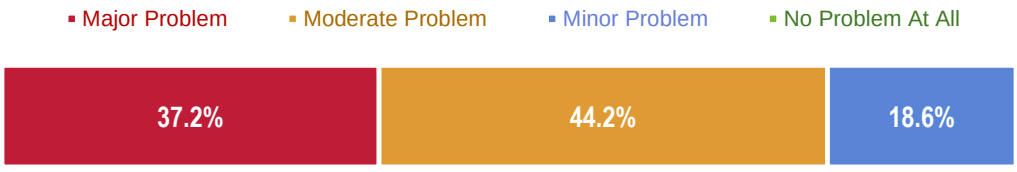
Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

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, regardless of gender.
- This indicator is relevant because excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

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, and Weight as a Problem in the Community
(Key Informants, 2022)



Sources:
- 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:

Contributing Factors

> Limited/good quality/reasonable priced fresh fruit and vegetable availability, culture of usual diets including meat/potato meals with limited fruit/vegetable/legume inclusion, limited healthy dining out options, harsh weather, limited exercise facility options especially for lower income, – Healthcare Provider
>
> Obesity is a condition that may result in so many other medical issues. I have worked with nutrition services for many years and it is a field that is quite discouraging! It is very difficult to establish and maintain a healthy lifestyle. We grow up learning unhealthy habits and changing them permanently to healthy habits is a life-long journey. Again, I think support groups are helpful here, to encourage people on a life-long journey to live healthier lifestyles. Sometimes it is an issue of people not able to afford fruits and vegetables and other health foods, but then I see those same folks drinking regular pop and eating fast food. So it is a matter of choice! Again, I have no answers! – Healthcare Provider
>
> Living in Glasgow, MT, you'd think the cost of living is cheaper as we're rural. In reality, this is quite the opposite. Fruit and veggies are much more expensive as they must get shipped way up here in addition to food just being expensive. Fast food is much quicker, and in some cases, cheaper than cooking healthy for a large family. As we are far north, much of the year is cold it's hard to exercise outside. We have 2 places you can pay to work out indoors, however, for a family it may not always be cost effective. At the end of the day, I think it's lack of prioritizing funds and time properly to be healthy. But there has to be ways that we could incentivize people to create better habits! – Community/Business Leader
>
> limited outside exercise options like walkways or trails nearby, extra limited options during winter months. nutrition: groceries are expensive, not lots of alternative food options that aren't fast food. 33.5% of VC adults are considered obese, which means even more are considered overweight- this is a result of and cyclical perpetuate of physical activity/nutrition concerns. large drinking culture out here which contributes to negative health outcomes including weight and nutrition – Public Health Representative
>
> Family responsibility and education in schools and civic clubs. – Healthcare Leadership
>
> Social activity based on food and alcohol. Weather not conducive to outdoor activities much of the year. Social norm to overindulge. Conventional methods of entertaining based around non nutritious offerings. Caretakers offer kids pop and candy far too often with no understanding or acceptance of the need to offer healthier alternatives. – Social Service Provider

Awareness/Education

> Education, some of this coincides with the mental health component, better mental health increases commitment to living a healthier lifestyle. – Public Health Representative
>
> The view of nutrition and physical health are not seen as issues in the area. Many people do not take them seriously and see the importance of healthy weight and physical activity. – Community/Business Leader
>
> Lack of education and health facilities with quality programs for healthy eating and living. – Healthcare Provider

Access to Affordable Healthy Food

> Lack of availability of local, healthy food. Corporate interests promoting unhealthy food. – Healthcare Leadership
>
> Limited access to nutritional foods. – Healthcare Provider

Access to Care/Services

> Again, very limited options, if any. Who can help with nutrition here? No one has access to FMDH dieticians, long and dark winter season (October-March) so outdoor activity very limited. Walk around a small gym while basketballs and volley balls are flying by? No thanks. – Public Health Representative

Nutrition

> Fast food is easy, people don't understand that your diet directly affects disease and your overall wellbeing. – Social Service Provider

SUBSTANCE ABUSE

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …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.

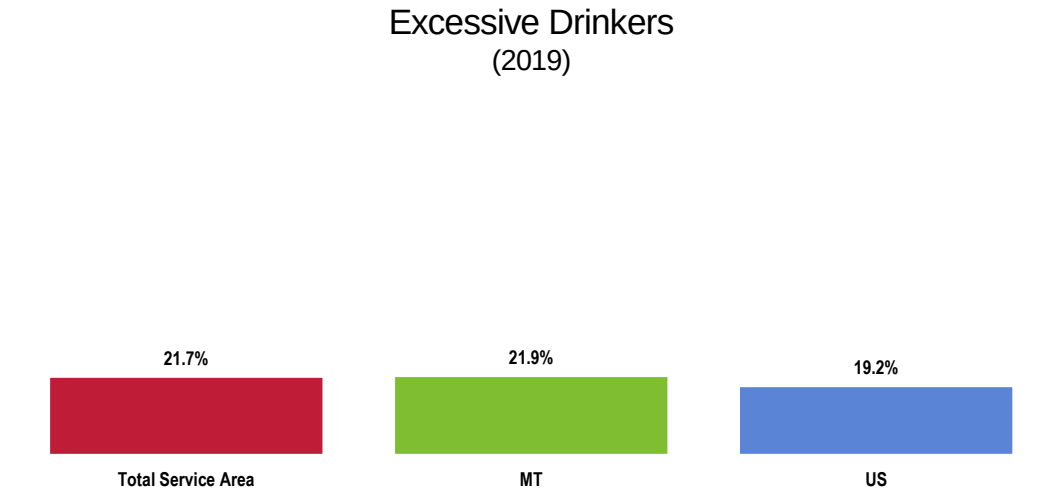
– Healthy People 2030 (https://health.gov/healthypeople)

Excessive Alcohol Use

Excessive drinking includes heavy and/or binge drinkers:

