## Executive Report

# 2019 Community Health Needs Assessment

## Total Service Area

### Daniels, Phillips, Roosevelt & Valley Counties, Montana

*Prepared for:*

Frances Mahon Deaconess Hospital

*By:*

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# Table of Contents


## Introduction 5

**Project Overview 6**

Project Goals 6

Methodology 6

**IRS Form 990, Schedule H Compliance 10**

**Summary of Findings 11**

Identified Health Needs of the Community 11

Secondary Data Tables: Comparisons With Benchmark Data 14

## Community Description 19

**Population Characteristics 20**

Total Population 20

Urban/Rural Population 22

Age 22

Race & Ethnicity 24

Linguistic Isolation 26

**Social Determinants of Health 27**

Poverty 27

Education 30

Employment 31

## General Health Status 32

**Overall Health Status 33**

Self-Reported Health Status 33

**Mental Health 34**

Suicide 35

Key Informant Input: Mental Health 35

## Death, Disease & Chronic Conditions 38

**Cardiovascular Disease 39**

Age-Adjusted Heart Disease & Stroke Deaths 39

Prevalence of High Blood Pressure 41

Key Informant Input: Heart Disease & Stroke 42

**Cancer 44**

Age-Adjusted Cancer Deaths 44

Cancer Incidence 45

Cancer Screenings 46

Key Informant Input: Cancer 47

**Respiratory Disease** **49**
Age-Adjusted Lung Disease Deaths 50
Key Informant Input: Respiratory Disease 50
**Injury & Violence** **52**
Unintentional Injury 52
Key Informant Input: Injury & Violence 54
**Diabetes** **55**
Prevalence of Diabetes 55
Key Informant Input: Diabetes 56
**Alzheimer's Disease** **57**
Key Informant Input: Dementias, Including Alzheimer's Disease 57
**Kidney Disease** **59**
Key Informant Input: Kidney Disease 59
**Potentially Disabling Conditions** **60**
Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions 60
Vision & Hearing Impairment 62

## Infectious Disease 64

**HIV** **65**
Key Informant Input: HIV/AIDS 66
**Sexually Transmitted Diseases** **67**
Chlamydia & Gonorrhea 67
Key Informant Input: Sexually Transmitted Diseases 68
**Immunization & Infectious Diseases** **70**
Key Informant Input: Immunization & Infectious Diseases 70

## Births 71

**Birth Outcomes & Risks** **72**
Low-Weight Births 72
Infant Mortality 73
Key Informant Input: Infant & Child Health 73
**Family Planning** **75**
Births to Teen Mothers 75
Key Informant Input: Family Planning 76

## Modifiable Health Risks 77

**Nutrition, Physical Activity & Weight** **78**
Nutrition 78
Physical Activity 80
Access to Physical Activity 81
Weight Status 82

Key Informant Input: Nutrition, Physical Activity & Weight 83
**Substance Abuse** **85**
Key Informant Input: Substance Abuse 86
**Tobacco Use** **89**
Cigarette Smoking Prevalence 89
Key Informant Input: Tobacco Use 90
**Access to Health Services** **91**
**Lack of Health Insurance Coverage** **92**
**Difficulties Accessing Healthcare** **93**
Key Informant Input: Access to Healthcare Services 93
**Primary Care Services** **95**
Access to Primary Care 95
**Oral Health** **96**
Key Informant Input: Oral Health 96
**Local Resources** **98**
**Healthcare Resources & Facilities** **99**
Federally Qualified Health Centers (FQHCs) 99
**Resources Available to Address the Significant Health Needs** **100**
**Appendix** **103**
**Evaluation of Past Activities** **104**
CHNA Action Update – Nutrition, Weight, and Physical Activity 104
January, 2017 104
January, 2018 105
October, 2018 105
January, 2019 106

# Introduction

Professional Research Consultants, Inc.

# Project Overview

## Project Goals

This Community Health Needs Assessment is a systematic approach to determining the health status, behaviors, and needs of residents in the Primary 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.

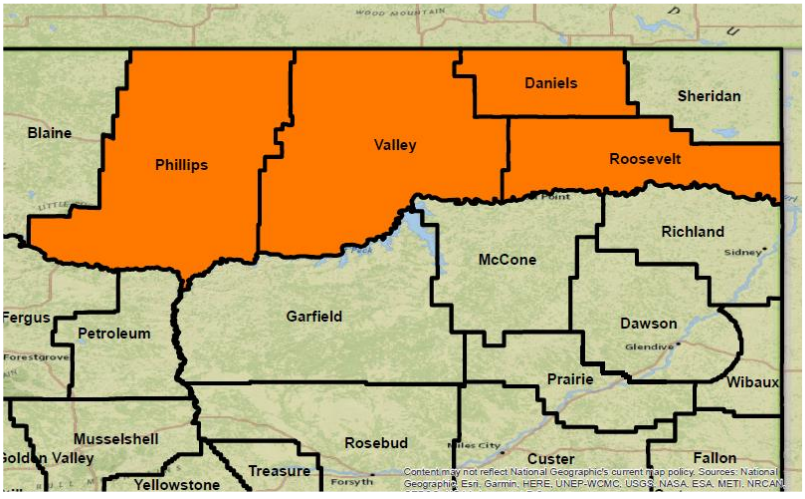
This assessment was conducted on behalf of Frances Mahon Deaconess Hospital by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

## Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input 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 gathered through the Online Key Informant Survey.

### Community Defined for This Assessment

The study area for this effort (referred to as the “Total Service Area” in this report) includes 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 key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey 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, 64 community stakeholders took part in the Online Key Informant Survey, as outlined below:

| Online Key Informant Survey Participation | | |
|---|---|---|
| **Key Informant Type** | **Number Invited** | **Number Participating** |
| Physicians | 8 | 1 |
| Public Health Representatives | 10 | 8 |
| Other Health Providers | 50 | 38 |
| Social Services Providers | 12 | 3 |
| Community/Business Leaders | 12 | 4 |
| Other Community Leaders | 45 | 10 |

Final participation included representatives of the organizations outlined below.

- Frances Mahon Deaconess Hospital (FMDH)
- Daniels Memorial Healthcare Center (DMHC)
- Valley County Health Department (VCHD)
- Eastern Montana Community Mental Health Center
- Fast Farms
- Glasgow Police Department
- Glasgow Recreation Department
- Hi-Line Eye Care, PLLC
- Prairie Ridge Village
- Riverside Family Clinic (RFC)
- Roosevelt County Health Department
- Valley County Health Board
- Youth Dynamics

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

**Minority/medically underserved populations represented:**

> *Adopted/foster care children, those with developmental disabilities, Filipinos, the homeless, non-White/minority/indigenous populations, low-income residents, Medicare/Medicaid recipients, those with mental health issues, Native Americans, older adults, rural residents, transient workers, the unemployed/underemployed, the uninsured/underinsured*

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: 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. Thus, these findings are based on perceptions, not facts.*

### Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Environmental Systems (CARES)
- 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
- Community Commons
- 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

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

## 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 a great number of 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 Form 990 Schedule H, the following table cross-references related sections.

| IRS Form 990, Schedule H (2018) | See Report Page(s) |
|---|---|
| **Part V Section B Line 3a**<br>*A definition of the community served by the hospital facility* | 6 |
| **Part V Section B Line 3b**<br>*Demographics of the community* | 20 |
| **Part V Section B Line 3c**<br>*Existing health care facilities and resources within the community that are available to respond to the health needs of the community* | 100 |
| **Part V Section B Line 3d**<br>*How data was obtained* | 6 |
| **Part V Section B Line 3e**<br>*The significant health needs of the community* | 11 |
| **Part V Section B Line 3f**<br>*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**<br>*The process for identifying and prioritizing community health needs and services to meet the community health needs* | 12 |
| **Part V Section B Line 3h**<br>*The process for consulting with persons representing the community's interests* | 7 |
| **Part V Section B Line 3i**<br>*The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)* | 104 |

# Summary of Findings

## Identified 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 and the guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the 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 Services** | • Lack of Health Insurance [Adults & Children]<br>• Primary Care Physician Ratio |
| **Cancer** | • Cancer Deaths<br>• Prostate Cancer Incidence<br>• Colorectal Cancer Incidence |
| **Diabetes** | • Diabetes Prevalence<br>• Diabetes ranked as a top concern in the Online Key Informant Survey. |
| **Heart Disease & Stroke** | • Leading Cause of Death<br>• Heart Disease Deaths<br>• Stroke Deaths |
| **Infant Health & Family Planning** | • Infant Deaths<br>• Teen Births |
| **Injury & Violence** | • Unintentional Injury Deaths |
| **Mental Health** | • Suicide Deaths<br>• Mental Health ranked as a top concern in the Online Key Informant Survey. |

— continued next page —

| Areas of Opportunity (continued) | |
|---|---|
| **Nutrition, Physical Activity & Weight** | • Low Food Access<br>• Obesity<br>• Leisure-Time Physical Activity<br>• Access to Recreation/Fitness Facilities<br>• Nutrition, Physical Activity & Weight ranked as a top concern in the Online Key Informant Survey. |
| **Respiratory Diseases** | • Chronic Lower Respiratory Disease (CLRD) Deaths |
| **Sexually Transmitted Diseases** | • Gonorrhea Incidence<br>• Chlamydia Incidence. |
| **Substance Abuse** | • Excessive Drinking<br>• Substance Abuse ranked as a top concern in the Online Key Informant Survey. |
| **Tobacco Use** | • Cigarette Smoking Prevalence<br>• Tobacco Use ranked as a top concern in the Online Key Informant Survey. |

## Community Feedback on Prioritization of Health Needs

On May 29, 2019, internal and external stakeholders of Frances Mahon Deaconess Hospital met to evaluate, discuss and prioritize health issues for the community, based on findings of the 2019 PRC Community Health Needs Assessment (CHNA). The meeting began with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above) and input from community stakeholders (key informants).

Following the data review, there was a dialogue to evaluate the scope and severity of the issues covered, as well the ability of Frances Mahon Deaconess Hospital to have significant impact on each. Through discussion, a consensus was reached to establish the following as priorities for Frances Mahon Deaconess Hospital to include in its Implementation Strategy to address the top health needs of the community in the coming years:

1. **Access to Health Care Services**
2. **Mental Health**
3. **Nutrition, Physical Activity, and Weight**

Additional significant health needs that emerged from this Community Health Needs Assessment are outlined below. These will not be specifically addressed in the Implementation Strategy, although some may be addressed in some way through addressing access to healthcare services.

- **Substance Abuse**
- **Diabetes**
- **Tobacco Use**
- **Heart Disease and Stroke**
- **Cancer**
- **Family Planning**
- **Sexually Transmitted Diseases**
- **Respiratory Diseases**
- **Injury and Violence**
- **Infant and Child Health**

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

## Secondary Data Tables: Comparisons With Benchmark Data

The following tables provide an overview of secondary data indicators in the Total Service Area. These data are grouped to correspond with the Topic Areas presented in Healthy People 2020 and the areas addressed in the Online Key Informant Survey.

### Reading the Summary Tables

In the following tables, Total Service Area results are shown in the larger, blue 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 2020 targets. Symbols indicate whether the Total Service Area compares favorably (☀), unfavorably (🌧), or comparably (🌥) to these external data.