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

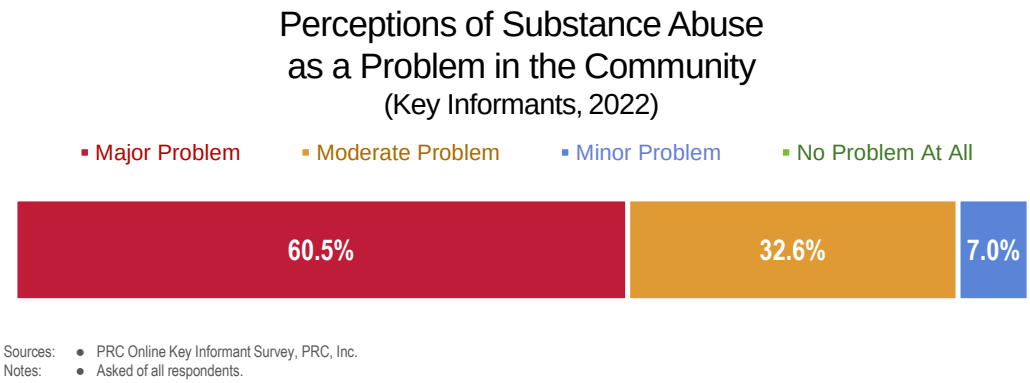


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of adults aged 18 and older who self-report heavy alcohol consumption (defined as more than two drinks per day on average for men and one drink per day on average for women). This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as cirrhosis, cancers, and untreated mental and behavioral health needs.

Key Informant Input: Substance Abuse

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



Top Concerns

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

Contributing Factors

> Lack of availability and capacity. Affordability. – Healthcare Leadership
>
> Our community needs an inpatient and residential treatment facility. Most don't come in to receive treatment until they are in trouble with either law enforcement or Child and family services. If there were more media messages (such as social media) making the connection known between mental health issues and substance use maybe more people would make that personal connection and come in and begin addressing the mental issues that are triggering the substance use issues before they are in trouble. Many who are heavily addicted also have underlying mental issues that cause them to be paranoid about receiving telehealth services only. It is a very uncomfortable process for them. Most will become accustomed to it and accept it, but some will not return because it causes them too much anxiety. Telehealth is a great alternative, but we need more in person addiction counselors. The price of court ordered alcohol and drug classes and treatment are astronomical and unreachable for most. – Social Service Provider
>
> There used to be a treatment center at the hospital in Glasgow many years ago, but nothing now. There is some service that I recently saw an ad for that just started up, so that is great! Again, resources are hard to find locally, and finances are an issue. – Healthcare Provider
>
> Location, time and money, and stigma. Substance abuse is socially accepted here. – Healthcare Provider
>
> Many people are unwilling to admit they need help with substance abuse. When they do admit to needing help, there are no facilities in our area to help them. – Community/Business Leader
>
> Stigma and lack of treatment options. – Public Health Representative
>
> Stigma, lack of care options, lack of mental health services requiring self-medication with illicit substances. – Healthcare Leadership
>
> Lack of providers and a negative stigma. – Social Service Provider

Access to Care/Services

> Licensed addiction counselors and local treatment facility. – Public Health Representative
>
> Access to care. – Healthcare Provider
>
> Location and lack of proper facilities. – Healthcare Provider
>
> Everything and anything. It's not just the meth, alcohol, and smoking. Access to treatment, then their lack of staffing, financial resources, and the need to help oneself. – Community/Business Leader

Denial/Stigma

> Stigma to seek out treatment and the fact that it is culturally the norm to abuse alcohol and tobacco. – Social Service Provider

> No one wants to be labeled as someone that uses drugs or is an alcoholic and again, in a small community everyone talks and it's hard to keep it to just yourself. We also don't have the resources. – Healthcare Leadership
>
> Stigma, small community and may not be able to avoid situations, lack of support groups. – Healthcare Provider
>
> Stigma is number one, denial, i.e. acceptance/acknowledging the problem, mental health struggles (addressed or not), extremely prevalent drinking culture, not caring to change. – Public Health Representative

Social Norms/Community Attitude

> Substance abuse is not seen as a problem in the area. It is seen as a norm for many people. – Community/Business Leader
>
> People in this area don't see an issue with binge drinking. Many also don't think there is a drug problem as well. Whenever a person/group puts on an event, there is always alcohol involved. There aren't many programs in our area for substance abuse treatment. There is our mental health center and two AA/NAA groups for support. There is no push for the reform system on those who come out of jail that were addicts or alcoholics. – Public Health Representative
>
> Binge drinking is four to five beers in one sitting. Here, that is an average rate of consumption, so the misconception is that there is "not a problem." – Social Service Provider
>
> Our culture. Substance abuse is not something new to this community. Trying to get people to recognize they have a problem when it's been a problem in their family since they were born is a never ending challenge. And if you get them to recognize they have a problem, the next challenge is getting them to accept help. – Community/Business Leader

Diagnosis/Treatment

> If ideal options goal was to get patients off suboxone would be great for community. what I say of ideal options out of Williston was increased amounts given and no one ever getting off. Really helping patients getting clean through suboxone, counseling and support would be great. – Public Health Representative

Employment

> Community members not wanting to find jobs and not choosing healthy lifestyles to include attending churches, etc. to help with their spiritual and emotional needs. – Community/Business Leader

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 Abuse as a "Major Problem")	
ALCOHOL	79.2%
METHAMPHETAMINE OR OTHER AMPHETAMINES	12.5%
MARIJUANA	4.2%
HEROIN OR OTHER OPIOIDS	4.2%

TOBACCO USE

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

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

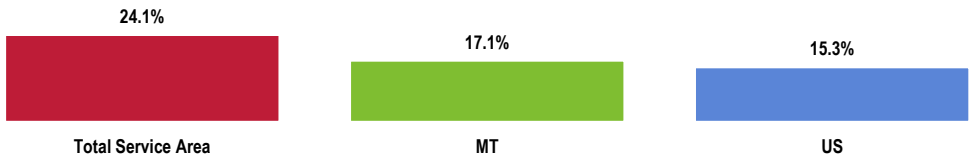
Tobacco use is linked to the two major leading causes of death: cancer and cardiovascular disease. Note below the prevalence of cigarette smoking in our community.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

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

"Current smokers" are defined as those who smoke every day or on some days.

Current Smokers
(2019)
Healthy People 2030 = 5.0% or Lower

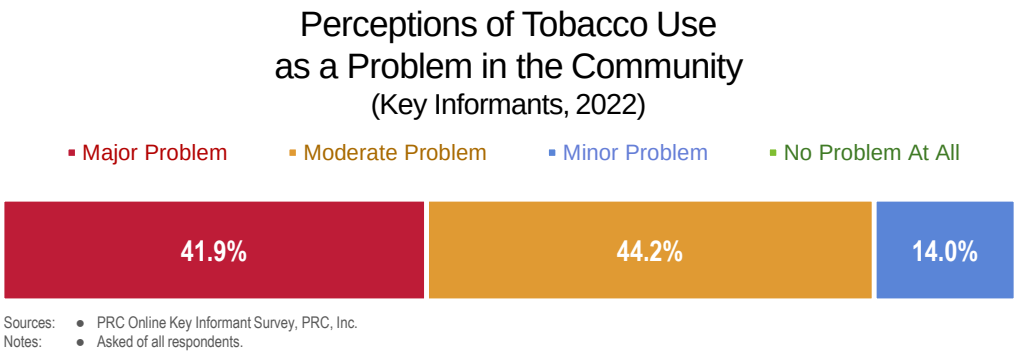


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).
- This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.

Key Informant Input: Tobacco Use

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



Top Concerns

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

Teen/Young Adult Usage

> Valley county youth tobacco or vape use is among the highest in MT, over 1/4 high school kids currently or frequently smoking + 60% have tried vaping and 42% currently vape. Over half of those kids got the nicotine from someone else which shows enabling/complacency from adults. About 1/5 of VC adults smoke, and neighboring Roosevelt City is 2nd in MT at 1/3 of the adults smoking. Cigarettes are sold in bars, which makes money but reduces friction in getting smokes. – Public Health Representative
>
> Any time young people purposefully begin using an addictive substance, it is a major problem in the community and for society. – Public Health Representative
>
> Tobacco use is started at an early age, and it is easy for underage users to obtain illegally. – Healthcare Provider
>
> Vaping, smoking, and chewing is getting into the younger population more and more. The biggest issue with tobacco use is the fact that our community does not see it as a problem. Most just roll their eyes at the sight of tobacco use prevention. – Public Health Representative

Incidence/Prevalence

> It is highly prevalent, especially chewing. It is socially acceptable and almost encouraged as a rural Montana person that you do one or the other. – Healthcare Provider
>
> Many people in the community use tobacco and many younger people see them do it. – Community/Business Leader
>
> Everyone smokes and chews. – Healthcare Leadership

Impact on Quality of Life

> Many people smoke or use chewing tobacco, which leads to multiple health issues. – Community/Business Leader
>
> Smoking causes so many health problems. – Social Service Provider

Social Norms/Community Attitude

> It is so accepted and accessible. – Social Service Provider
>
> Socially and culturally accepted. Generationally accepted. False sense of safety of the alternatives, such as switching to chew and vaping from smoking. – Social Service Provider

Anxiety/Stress

> People resort to tobacco use to curb their anxieties and such and it is costly to them to keep buying tobacco, so they move on to the next issue, substance abuse. – Community/Business Leader

Easy Access

> Easy access, community perception. – Social Service Provider

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.

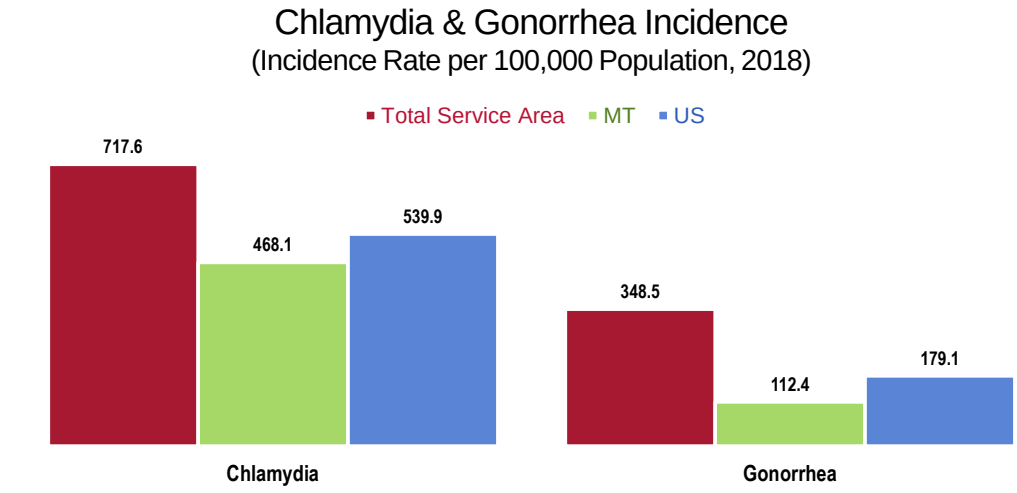
Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the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

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

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.

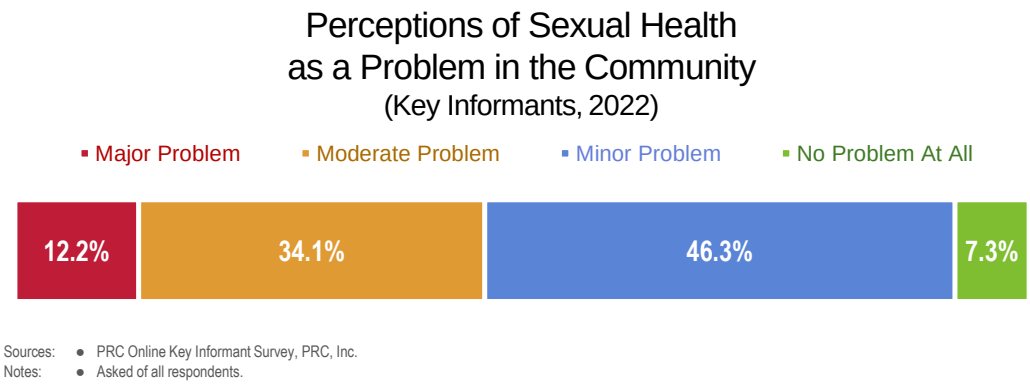


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

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



Sources: 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:

Awareness/Education

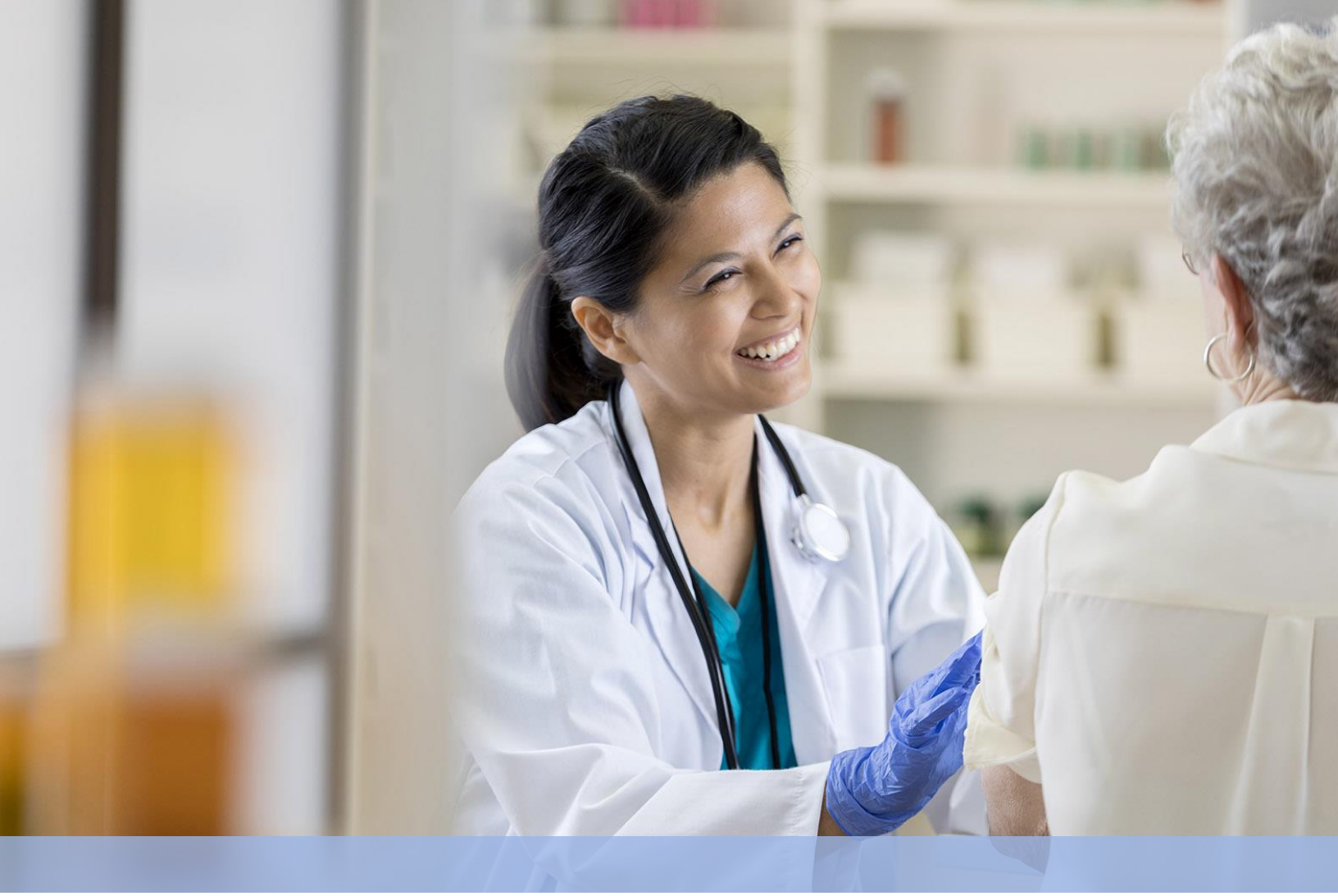
> It is taboo to talk to youth in school about sexual health. Parents think too much information will give the youth ideas. – Public Health Representative
>
> Lack of education. – Healthcare Provider
>
> STDs are on the rise, I've heard, "No one uses condoms anymore." I don't know what sex education is like in VC schools, but MT only requires abstinence and HIV/AIDS education to be part of the curriculum (not about contraceptives). – Public Health Representative

Contributing Factors

> The drug use is high and most aren't educated on sexual health, which is direly needed. – Community/Business Leader

Incidence/Prevalence

> High number of STDS. – Public Health Representative



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. …About 1 in 10 people in the United States don't have health insurance. 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.

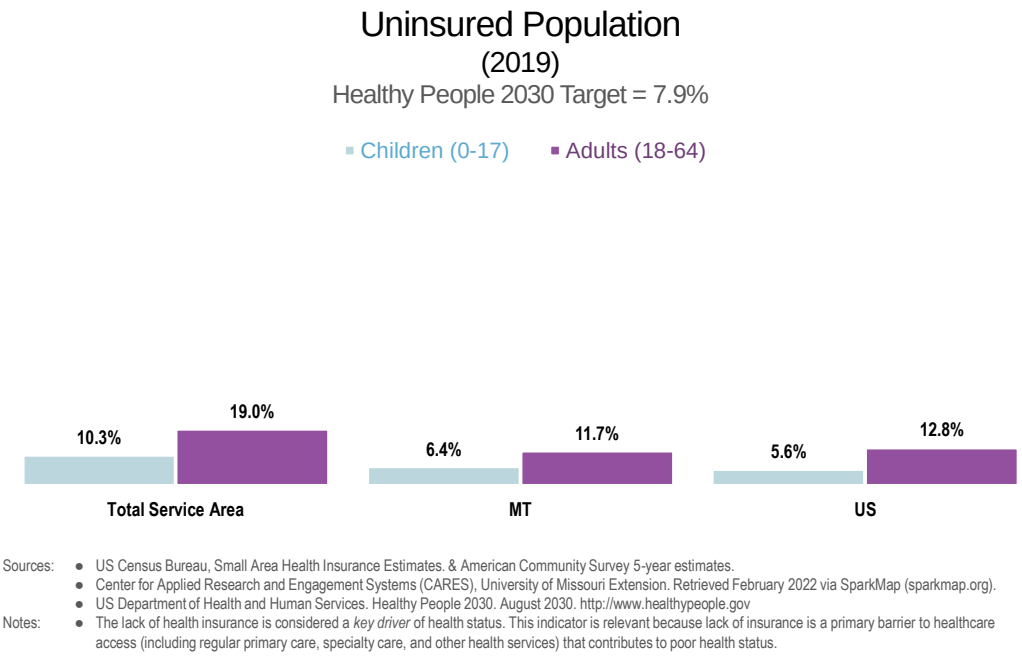
Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — 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 (e.g., Medicaid).