Note that blank table cells 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. HP2020 |
| Linguistically Isolated Population (Percent) | 0.1 | ☀ 0.3 | ☀ 4.4 | |
| Population in Poverty (Percent) | 18.8 | 🌧 14.4 | 🌧 14.6 | |
| Children in Poverty (Percent) | 26.5 | 🌧 17.6 | 🌧 20.3 | |
| No High School Diploma (Age 25+, Percent) | 11.0 | 🌧 7.0 | ☀ 12.7 | |
| Unemployment Rate (Age 16+, Percent) | 3.4 | 🌧 3.2 | ☀ 4.0 | |
| | | ☀ better | 🌥 similar | 🌧 worse |

| Overall Health | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Fair/Poor Overall Health (Percent) | 17.2 | 🌧 14.4 | 🌧 6.2 | |
| | | ☀ better | 🌥 similar | 🌧 worse |

| Access to Health Services | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Uninsured (% Adults 18-64) | 24.1 | 16.5 | 14.8 | 0.0 |
| Uninsured (% Children 0-17) | 12.7 | 7.6 | 5.7 | 0.0 |
| Primary Care Doctors per 100,000 | 44.1 | 81.9 | 87.8 | |
| | | better | similar | worse |

| Cancer | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Cancer (Age-Adjusted Death Rate) | 167.3 | 153.6 | 160.9 | 161.4 |
| Mammogram in Past 2 Years (Medicare Women 67-69, Percent) | 60.3 | 62.0 | 63.2 | 81.1 |
| Prostate Cancer Incidence per 100,000 | 125.3 | 111.1 | 109.0 | |
| Female Breast Cancer Incidence per 100,000 | 85.4 | 123.2 | 124.7 | |
| Lung Cancer Incidence per 100,000 | 61.2 | 55.7 | 60.2 | |
| Colorectal Cancer Incidence per 100,000 | 51.2 | 38.2 | 39.2 | |
| | | better | similar | worse |

| Diabetes | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Prevalence of Diabetes (Percent) | 10.1 | 7.1 | 9.3 | |
| | | better | similar | worse |

| Family Planning | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Teen Births per 1,000 (Age 15-19) | 66.7 | 34.8 | 36.6 | |
| | | better | similar | worse |

| Heart Disease & Stroke | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Diseases of the Heart (Age-Adjusted Death Rate) | 172.5 | 84.7 | 99.6 | 156.9 |
| Stroke (Age-Adjusted Death Rate) | 78.2 | 34.7 | 36.9 | 33.8 |
| Told Have High Blood Pressure (Percent) | 25.2 | 24.8 | 28.2 | 26.9 |
| | | better | similar | worse |

| Injury & Violence Prevention | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Unintentional Injury (Age-Adjusted Death Rate) | 94.1 | 54.7 | 41.9 | 36.0 |
| Violent Crime per 100,000 | 318.6 | 297.6 | 379.7 | |
| | | better | similar | worse |

| Maternal, Infant & Child Health | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Low Birthweight Births (Percent) | 6.0 | 7.3 | 8.2 | 7.8 |
| Infant Death Rate | 9.8 | 6.2 | 6.5 | 6.0 |
| | | better | similar | worse |

| Mental Health | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Suicide (Age-Adjusted Death Rate) | 38.3 | 24.3 | 13.0 | 10.2 |
| | | better | similar | worse |

| Nutrition, Physical Activity & Weight | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Population With Low Food Access (Percent) | 44.7 | 24.3 | 22.4 | |
| Prevalence of Obesity (BMI 30+, Percent) | 32.5 | 25.2 | 28.3 | 30.5 |
| Recreation/Fitness Facilities per 100,000 | 0.0 | 24.3 | 22.4 | |
| No Leisure-Time Physical Activity (Percent) | 25.4 | 18.7 | 21.6 | 32.6 |
| | | better | similar | worse |

| Respiratory Diseases | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| CLRD (Age-Adjusted Death Rate) | 43.5 | 50.3 | 41.3 | |
| | | better | similar | worse |

| Sexually Transmitted Diseases | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Gonorrhea Incidence per 100,000 | 291.3 | 83.9 | 145.8 | |
| Chlamydia Incidence per 100,000 | 650.3 | 427.5 | 497.3 | |
| | | better | similar | worse |

| Substance Abuse | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Excessive Drinking (Percent) | 24.8 | 19.9 | 16.9 | 25.4 |
| | | better | similar | worse |

| Tobacco Use | Total Service Area | Total Service Area vs. Benchmarks | | |
|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2020 |
| Current Smoker (Percent) | 22.6 | 18.8 | 18.1 | 12.0 |
| | | better | similar | worse |

# Community Description

Professional Research Consultants, Inc.

# Population Characteristics

## Total Population

**The Total Service Area, the focus of this Community Health Needs Assessment, encompasses 13,847.01 square miles and houses a total population of 24,706 residents, according to latest census estimates.**

### Total Population
(Estimated Population, 2013-2017)

| | Total Population | Total Land Area (Square Miles) | Population Density (Per Square Mile) |
|---|---|---|---|
| **Total Service Area** | 24,706 | 13,847.01 | 1.78 |
| **Montana** | 1,029,862 | 145,545.42 | 7.08 |
| **United States** | 321,004,407 | 3,532,315.66 | 90.88 |

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

### Population Change 2000-2010

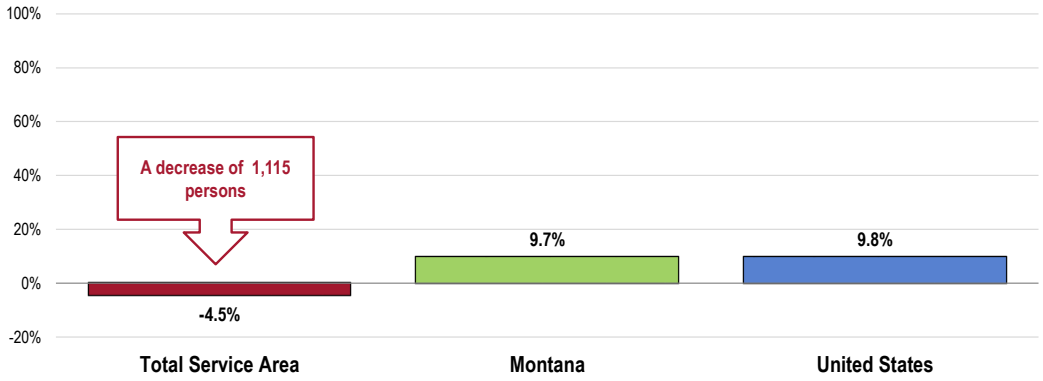
A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

**Between the 2000 and 2010 US Censuses, the population of the Total Service Area decreased by 1,115 persons, or 4.5%.**

- Both the Montana and US populations increased during this time.

## Change in Total Population

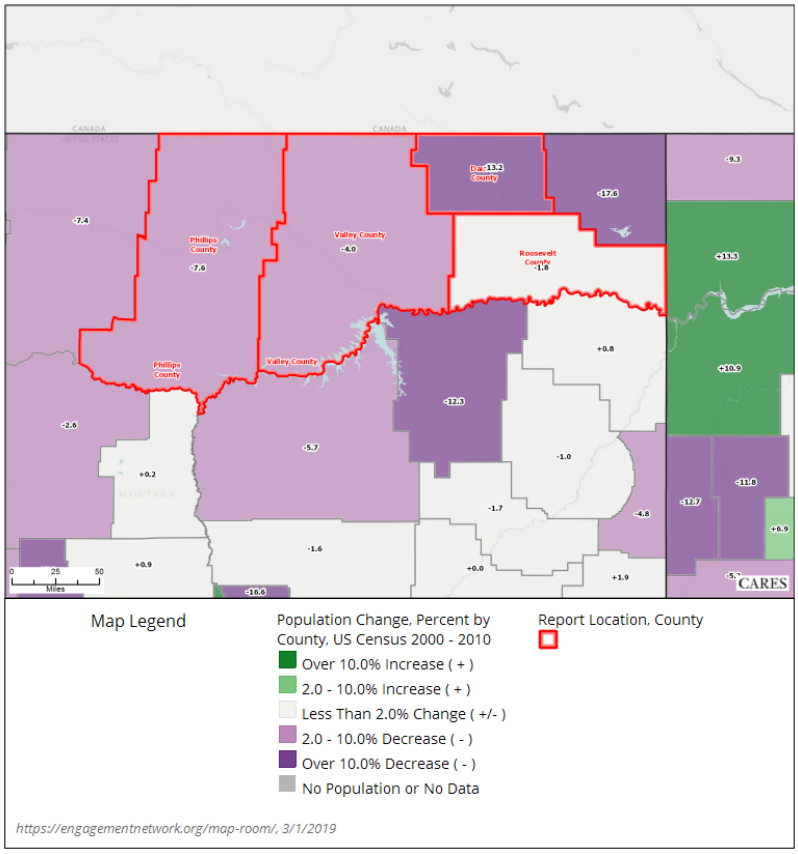
(Percentage Change Between 2000 and 2010)




Sources:
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Census Bureau Decennial Census (2000-2010).

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

- Note that the greatest proportional decrease in population occurred in Daniels County.



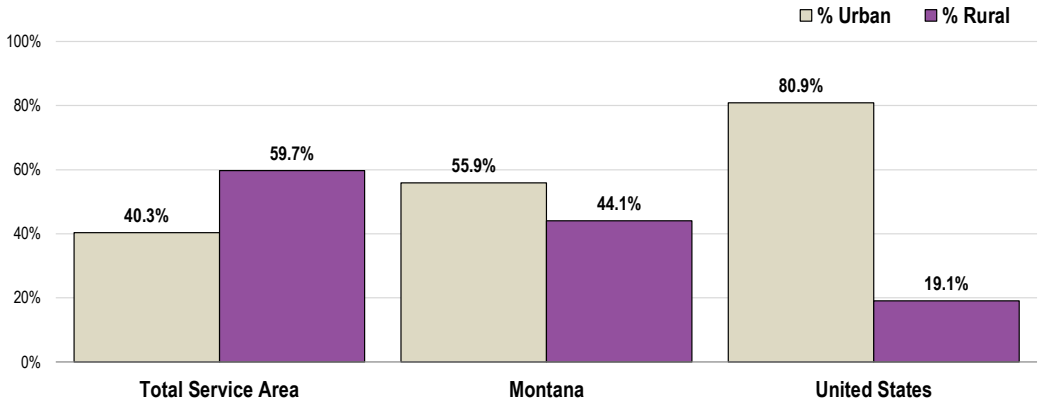
## Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

**The Total Service Area is predominantly rural, with 59.7% of the population living in communities designated as rural.**

- In contrast, over 50% of the state population and over 80% of the national population live in urban areas.

### Urban and Rural Population
(2010)




Sources:
- US Census Bureau Decennial Census.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

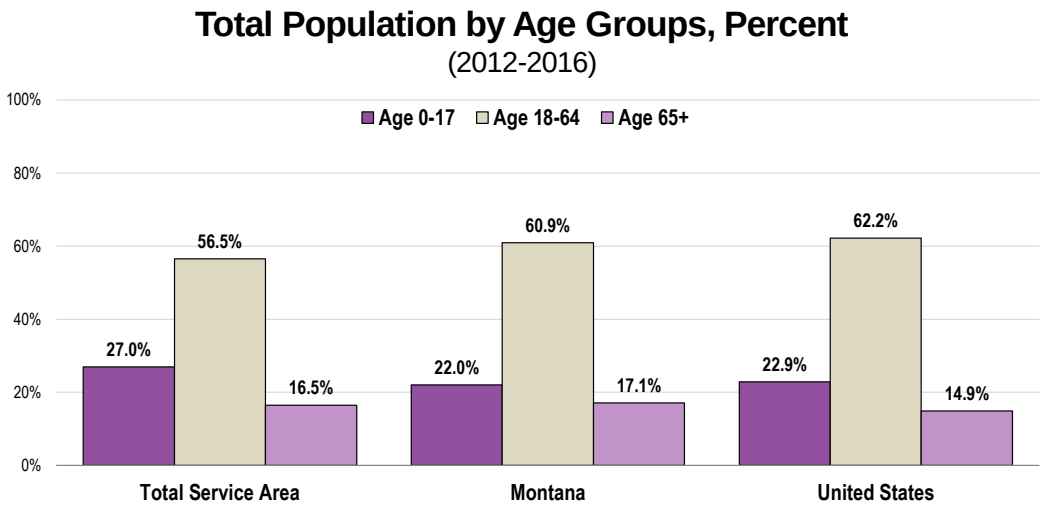
Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

## 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.

**In the Total Service Area, 27.0% of the population are infants, children, or adolescents (age 0-17); another 56.5% are age 18 to 64, while 16.5% are age 65 and older.**

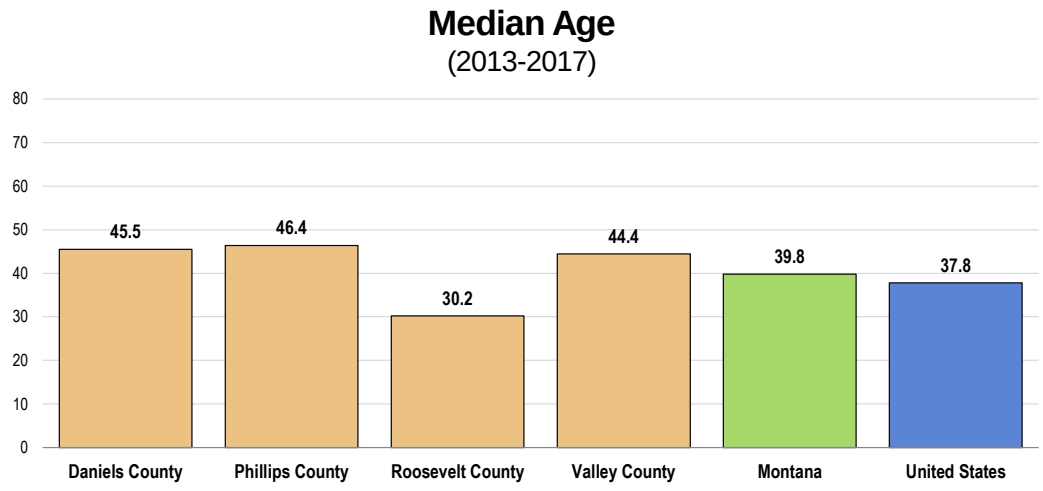
- The percentage of older adults (65+) is lower than found statewide, but higher than found nationally.




Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

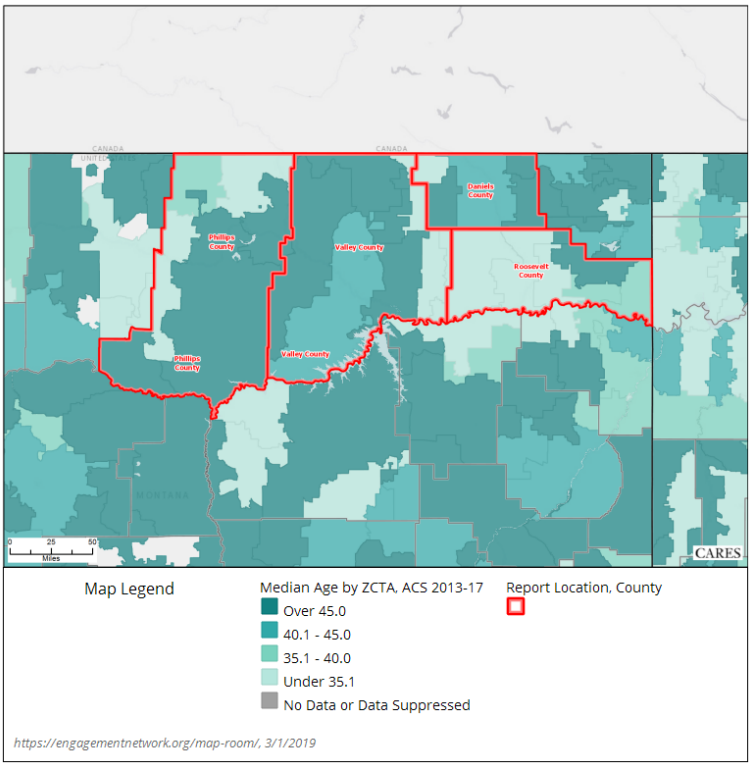
## Median Age

**Three of the four Total Service Area counties are "older" than the state and the nation in that the median ages are higher.**




Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- Median age not available for the Total Service Area.

- The following map provides an illustration of the median age in the Total Service Area by census tract.



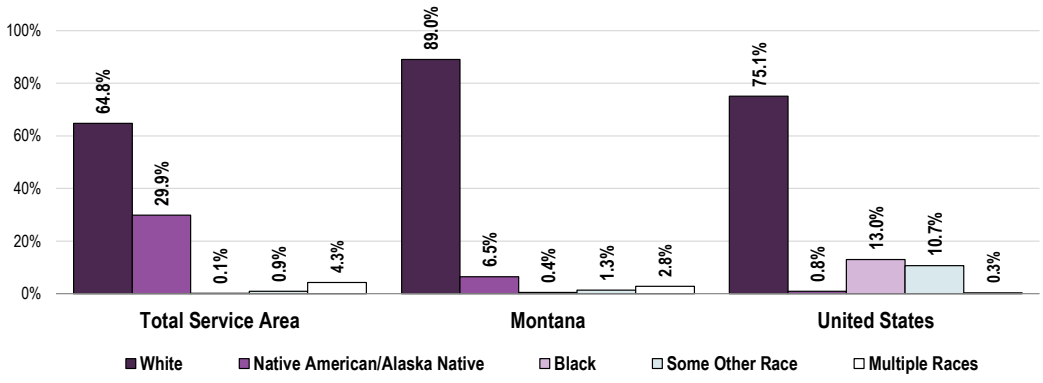

## Race & Ethnicity

### Race

**In looking at race independent of ethnicity (Hispanic or Latino origin), 64.8% of residents of the Total Service Area are White, and 29.9% are Native American/Alaska Native.**

- The distributions across the state and nation are predominantly White, with much lower proportions of native populations.

**Total Population by Race Alone, Percent**
(2013-2017)

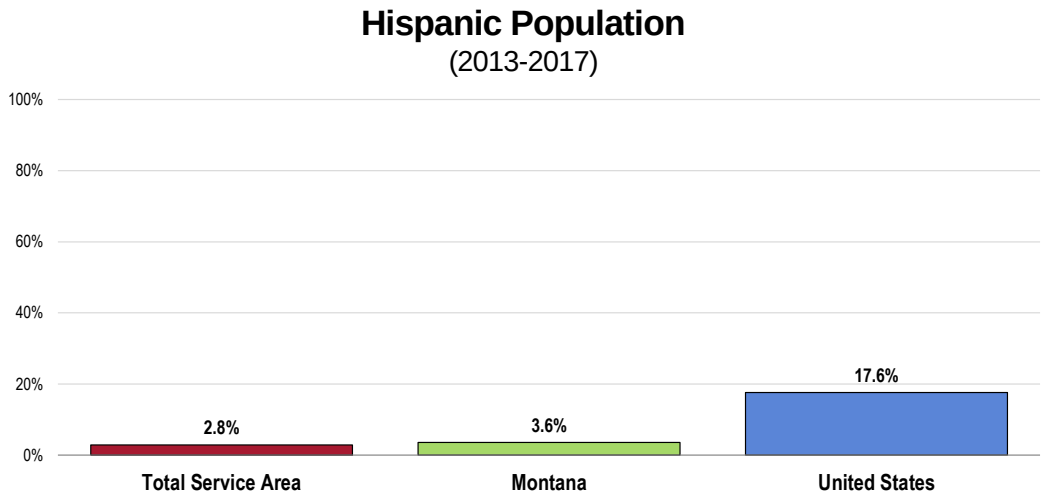



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

## Ethnicity

**A total of 2.8 % of service area residents are Hispanic or Latino.**

- Lower than found statewide and (especially) nationally.

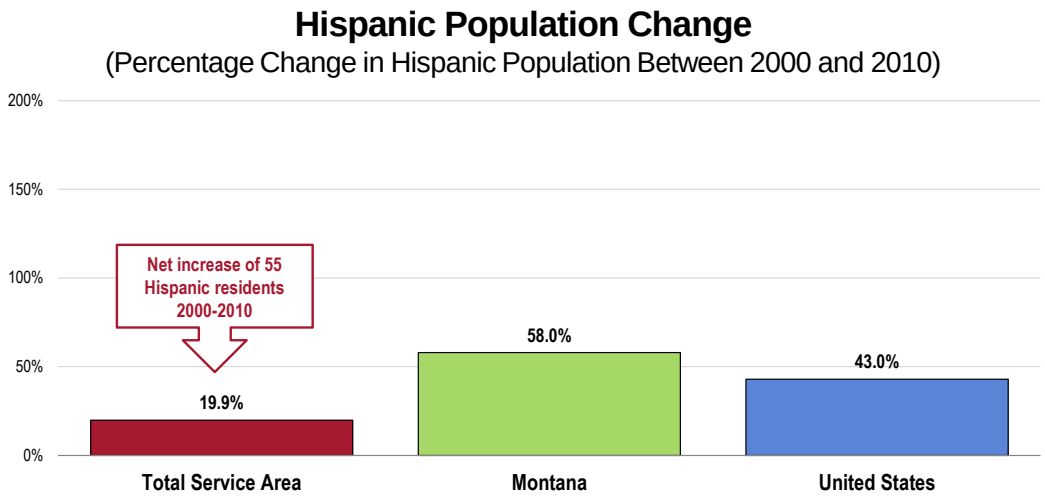



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

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.

**Between 2000 and 2010, the Hispanic population in the Total Service Area increased by 55 residents, or 19.9%.**

- Considerably lower (in terms of percentage growth) than found statewide and nationally.

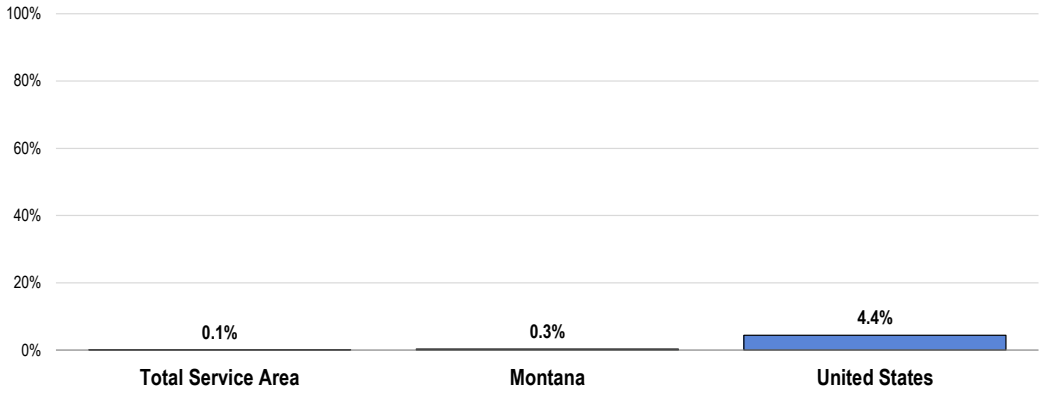



Sources:
- US Census Bureau Decennial Census (2000-2010).
- Retrieved April 2019 from Community Commons at http://www.chna.org.

## Linguistic Isolation

**Only 0.1% of the Total Service Area population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English, or speaking English "very well").**

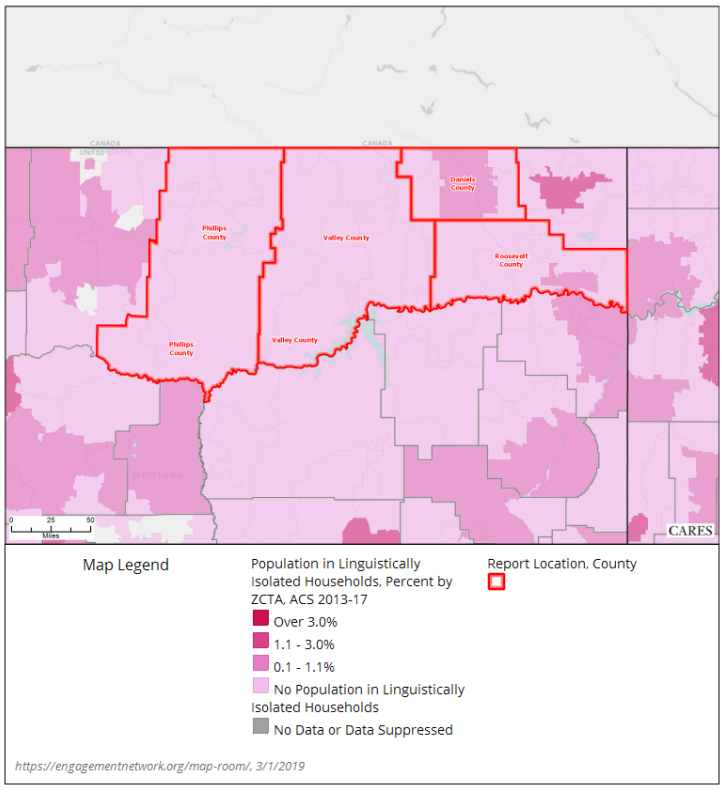
- More favorable than that found statewide and nationally.




Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.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."

- Note the following map illustrating linguistic isolation by census tract.