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) in the Total Service Area.

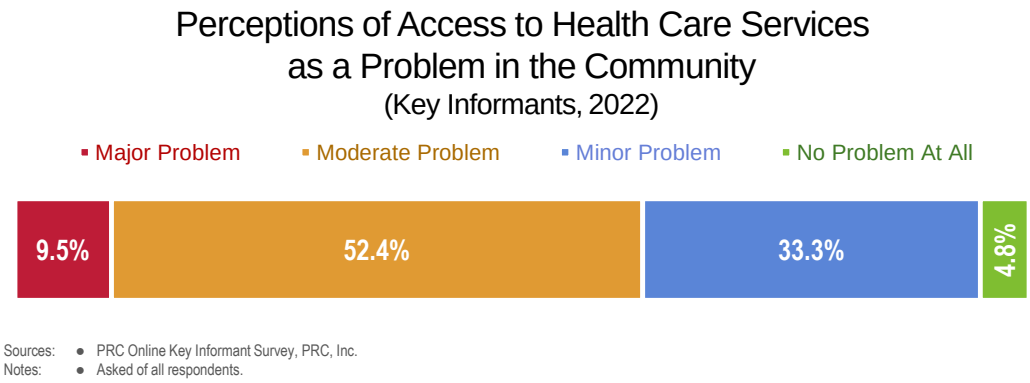


Sources:
- US Census Bureau, Small Area Health Insurance Estimates. & American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- The lack of health insurance is considered a *key driver* of health status. This indicator is relevant because lack of insurance is a primary barrier to healthcare access (including regular primary care, specialty care, and other health services) that contributes to poor health status.

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: 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:

Burnout

> Access to care isn't an issue for most health issues. However, availability of healthcare workers at the access point is a major issue. For example, EMT personnel to work on ambulance crews, RNs/CNAs/etc in hospitals, practitioners in clinics, etc. Communities overcome those shortfalls through traveling professionals. However, that is not sustainable due to the extreme cost of travelers. Healthcare organization budgets & finances are very tight. Spending money on travelers means they are unable to allocate funds to equipment upgrades/replacement, facility improvements, etc. We are witnessing the gradual death of our healthcare organizations. – Healthcare Leadership

Access to Care/Services

> The availability of doctors and the travel distance. – Community/Business Leader

Contributing Factors

> Cost of services. Education as to how to obtain health care. Lack of emphasis on preventative healthcare. – Healthcare Leadership

Cost of Care

> Financial. – Healthcare Provider

Lack of Providers

> Limited number of providers for every possible body system. Getting an appointment with provider of choice, and then with any provider is not always possible in a timely manner. Specialists and specialty testing are sorely lacking. Health care beyond the basics usually involves driving hours away and paying for a hotel overnight. – Public Health Representative

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.

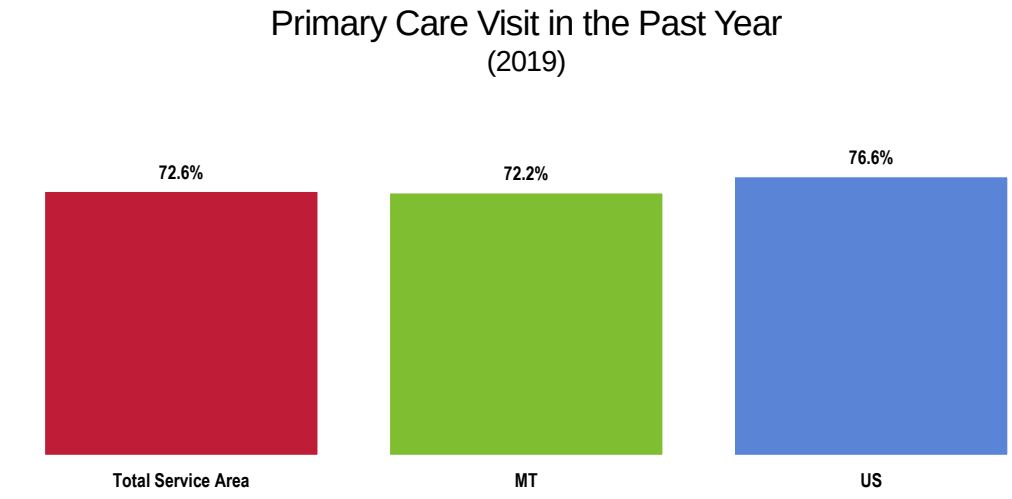
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't 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 have had at least one visit to a doctor for a routine checkup in the past year.



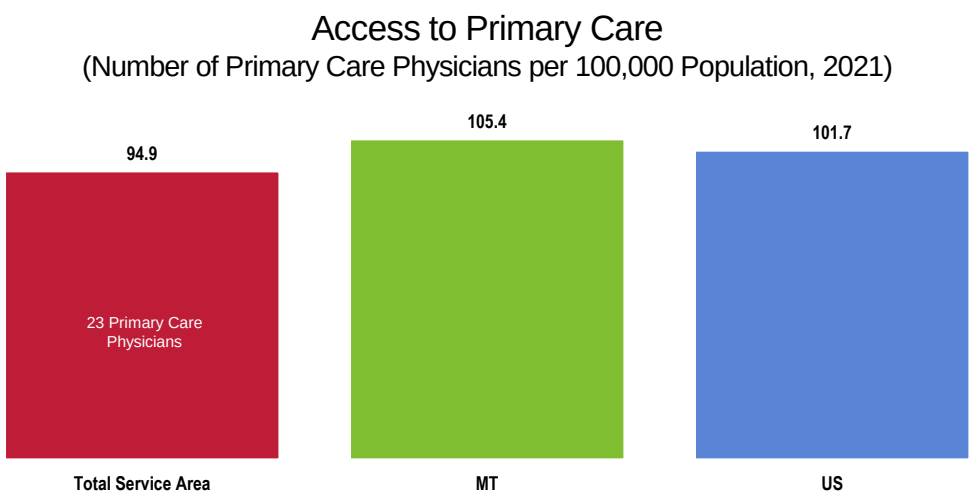
Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

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 sub-specialties within the listed specialties are excluded.

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:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 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. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

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.

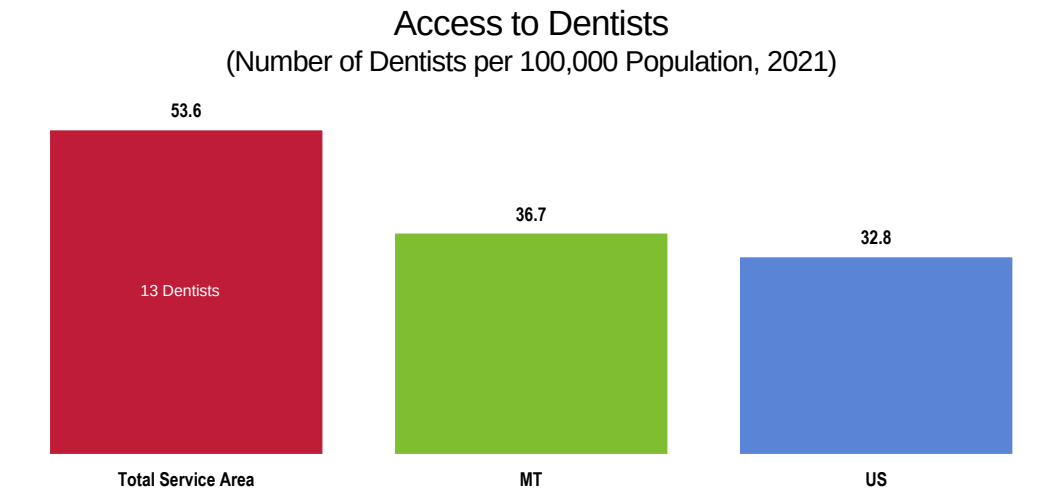
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching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

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

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.

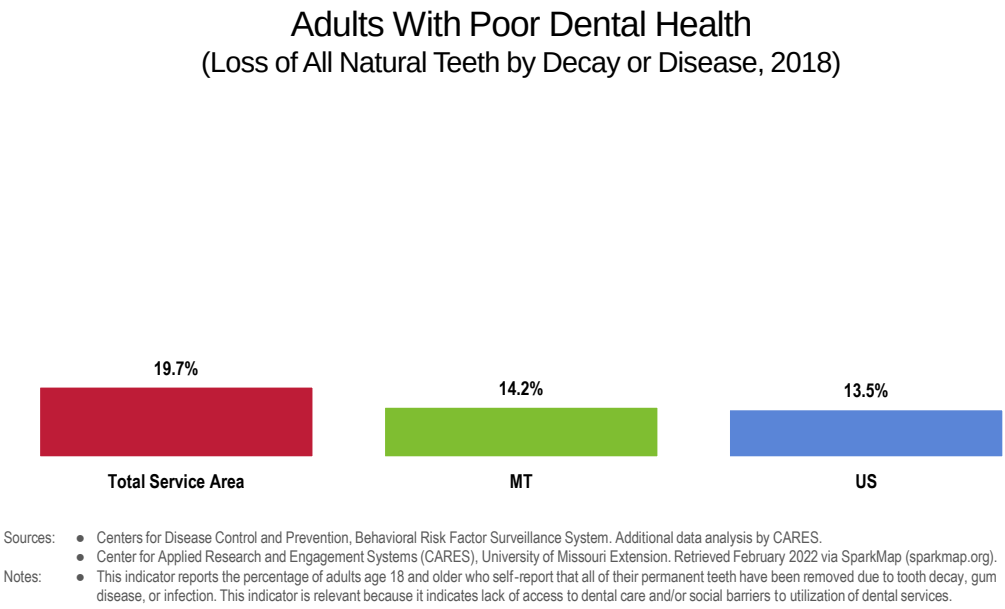


Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

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.

Poor Dental Health

The following chart shows the percentage of Total Service Area adults age 18 and older who have had all of their permanent teeth removed due to tooth decay, gum disease, or infection. This indicator can signify a lack of access to dental care and/or other barriers to the use of dental services.

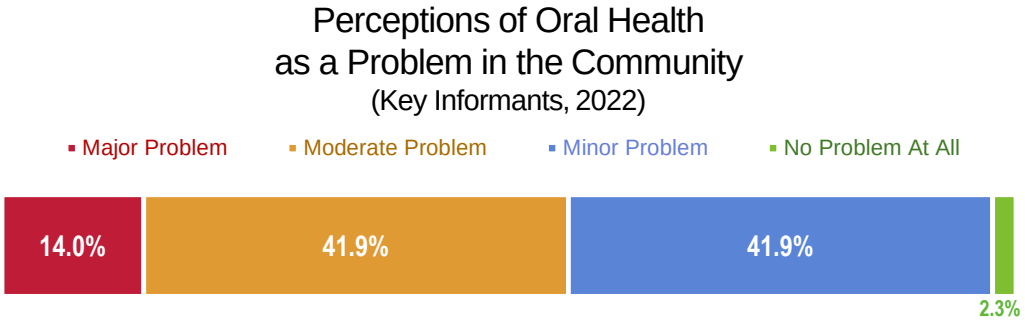


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of adults age 18 and older who self-report that all of their permanent teeth have been removed due to tooth decay, gum disease, or infection. This indicator is relevant because it indicates lack of access to dental care and/or social barriers to utilization of dental services.