# Social Determinants of Health

## About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

- Healthy People 2020 (www.healthypeople.gov)

## Poverty

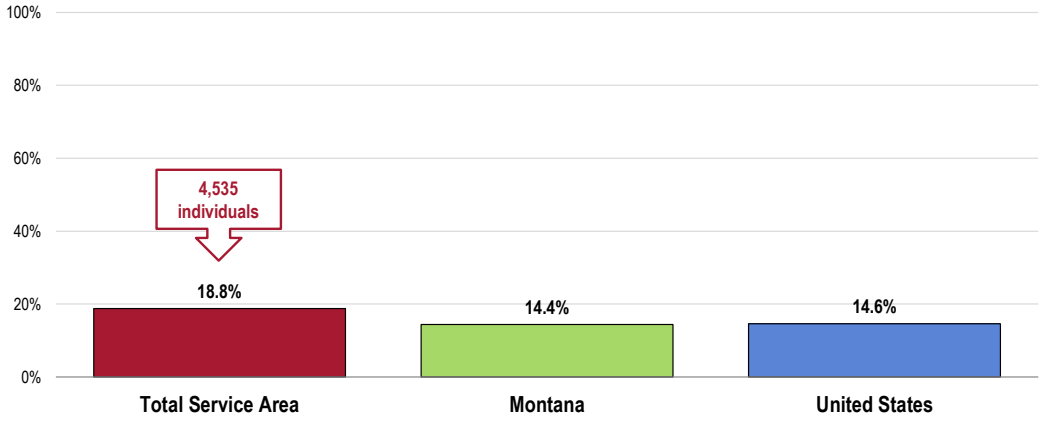
### Total Population

**The latest census estimate shows 18.8% of the Total Service Area population (over 4,500 individuals) living below the federal poverty level.**

- Above the proportions reported statewide and nationally.

**Population in Poverty**

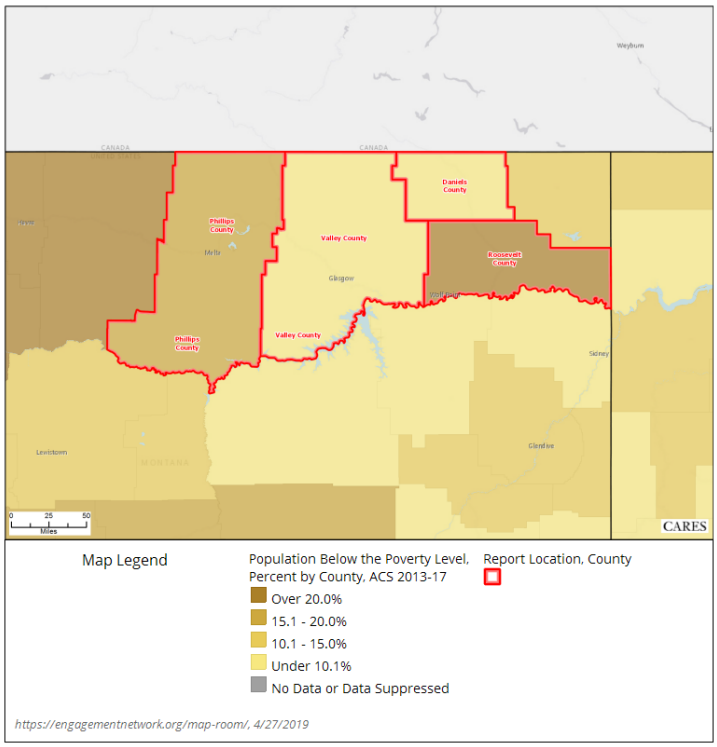
(Populations Living Below 100% of the Poverty Level; 2013-2017)




Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

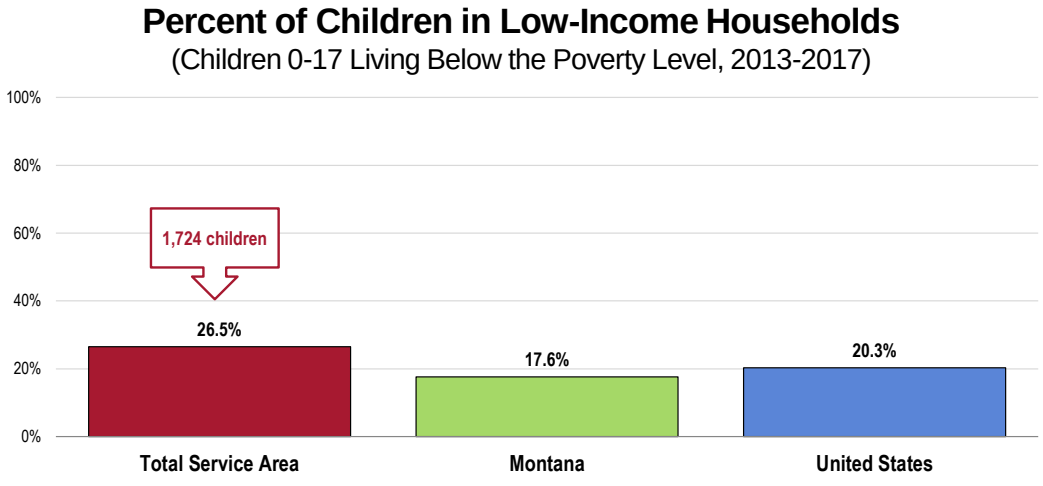
Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

- Roosevelt County has the highest proportion of households below poverty.




## Children in Low-Income Households

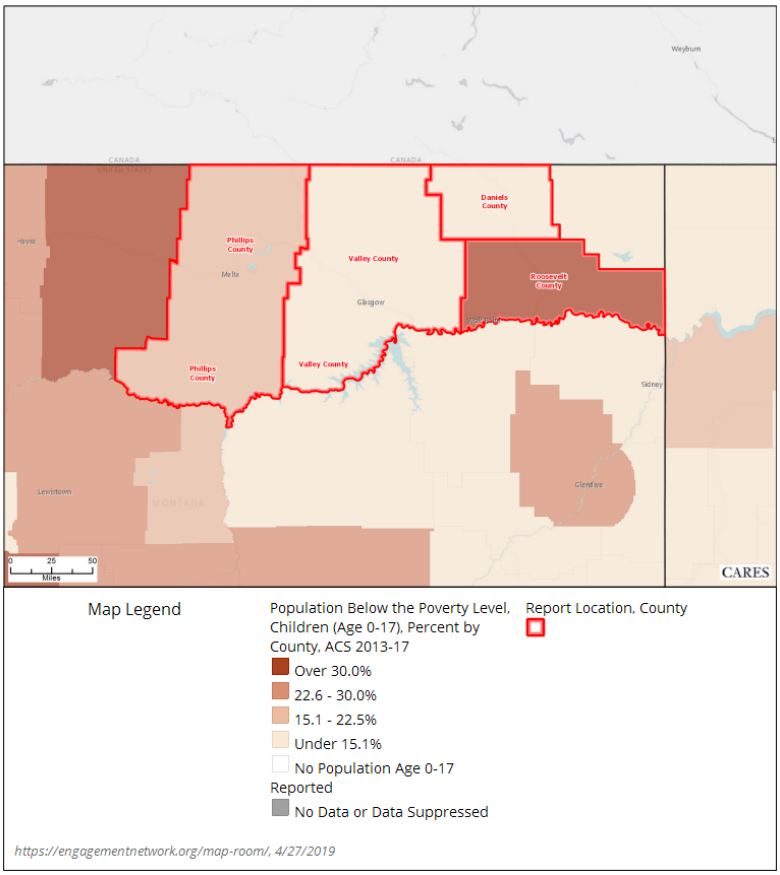
**Additionally, 26.5% of Total Service Area children age 0-17 (representing an estimated 1,724 children) live below the poverty threshold.**




Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of children aged 0-17 living in households with income below 100% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

- Geographically, a notably higher concentration of children in lower-income households is found in Roosevelt County.



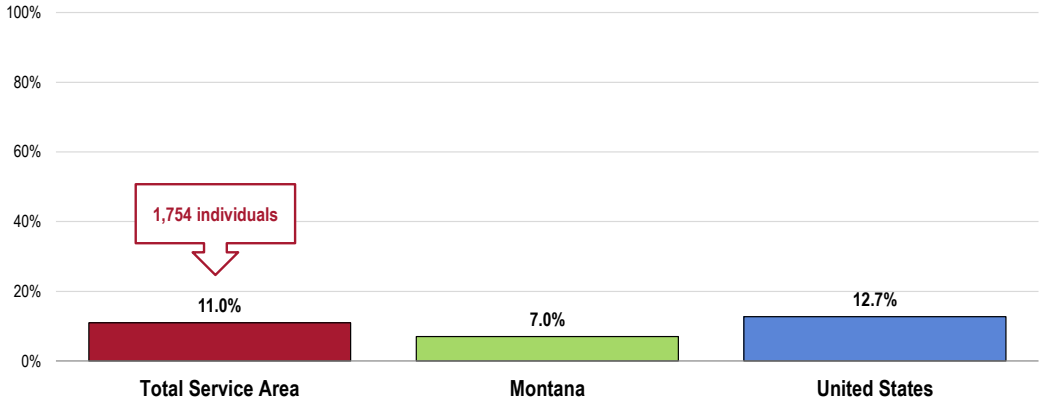
## Education

**Among the Total Service Area population age 25 and older, an estimated 11.0% (over 1,700 individuals) do not have a high school diploma.**

- Less favorable than found statewide.
- More favorable than found nationally.

### Population With No High School Diploma

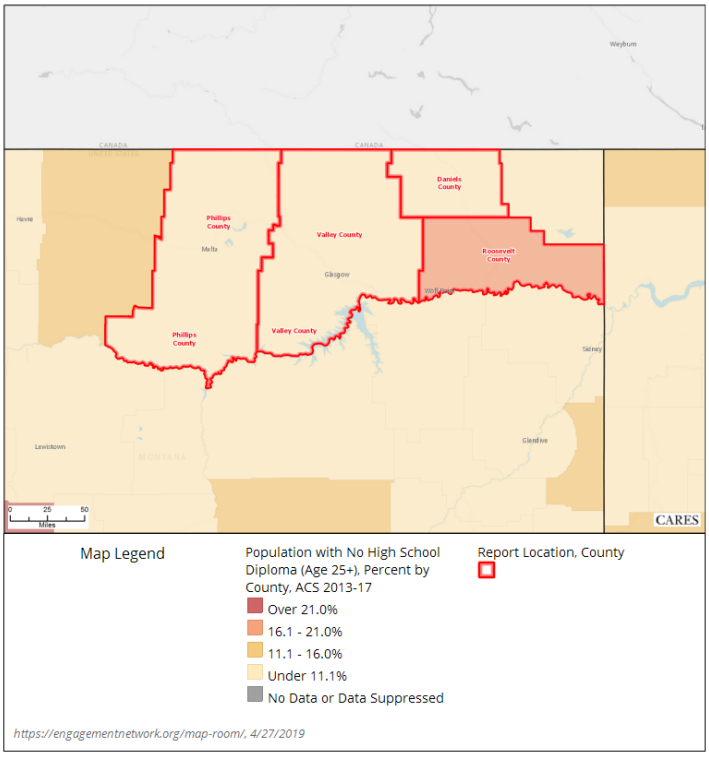
(Population Age 25+ Without a High School Diploma or Equivalent, 2013-2017)




Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

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

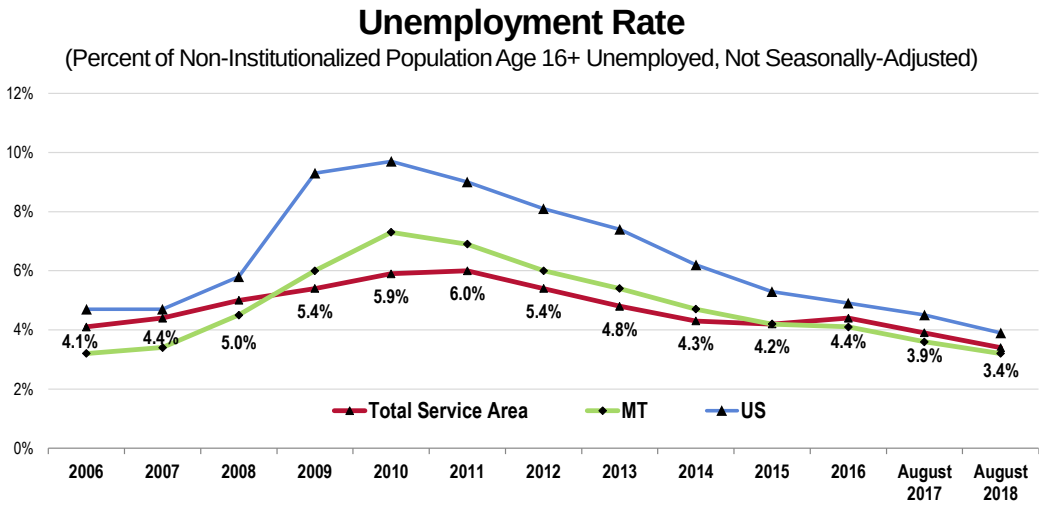
- Geographically, this indicator is more concentrated in Roosevelt County.