Key Informant Input: Oral Health

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



Sources:
- 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 for Medicare/Medicaid Patients

> No one accepts Medicaid in Valley County, so no low-income children have local access to a dentist. – Public Health Representative
>
> Dentists in Northeastern MT do not take Medicaid. There are so few dentists in the area that it is also hard to get into them. – Community/Business Leader

> We have three dentists in our area, none of which take Medicaid as a payment source. Therefore, making it very difficult for consumers with limited income or fixed income to seek care. – Social Service Provider

Insurance Issues

> In our surrounding counties, specifically Valley, it is hard to find a place that will take your insurance. Dental work out of pocket is expensive and many can't afford to pay it themselves and wait for insurance reimbursement. If more places accepted insurance, there would not be such a major issue. It is to the point, people need to travel 3-4 hours just to get dental work. Some have to go once every month or two. – Public Health Representative

> Nobody takes insurance or has office hours five days per week. – Public Health Representative

Dental Expansion

> Dental is still in need of more expansion to include healthy Montana kids. The visiting dentist isn't advertised or known enough. I am not sure how busy they are though. – Community/Business Leader

Contributing Factors

> Lack of insurance and education in families. – Healthcare Leadership

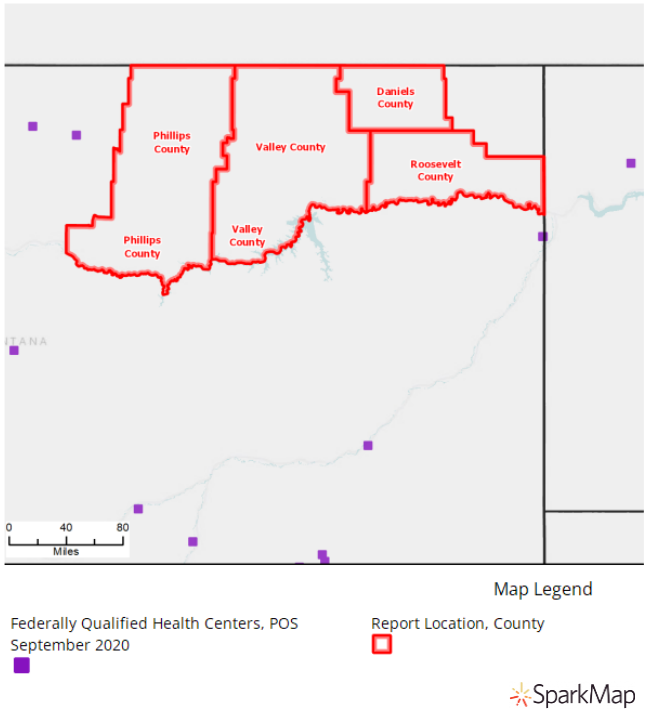
LOCAL RESOURCES

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) in the region.



Resources Available to Address the 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

- Adult Protective Services
- Community Integrated Health/EMS
- County Extension
- County Nurse
- Dentist's Offices
- Doctor's Offices
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Home Care Montana
- Malta Clinic
- School System
- Sugg Health Clinic
- Valley County Council on Aging Ombudsman

Cancer

- Advanced Accelerator Applications
- Cancer Coalition
- Daniels County Cancer Coalition
- Daniels County Public Health
- Daniels Memorial Hospital
- Doctor's Offices
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Health Department
- Hospitals
- Media
- Montana State University County Extension
- Sidney Hospital Cancer Center
- Valley County Hope Project
- Veterans Health Providers

Dementia/Alzheimer's Disease

- Faith Home
- Glasgow Clinic
- Home Health Care
- Hospitals
- Long-Term Care Facilities
- Montana State University County Extension
- Prairie Ridge
- Senior Center
- Valley County Elder Care Programs
- Valley View Nursing Home
- Veterans Health Providers

Diabetes

- Billings Clinic Telemed
- Doctor's Offices
- Extension Office
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Hospitals
- Indian Health Services
- Montana State Representatives
- Radio
- School System

Disability & Chronic Pain

- Casterline Family Chiropractic
- Doctor's Offices
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Massage Therapists
- Milk River Activity Center
- Montana State University County Extension
- Social Security Disability Determination Department
- State Legislators
- Sugg Health Clinic
- Vocational Rehabilitation

Heart Disease & Stroke

- Cardia Ready Program
- Community Integrated Health/EMS
- Daniels County Ambulance Association
- Fitness Centers/Gyms
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Hospitals
- Physical Therapy Centers

- Public Health
- Radio
- School System
- Stat Air Ambulance Cooperative

Infant Health & Family Planning

- Churches
- Daniels Memorial Hospital
- Glasgow Clinic
- Health Department
- Office of Public Assistance
- School System
- Sugg Health Clinic
- Valley County Health Department
- Women, Infants and Children

Injury & Violence

- Glasgow Clinic
- Valley County Sheriff's Office

Kidney Disease

- Dialysis Center
- Glasgow Clinic
- Indian Health Services

Mental Health

- Affordable Healthcare for Everyone
- Care Coalition
- Child and Family Services
- Churches
- Counseling Services
- Daniels Memorial Hospital
- Eastern Montana Community Mental Health Center
- Frances Mahon Deaconess Hospital
- Frontier Psychiatry
- Glasgow Clinic
- Glasgow Mental Health Center
- Health Promotion Disease Prevention Social Worker
- Highline Homes
- Hospitals
- Ideal Options
- Insurance Commission
- Life Path Connections
- Mental Health Center
- Mental Health Services
- Milk River
- Montana Hope
- Neighbors and Friends
- North Hinsdale Health Clinic Primary Care
- Northeast Montana Mental Health
- Online Resources
- Sugg Health Clinic
- Suicide Hotline
- Teaming Together Counseling
- Telemed
- The Gathering Place Counseling
- Tribal Health
- Valley CARE Coalition
- Valley County Health Department
- Valley View Nursing Home
- Youth Dynamics

Nutrition, Physical Activity, & Weight

- Billings Clinic Telemed
- Bountiful Baskets
- Churches
- Civic Center
- County Extension
- Farmer's Market
- Fitness Centers/Gyms
- Food Bank
- Food Stamp Program
- Frances Mahon Deaconess Hospital
- Friends/Family
- Glasgow Clinic
- Glasgow Recreation Department
- Health Department
- Hospitals
- Just for Kicks
- Kraze Fitness
- Parks and Recreation
- School System
- The Body Building
- Valley CARE Coalition
- Women, Infants and Children