## Employment

**According to data derived from the US Department of Labor, the unemployment rate in the Total Service Area in August 2018 was 3.4%.**

- Higher than the statewide unemployment rate.
- Lower than the national unemployment rate.




Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

# General Health Status

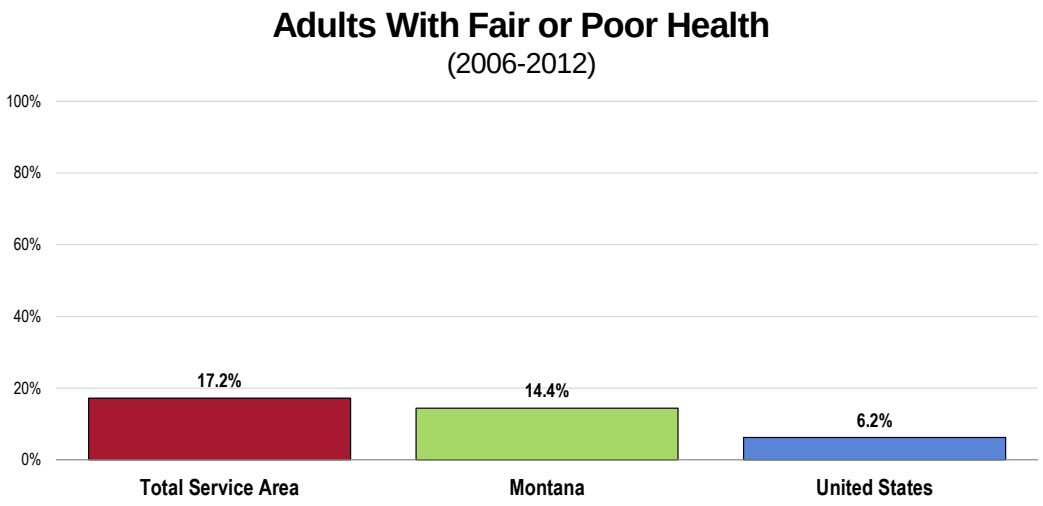
Professional Research Consultants, Inc.

# Overall Health Status

## Self-Reported Health Status

**A total of 16.3% of Total Service Area adults rate their overall health as "fair" or "poor."**

- Less favorable that statewide and national percentages.




Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

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

# Mental Health

RELATED ISSUE:

See also *Potentially Disabling Conditions* in the **Death, Disease & Chronic Conditions** section of this report.

## About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, and it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

- Healthy People 2020 (www.healthypeople.gov)

## Suicide

**Between 2012 and 2016, there was an annual average age-adjusted suicide rate of 38.3 deaths per 100,000 population in the Total Service Area.**

- Notably higher than Montana or US rates.
- Fails to satisfy the Healthy People 2020 target of 10.2 or lower.

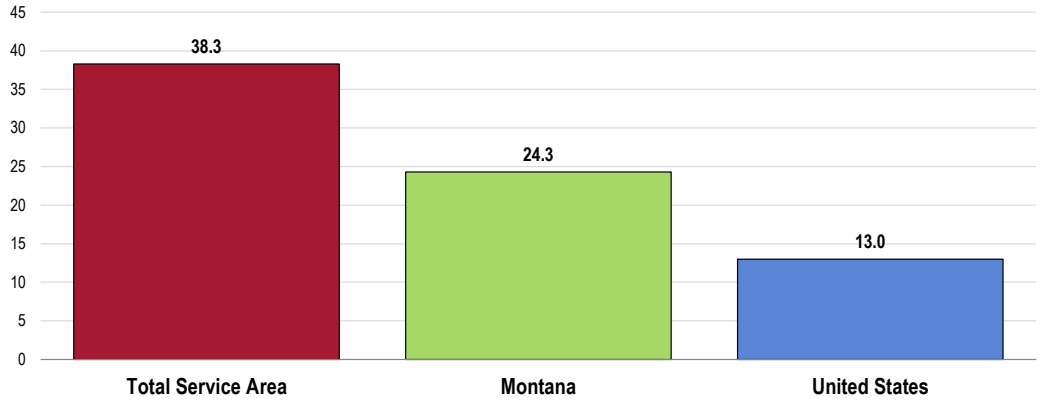
**Age-Adjusted Death Rates**
In order to compare mortality in the region with other localities (in this case, Montana and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 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 2020 targets.

### Suicide: Age-Adjusted Mortality

(2012-2016 Annual Average Deaths per 100,000 Population)

**Healthy People 2020 Target = 10.2 or Lower**




Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2012-2016. Accessed using CDC WONDER.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

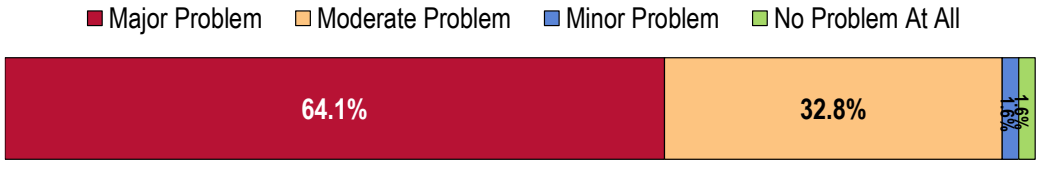
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

## Key Informant Input: Mental Health

**More than six in ten key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.**

### Perceptions of Mental Health as a Problem in the Community

(Key Informants, 2019)




Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

## Challenges

Among those rating this issue as a "major problem," the following represent what key informants see as the main challenges for persons with mental illness:

### Lack of Providers

*We live in a rural community with limited access to mental health providers. People often feel there is a stigma attached to seeking mental health treatment, especially in a small community. During a 2016 community assessment, only 43% of the respondents would refer someone needing mental health services to a mental health center. — Public Health Representative (Valley County)*

*Local mental health clinic is very helpful; however, our community could use more access to psychologist/psychiatrists and more manpower at the mental health clinic to regularly see patients. Also, better access to inpatient facilities and better processes to getting patients to inpatient emergent mental health care. — Other Health Provider (Valley County)*

*Finding a qualified psychologist, therapist, or psychoanalyst for regular treatment or diagnosis of mental illness is almost impossible in our rural area- especially when we have to travel 4 hours (in good weather via driving) to a mental health appointment, treatment, or counselling of any type. The teenagers and adolescents in this area are significantly underserved and undertreated. This includes eating disorders and teenage mental health counselling. — Community Leader (Valley County)*

*Lack of therapy. Closest therapist is 45 miles away and is booking out for 8 weeks. Second closest is 90 miles away. Psychiatrist or psych NP is very difficult to refer to. Tele-med is limited. We have no AA meetings at all. We do have a local chemical dependency counselor. Depression and suicide numbers are high, with very limited resources to help with treatment with these patients. — Other Health Provider (Daniels County)*

*Access to professional mental health providers along with the stigma that exists about mental health disorders. I have seen an improvement and hope that it continues to improve but know that a large deficit exists for adequate mental health access. — Other Health Provider (Valley County)*

*Services in themselves are somewhat limited because of lack of providers or consistency in keeping providers. Affordability for some that fall in the gap of what their now able to afford for insurance. Some plans are very limited in the mental health scope. — Community Leader (Valley County)*

*There is really no physiologist when you need one; you have to drive yourself to a facility, possibly, unless they commit you. It seems that having mental health issues are still taboo. We need more education. Very few of the rural facilities have a way to hold someone for observation. — Community/Business Leader (Daniels County)*

*Access to psychiatrists who are experienced in managing the whole mental health continuum, including medications. Access to good counselors, especially pediatrics. — Other Health Provider (Valley County)*

*There are not enough providers to see patients that need help. Educate the public about the stigma of a mental health disorder. — Community Leader (Valley County)*

*Lack of licensed psychiatrists, few counselors, environment. — Other Health Provider (Roosevelt County)*

*Lack of mental health providers, breakdown of the family, stigma, long distance to a psychiatrist. — Other Health Provider (Roosevelt County)*

*No mental health care providers. — Other Health Provider (Valley County)*

*Lack of providers, stigma. — Other Health Provider (Valley County)*

*Finding a health care provider, paying for services. — Other Health Provider (Valley County)*

### Access to Care/Services

*No availability of local or access to even neighboring facilities for mental health counseling. Either distance is too far, not enough services available or scheduling an appointment is booking out a long way due to lack of resources. People not able to afford the cost of counseling or travel expense. Some individuals not seeking treatment due to social bias. — Other Health Provider (Daniels County)*

*In-state inpatient mental health facilities- helpful, however, admission cannot be guaranteed and has to be based on their assessment. There are times I am very concerned about a patient's mental health, and I send them to these facilities by private vehicle (with family or friend)- and those facilities send them straight back home. — Other Health Provider (Valley County)*

*Lack of services in general, as well as in crisis situations. People's only option in crisis is to present to the emergency department and then look at commitment to the state hospital. Minimal med*

*management services for these patients as well. — Other Health Provider (Valley County)*

*Access to affordable mental health services is a huge problem. The patients that need this type of services are typically low income without the appropriate means to get help. — Other Health Provider (Valley County)*

*Access to a trained mental health provider in a timely fashion. No counselling services readily available in the community. — Other Health Provider (Daniels County)*

*Extremely difficult to get an appointment with any mental health care professional, let alone one that focuses on a specific need. — Other Health Provider (Valley County)*

*Major lack of appropriate services available in this small community. — Other Health Provider (Valley County)*

*Availability of quality resources and community support. — Social Services Provider (Valley County)*

*Not enough resources available. All the folks on the same page. Judges, physicians/providers, agencies. — Other Health Provider (Valley County)*

### Prevalence/Incidence

*We see a lot of people with depression, suicidal ideation, many mental illnesses. With these illnesses, our mental health center does not have the capacity to meet the needs of the people. We lack counselors and resources for people to seek assistance. — Public Health Representative (Valley County)*

*Huge issues with suicide and mental health. No resources. — Other Health Provider (Valley County)*

### Alcohol/Drug Abuse

*Mental health care in Valley County is improving, due to the efforts of Glasgow Clinic, mental health continues to be at crisis levels. Alcohol abuse drug abuse depression and anxiety plugged the residents of Valley County. There are no local treatment programs available other than an NA. — Other Health Provider (Valley County)*

### Denial/Stigma

*I don't know how to fix this because many folks with mental health issues don't believe they need help unless it is court-mandated. we don't have a mental health counselor available in Daniels County. Seems like folks can't afford to travel for this service and often this issue leads to substance abuse. — Community/Business Leader (Daniels County)*

### Diagnosis/Treatment

*I feel it is underdiagnosed, and we have limited resources/providers that specialize in psychiatric care. People don't seem to be able to cope efficiently. — Other Health Provider (Valley County)*

### Funding

*Mental Health Services offers 2 licensed mental health providers, 2 case managers and 2 CD counselors; however, funding and is an ongoing fight, and 3 more counselors are needed to be able to operate at full capacity. Also, the middle class is lacking in services, due to insurance or out-of-pocket expense. It is a concern to me that your middle class is unable to pay more often than not due to financial concerns, whether it be for limited or no insurance. — Community Leader (Valley County)*

### Vulnerable Populations

*The services are not adequate to serve the preschool through 12-year-old population that have abuse, trauma, and neglect backgrounds. There are no mental health services for students with autism or learning disabilities with abuse, trauma, and neglect backgrounds. — Community Leader (Valley County)*

# Death, Disease & Chronic Conditions

Professional Research Consultants, Inc.

# Cardiovascular Disease

### About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than $500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 (www.healthypeople.gov)

## Age-Adjusted Heart Disease & Stroke Deaths

### 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 2020* targets.

## Heart Disease Deaths

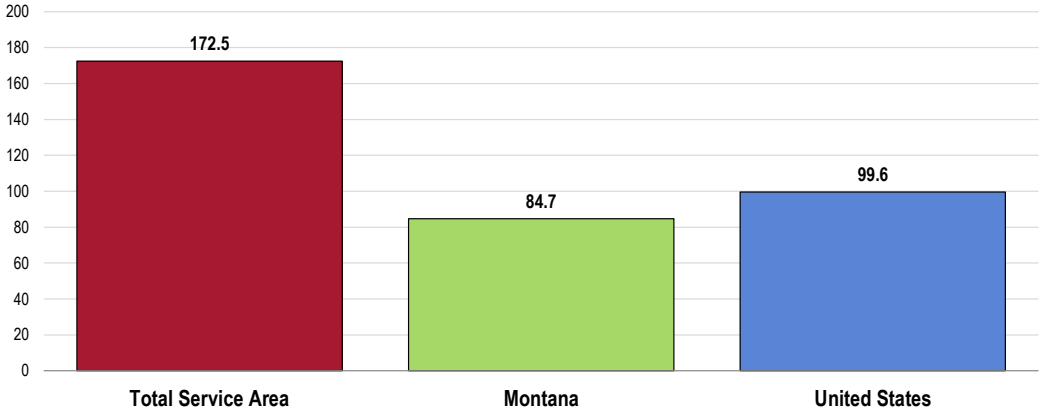
**Between 2012 and 2016, there was an annual average age-adjusted heart disease mortality rate of 172.5 deaths per 100,000 population in the Total Service Area.**

- Notably less favorable than the state and national rates.
- Fails to satisfy the Healthy People 2020 objective of 156.9 or lower.

### Heart Disease: Age-Adjusted Mortality

(2012-2016 Annual Average Deaths per 100,000 Population)

**Healthy People 2020 Target = 156.9 or Lower (Adjusted)**




Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2012-2016. Accessed using CDC WONDER.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

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

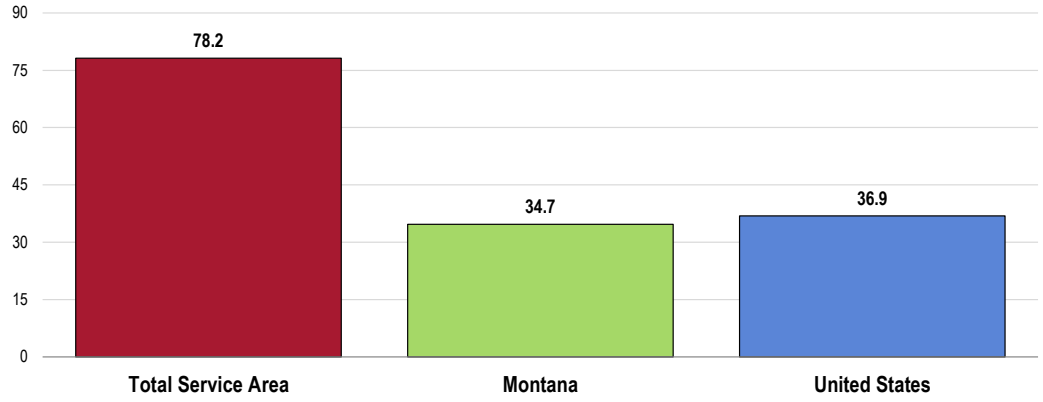
**Between 2012 and 2016, there was an annual average age-adjusted stroke mortality rate of 78.2 deaths per 100,000 population in the Total Service Area.**

- Much less favorable than the Montana and US rates.
- Fails to satisfy the Healthy People 2020 target of 33.8 or lower.

## Stroke: Age-Adjusted Mortality

(2012-2016 Annual Average Deaths per 100,000 Population)

**Healthy People 2020 Target = 33.8 or Lower (Adjusted)**




Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2016-2016. Accessed using CDC WONDER.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

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.

## Prevalence of High Blood Pressure

### About Cardiovascular Risk

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

- Healthy People 2020 (www.healthypeople.gov)

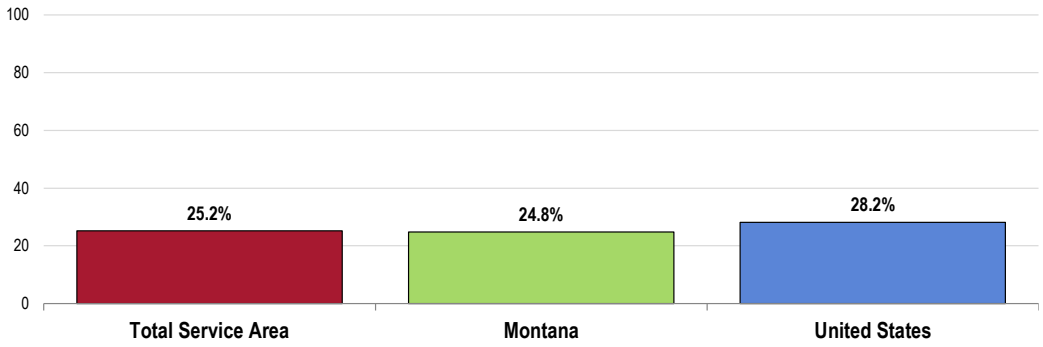
**A total of 25.2% of Total Service Area adults have been told at some point that their blood pressure was high.**

- Comparable to the Montana prevalence.
- Better than the national prevalence.
- Satisfies the Healthy People 2020 target (26.9% or lower).

## Prevalence of High Blood Pressure

(2006-2012)

**Healthy People 2020 Target = 26.9% or Lower**




Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives HDS-5.1 and HDS-7]

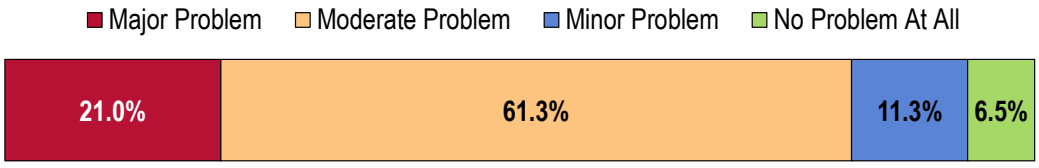
Notes:
- This indicator is relevant because coronary heart disease is a leading cause of death in the US and is also related to high blood pressure, high cholesterol, and heart attacks.

## Key Informant Input: Heart Disease & Stroke

**Six in ten key informants taking part in an online survey characterized *Heart Disease & Stroke* as a "moderate problem" in the community.**

## Perceptions of Heart Disease and Stroke as a Problem in the Community

(Key Informants, 2019)




Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, 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

> *This is a major problem for getting the care that is needed, specifically for VA patients. That go across many other problems for VA patients. I considered this a major problem because of its prevalence in this area. — Other Health Provider (Valley County)*
>
> *No specialty care. Long distance to secondary or tertiary care. — Other Health Provider (Roosevelt County)*

### Obesity

*Obesity, smoking, lack of physical activity, etc., are likely similar or worse than average rates across Northern Plains. In case of heart attack or stroke, air ambulance to Billings or similar facility is 90+ minutes after incident. — Community/Business Leader (Daniels County)*

*This is a huge issue. Obesity, diabetes, lack of exercise facilities. Aging population. — Other Health Provider (Valley County)*

### Aging Population

*Older generation of folks. Rural area. — Other Health Provider (Valley County)*

### Awareness/Education

*The largest issue is that there is not a dynamic enough educational approach available to deal with the precursors to heart disease and stroke in our community. As well, the medical resources to deal with this issue are not truly supportive or accurate. — Social Services Provider (Valley County)*

### Comorbidities

*Heart disease and stroke are linked to diabetes and tobacco abuse, as well as alcohol abuse. Due to the rural nature of Valley County, heart disease and strokes are often fatal. — Other Health Provider (Valley County)*

### Co-occurrences

*Diet, genetics, lifestyle. — Other Health Provider (Roosevelt County)*

# Cancer

## About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

- Healthy People 2020 (www.healthypeople.gov)

## Age-Adjusted Cancer Deaths

### All Cancer Deaths

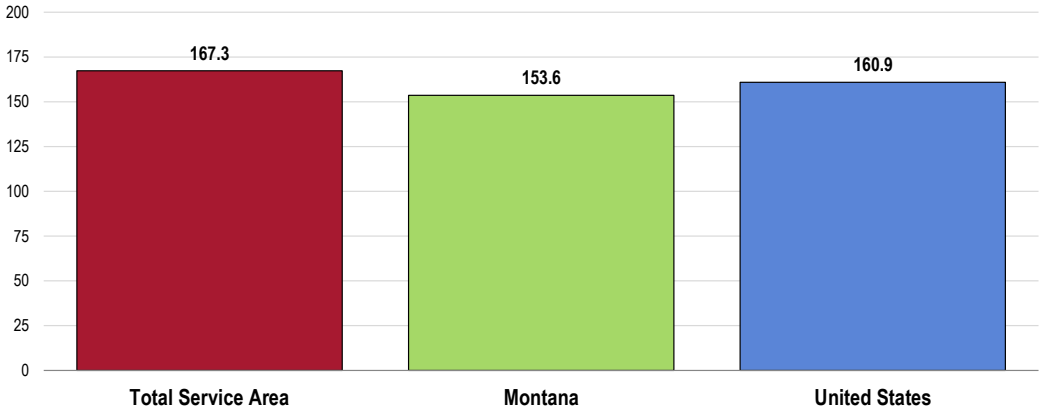
**Between 2012 and 2016, there was an annual average age-adjusted cancer mortality rate of 167.3 deaths per 100,000 population in the Total Service Area.**

- Less favorable than the statewide rate.
- Comparable to the national rate.
- Statistically similar to the Healthy People 2020 target of 161.4 or lower.

## Cancer: Age-Adjusted Mortality

(2012-2016 Annual Average Deaths per 100,000 Population)

**Healthy People 2020 Target = 161.4 or Lower**




Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2012-2016. Accessed using CDC WONDER.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

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 rates reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted.

"Incidence rate" or "case rate" is the number of new cases of a disease occurring during a given period of time.

It is usually expressed as cases per 100,000 population per year.

**These 2011-2015 Total Service Area annual average age-adjusted cancer incidence rates are worse than US rates.**

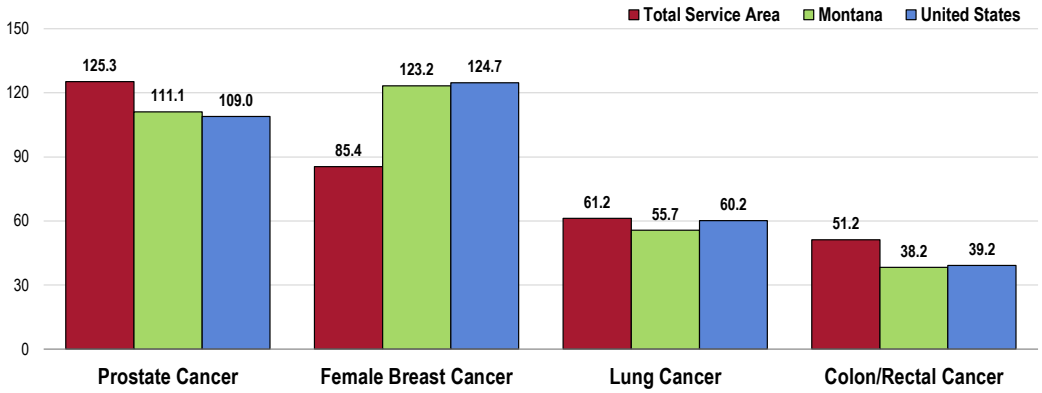
- Prostate cancer.
- Colorectal cancer.

**These Total Service Area cancer incidence rates are worse than state rates for the same years.**

- Prostate cancer.
- Lung cancer.
- Colorectal cancer.