Oral Health

- Budde Family Dentistry
- Doctor's Offices
- Friends/Family
- Health Department
- School System

Respiratory Disease

- Glasgow Clinic

Sexual Health

- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Health Department
- School System
- Valley County Health Department

Substance Abuse

- Chemical Dependency Services
- Churches
- Community Mental Health and Chemical Dependency Clinic
- Counseling Services
- Daniels Memorial Hospital
- Eastern Montana Community Mental Health Center
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Hospitals
- Ideal Options
- Mental Health Center
- Mental Health Services
- Online Resources
- Valley CARE Coalition

Tobacco Use

- Daniels Memorial Hospital
- Department of Public Health and Human Services Quit Programs
- Doctor's Offices
- Eastern Montana Community Mental Health Center
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Health Department
- High Tax Rates on Tobacco
- Hospitals
- Ideal Options
- Montana Quit Line
- Montana Tobacco Use Prevention Program
- My Life My Quit
- Smoking Hotline
- Sugg Health Clinic
- Tobacco Cessation Programs
- Valley County Health Department
- Veterans Health Providers

APPENDIX

EVALUATION OF PAST ACTIVITIES

CHNA Evaluation Report (2019-2022)

Access to Care

- Working on a project to provide free passes for the Transit Bus to people in need of medical care
    - Provide to ER, then, if it works, expand it to other areas of the hospital
- FMDH Glasgow Clinic Primary Care is extending hours to 6:00 pm to accommodate more people
- Orthopedic Clinic - fully staffed 24/7 starting Nov 2020
    - Sports medicine
    - Joint replacement – hips, shoulders, knees
    - Arthroscopic surgery
- Transitional Care/Swing Bed Program – able to take people from hospitals (ex: Billings) who want to be back home but aren't ready to go home. We provide care to those that will eventually go home but need some rehab and don't want to go to assisted living or nursing home since they will be able eventually go to back to independent living.
- Psychiatric Evals in the ER and Inpatient (Telehealth through Fronter) – starts Tuesday, June 1st, 2021
- OB/GYN to be staffed full time, 2 weeks/month starting May 5th, 2022
- General Surgery to be fully staffed 24/7 staring May 1st, 2022
- Purchased a handicap accessible van for Valley View Home so they could transport their residents to hospitals for care.
- Provided funding for Valley View Home to hire a temporary marketing person that would run another 'Vote Yes Valley View' campaign to potentially pass more funding for VVH through a levee.
- Tuesday, November 9th FMDH hosted a flu vaccine clinic from 5:00 – 6:30 pm for ages 6 months + to get their flu shot to help relieve VCHD.
- FMDH provided free rides to anyone, through the Transit Bus, to come to the COVID-19 Vaccine Clinic in Nov 2021.

Mental Health

- Gray Area Project (GAP) – connects behavioral health services with those that need them (ex: people coming to ER for substance or alcohol abuse)
- Resource Guide – put around different businesses – has all the numbers of legal service, emergency and law enforcement, transportation, city and government, elderly services, etc.

- Live Under the Big Sky – mental and behavioral health series
    - Oct 29, 2020 – Montana Suicide Prevention
    - Nov 24, 2020 – Team Together Counseling – Melanie Burner
    - Dec 16, 2020 – Emmaline Keesee – Stories from the Strong and Pen Pal program
    - August 2021 – 988
- Stories from the Strong – people anonymously telling their stories to raise awareness for mental health and substance use and bring hope
- Senior Pen Pal Program – connects those who are unable to get out (ex: in resident homes) to people in the community
- NARCAN training – automatic reversal for opioids (train our first responders yearly)
- Behavioral Health Resource guide posted to Valley CARE's website (www.valleycarecoalition.com)
    - Has resources for Valley, Daniels, Phillips, Roosevelt, Garfield, McCone and Sheridan County for mental health, addiction, and development disability
- QPR (Question, Persuade, Refer) and Mental Health First Aid trainings
    - 275 trained in QPR in Valley County
    - 11 in MHFA in Valley County
- Community Mental Health Assessment – 137 surveys filled out during NEMT Fair (Aug 2021)
    - The survey was conducted a few years ago and these results increased/changed from last time:
        - Awareness that mental health is an issue in our community
        - People wanting mental health talked about in schools
        - When people are struggling with mental health, pastor or trusted friend are the main ones sought out
- Tri-Ethnic Assessment – evaluated Valley County's readiness to tackle certain issues related to mental health (substance abuse, alcohol)
    - Results – Valley County knows underage drinking is an issue. It is culturally acceptable in this area. People aren't generally concerned with fixing it or have no knowledge about city/county leadership making efforts to do so.
- Working on Mental Health Billboard with 988 number
    - What is 988?? In a medical emergency, you would dial 911. In a mental health emergency, you dial 988 which will connect you to someone qualified to handle the situation whether you're the one in it or you are with someone who is.
- Annual Mental Health Awareness Walk (either in May or June each year)
- Annual Community Meeting where we bring in speakers on mental health topics and collaborate with community members on what they think we can focus more on each year
- Youth Coalition – based on survey data gained, many youth in this community believe that mental health is an issue; working with Superintendent to start a Youth Coalition for kids to be actively involved in bettering fellow classmate's mental health

Physical Activity & Nutrition

- Resource Guide for physical activity options in Glasgow, MT (paid/free, indoor/outdoor, intensity level, etc.)
- Working with Farmer's Market to potentially accept food stamps
- Fruit & Veggie Program
    - We continue to sponsor the Fruit & Veggie Program at the Glasgow Schools. Some of the past few week's options have been broccoli, bananas, blood oranges, grapes, kiwis, apples, and snap peas.

COVID-19

- Contact tracing for COVID-19 at Senior Citizen Center (pre surgical, employees, community)
    - October 2020 – April 2021
- Community Immunizations – every Wednesday starting Jan. 27th until May 26th