## Cancer Incidence Rates by Site

(Annual Average Age-Adjusted Incidence per 100,000 Population, 2011-2015)




Sources:
- State Cancer Profiles.
- Retrieved April 2019 from Community Commons at http://www.chna.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

## Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

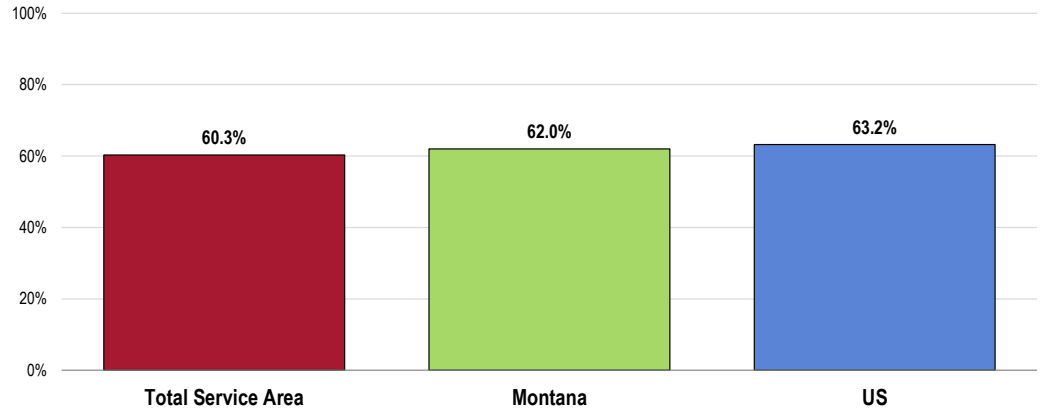
**Among service area women age 67-69 enrolled in Medicare, six in 10 (60.3%) had a mammogram within the past two years.**

- Comparable to statewide findings.
- Comparable to national findings.
- Fails to satisfy the Healthy People 2020 target (81.1% or higher).

## Mammogram in Past 2 Years

(Female Medicare Enrollees, Age 67-69)

**Healthy People 2020 Target = 81.1% or Higher**



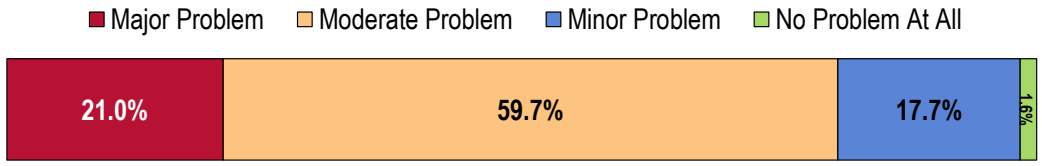

Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-12.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

## Key Informant Input: Cancer

**Key informants taking part in an online survey most often characterized *Cancer* as a "moderate problem" in the community.**

## Perceptions of Cancer as a Problem in the Community

(Key Informants, 2019)




Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

### Top Concerns

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

#### Prevalence/Incidence

> *Seems to be a high prevalence of it. People often have to travel a long distance for treatments, may be more difficult to lead a healthy lifestyle with long, cold winters and limited physical activity options, diets that contain less fresh fruits/veggies due to limited availability, diets containing a lot of meats as we are a farming/ranching community, people in our community may be less apt to get regular checkups and only go to the doctor when sick — Other Health Provider (Valley County)*
>
> *Cancer continues to be a growing problem in the area. Valley County is not immune from this problem. Newly-diagnosed patients are unable to stay in the Valley County community as they work with their initial treatments of this life-threatening condition. — Other Health Provider (Valley County)*

*Cancer rates are likely similar to rest of Northern Plains. However, due to distances (from Billings, Mayo, etc.), diagnosis sometimes takes longer. Treatment also is difficult at times if it has to be done out of town. — Community/Business Leader (Daniels County)*

*It seems there are many cancer diagnoses in this community. Not sure why this is the case, but it is a perception. — Community Leader (Valley County)*

*It affects a lot of families that I know. — Social Services Provider (Roosevelt County)*

*I know lots of people with cancer, maybe since I am from the community. Also use of lots of toxins on farm/ranch years ago. — Other Health Provider (Valley County)*

*The number of individuals that have been diagnosed. — Community Leader (Valley County)*

### Access to Care/Services

*We do not have a doctor who specializes in cancer treatments, so it's best if that person goes elsewhere for medical care. — Other Health Provider (Valley County)*

*There is a lack of resources to get care in our area. You have to travel far for treatment. — Public Health Representative (Valley County)*

### Aging Population

*It's an aging population, and cancer risk increases with age. There is a lack of a treatment center. Lack of screening services for cancer. — Other Health Provider (Valley County)*

### Environmental Contributors

*Being in an agricultural area, much of the population is exposed to agricultural pesticides and herbicides that are carcinogenic. Also, many homes have underground water sources for daily living, and many of these have never been tested for contaminates for safe consumption or daily use. — Other Health Provider (Valley County)*

# Respiratory Disease

## About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

**Asthma**. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

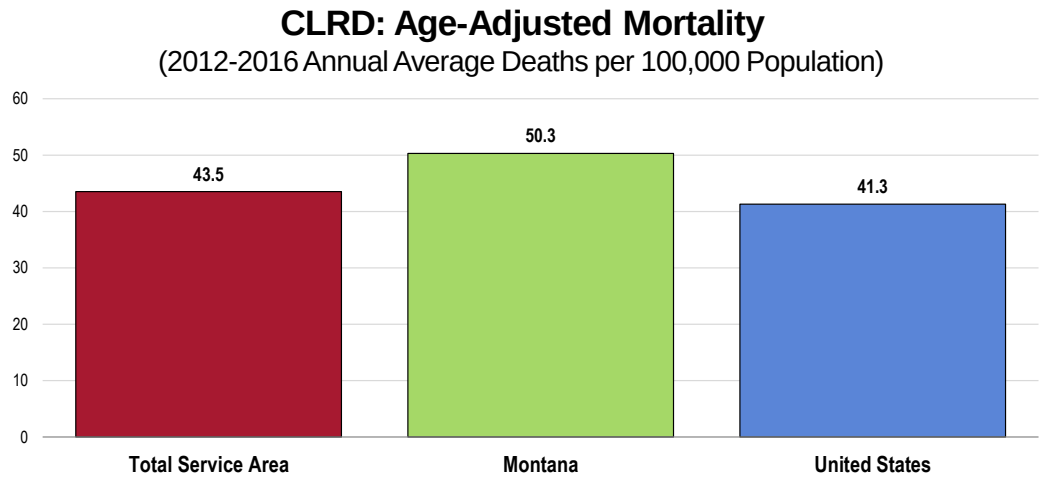
- Healthy People 2020 (www.healthypeople.gov)

[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

## Age-Adjusted Lung Disease Deaths

**Between 2012 and 2016, there was an annual average age-adjusted lung disease mortality rate of 43.5 deaths per 100,000 population in the Total Service Area.**

- Lower than found statewide.
- Higher than the national rate.

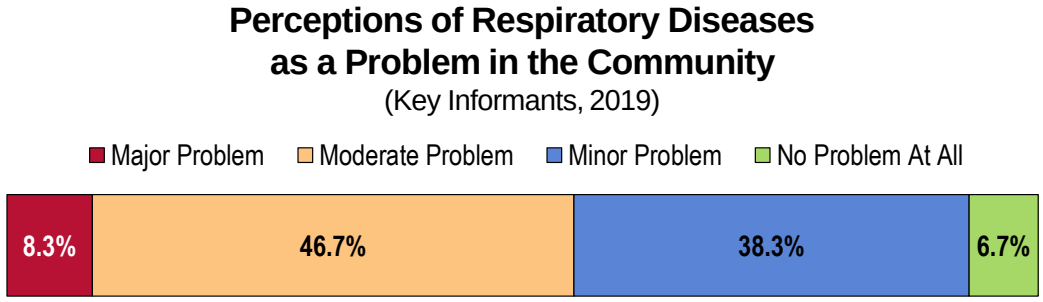



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2012-2016. Accessed using CDC WONDER.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

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.

## Key Informant Input: Respiratory Disease

**Key informants taking part in an online survey generally characterized *Respiratory Disease* as a "moderate problem" in the community.**




Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

## Top Concerns

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

### Leading Cause of Death

> *We have high-risk factors for developing COPD, with a high rate of smoking and a high number of jobs in agriculture for increased exposure to chemicals, dust, etc. We have a large population on oxygen. — Other Health Provider (Valley County)*

### Prevalence/Incidence

> *Asthma, smoking in homes, non-compliance. — Other Health Provider (Roosevelt County)*

### Tobacco Use

> *Lots of smoking and secondhand smoke, with issues of COPD and asthma. No pulmonologist. — Other Health Provider (Valley County)*

# Injury & Violence

## About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as "accidents," "acts of fate," or as "part of life." However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

- Healthy People 2020 (www.healthypeople.gov)

## Unintentional Injury

### Age-Adjusted Unintentional Injury Deaths

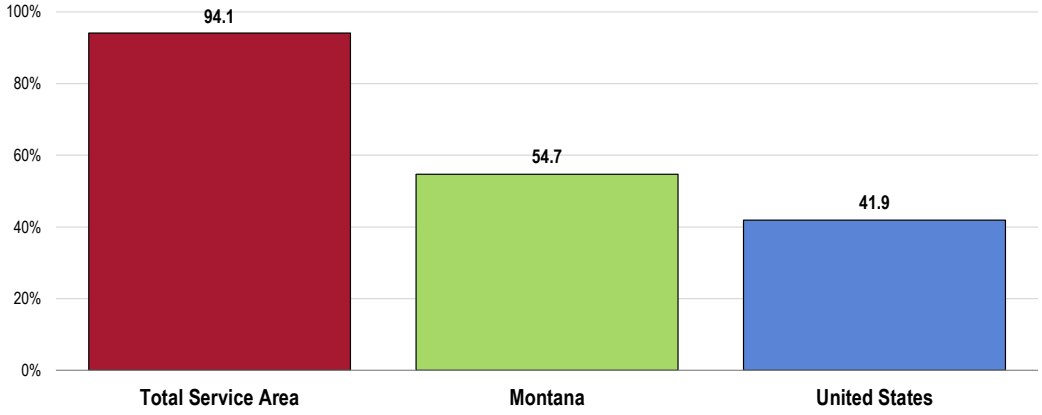
**Between 2012 and 2016, there was an annual average age-adjusted unintentional injury mortality rate of 94.1 deaths per 100,000 population in the Total Service Area.**

- Much less favorable than the Montana and US rates.
- Far from satisfying the Healthy People 2020 target of 36.0 or lower.

## Unintentional Injuries: Age-Adjusted Mortality

(2012-2016 Annual Average Deaths per 100,000 Population)

**Healthy People 2020 Target = 36.0 or Lower**




Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2012-2016. Accessed using CDC WONDER.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

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.

### Violent Crime

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

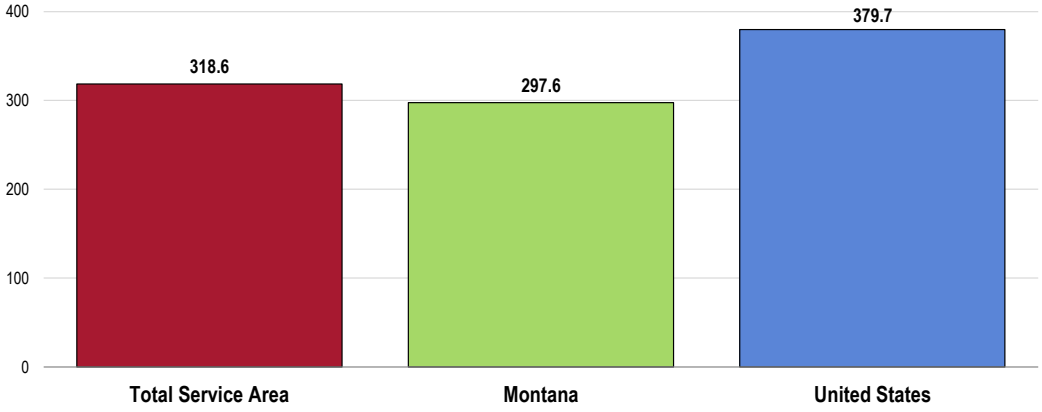
Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

**Between 2012 and 2014, there were a reported 318.6 violent crimes per 100,000 population in the Total Service Area.**

- Higher than the Montana rate for the same period.
- Well below the national rate.

## Violent Crime

(Rate per 100,000 Population, 2012-2014)




Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

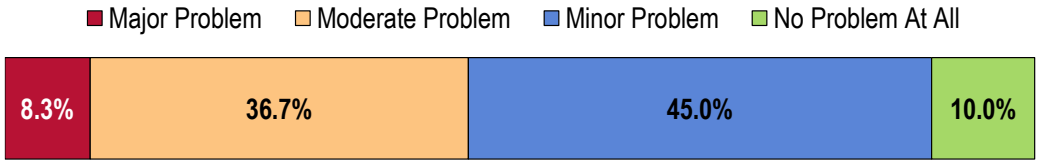
Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation 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

**The greatest share of key informants taking part in an online survey characterized *Injury & Violence* as a "minor problem" in the community.**

### Perceptions of Injury and Violence as a Problem in the Community

(Key Informants, 2019)




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

### Top Concerns

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

**Prevalence/Incidence**

> *Constant reports of child abuse, sex abuse and domestic violence. Lack of mental health facilities. — Other Health Provider (Valley County)*

**Alcohol/Drug Abuse**

> *High rates of drug and alcohol abuse. — Other Health Provider (Roosevelt County)*

**Sexual Assaults**

> *I think that sexual assault/abuse is a huge problem in this area, based on personal experience and talking to experts from Mental Health, Youth Dynamics, etc. There is a lack of services to help the victims navigate the system; a great deal of perpetrators go unpunished, and victims go untreated. — Other Health Provider (Valley County)*

# Diabetes

## About Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus: lowers life expectancy by up to 15 years; increases the risk of heart disease by 2 to 4 times; and is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

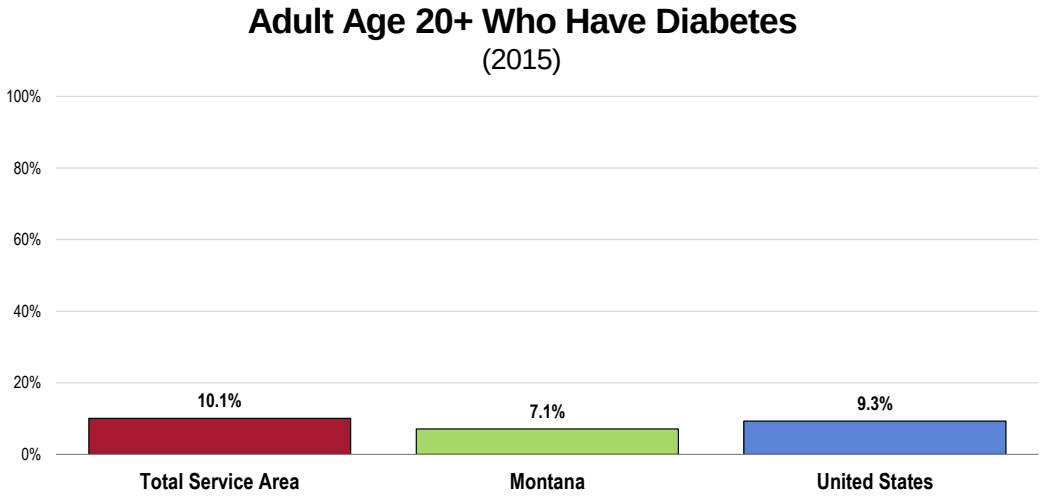
People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes. Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

- Healthy People 2020 (www.healthypeople.gov)

## Prevalence of Diabetes

**Among Total Service Area adults age 20 and older, 10.1% have been diagnosed with diabetes.**

- Less favorable than the statewide and national prevalence.

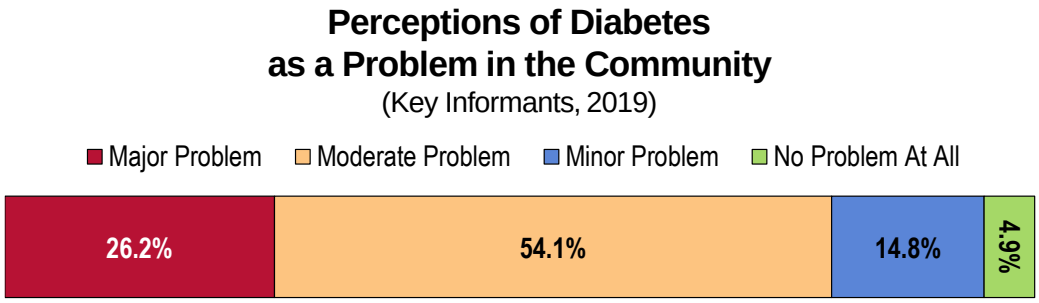



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas
- Retrieved April 2019 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. 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

**More than half of key informants taking part in an online survey characterized *Diabetes* as a "moderate problem" in the community.**




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

### Challenges

Among those rating this issue as a "major problem," the biggest challenges for people with diabetes are seen as:

#### Awareness/Education

*Education on disease and how to better take care of themselves. There are no support groups. People struggle with medication management and there are no services to help them with that. — Other Health Provider (Valley County)*

*Having access to diabetes education/dietician. Ability to afford the medications or supplies needed. — Other Health Provider (Daniels County)*

*No diabetes education for non-Natives. — Other Health Provider (Roosevelt County)*

*I am not sure. I know we have a diabetic educator in the clinic now, and I think that helps. — Other Health Provider (Valley County)*

#### Access to Care/Services

*Medical care providers/programs that specializes in diabetes management, physical activity, higher cost of eating well. — Other Health Provider (Valley County)*

*Lack of access to care and medications. Large Native American population here with significant prevalence of diabetes. There is a lack of treatment options, including a lack of options for obesity treatment. — Other Health Provider (Valley County)*

#### Disease Management

*Compliance with diet, exercise and medication. — Other Health Provider (Roosevelt County)*

*Compliance, access to Endocrinologist without having to travel to Billings. — Other Health Provider (Valley County)*

#### Affordable Medication/Supplies

*Cost of diabetic supplies. Price of more healthy food options in this community is higher. — Other Health Provider (Valley County)*

#### Prevalence/Incidence

*Diabetes is a continually growing epidemic in United States and Valley County. Access to primary care is limited by county at this current time; as such, I do not believe these residents receive optimal care. — Other Health Provider (Valley County)*

# Alzheimer's Disease

## About Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

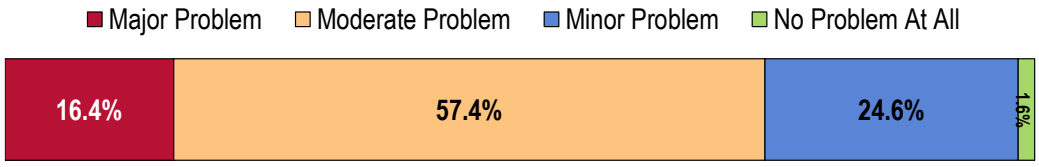
- Healthy People 2020 (www.healthypeople.gov)

## Key Informant Input: Dementias, Including Alzheimer's Disease

**More than half of key informants taking part in an online survey characterized *Dementias, Including Alzheimer's Disease* as a "moderate problem" in the community.**

### Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community

(Key Informants, 2019)




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

## Top Concerns

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

### Aging Population

*With the elderly community, we have very limited-to-no home care provided for those with Alzheimer's or dementia to be able to continue living at home. The availability of nursing home spots for these individuals is very limited also. — Other Health Provider (Valley County)*

*Large and growing aging community, with many elderly without immediate family that live in this rural area, or early onset dementia/Alzheimer's without support services for this age group that are typically still working and raising children. — Community Leader (Valley County)*

*We have an aging population in our county. Support systems are lacking for caregivers. For example, senior companions, adult day cares, support and continuing education for families are needed. With the expected increase of diagnoses, Valley View Home will need to increase occupancy, which means adding on to their secured unit. — Community Leader (Valley County)*

*We have a large percentage of population who is elderly, which increases the amount of these cases. — Community Leader (Valley County)*

*Aging population and old people develop dementia. — Other Health Provider (Valley County)*

### Availability of Home Health Care Services

> *Lack of availability of home health services or home assistance that does not require a nurse for the elderly or disabled. Also, there is a great need for assisted living and long-term care availability. — Other Health Provider (Daniels County)*

# Kidney Disease

## About Chronic Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

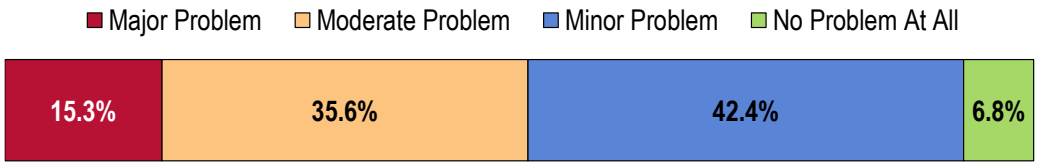
Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

- Healthy People 2020 (www.healthypeople.gov)

## Key Informant Input: Kidney Disease

**The largest share of key informants taking part in an online survey characterized *Chronic Kidney Disease* as a "minor problem" in the community.**

**Perceptions of Kidney Disease as a Problem in the Community**
(Key Informants, 2019)




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

### Top Concerns

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

#### Comorbidities

*There are many uncontrolled diabetic and hypertensive patients, which leads to kidney disease, failure, and thus dialysis. Many patients have a hard time staying compliant with dialysis. — Other Health Provider (Roosevelt County)*

*Lots of diabetes and obesity in the population, which is a significant contributor to kidney failure. — Other Health Provider (Valley County)*

*Diabetes and lack of compliance with treatment. — Other Health Provider (Roosevelt County)*

#### Access to Care/Services

*Dialysis is located sixty miles away. — Other Health Provider (Valley County)*

# Potentially Disabling Conditions

## About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than $128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least $50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

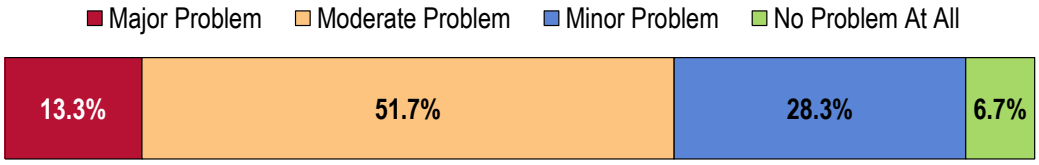
- Healthy People 2020 (www.healthypeople.gov)

## Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

**More than half of key informants taking part in an online survey most often characterized *Arthritis, Osteoporosis & Chronic Back Conditions* as a "moderate problem" in the community.**

## Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community

(Key Informants, 2019)




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

### Top Concerns

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

#### Aging Population

*It is an aging population in the community. There is lots of chronic pain and osteoporosis related to aging. There is limited access to help treat these issues. — Other Health Provider (Valley County)*

*Valley County is an aging population of farmers and ranchers. Most individuals have some sort of degenerative process present. Chronic pain management is an issue for these folks. — Other Health Provider (Valley County)*

*Average age of the community. — Other Health Provider (Valley County)*

#### Prevalence/Incidence

*Affects a large population, from middle-age to elderly. Some medications are very expensive and getting coverage for them is difficult. No really good aquatic facility in town to promote good exercise without weight-bearing through arthritic joints and backs. — Other Health Provider (Valley County)*

*Because I see it in my patients. — Physician (Valley County)*

#### Lack of Providers

*No rheumatologist in the area, nor visiting the area- or even tele-med. — Other Health Provider (Valley County)*

#### Rural Community

*As a ranch/farm community, it leads to lots of heavy physical work which causes wear and tear on body leading to osteoarthritis. This is not taking into account accidents on farm/ranch. — Other Health Provider (Valley County)*

# Vision & Hearing Impairment

## About Vision

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

- Healthy People 2020 (www.healthypeople.gov)

## About Hearing & Other Sensory or Communication Disorders

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such as social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

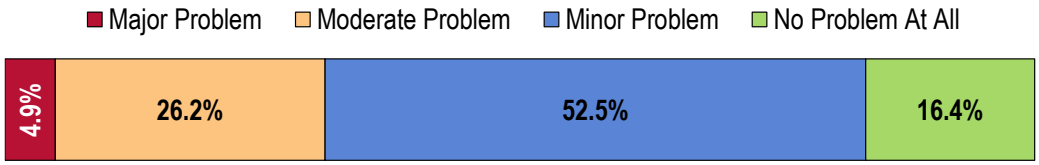
- Healthy People 2020 (www.healthypeople.gov)

## Key Informant Input: Vision & Hearing

**A majority of key informants taking part in an online survey characterized *Vision & Hearing* as a "minor problem" in the community.**

### Perceptions of Vision and Hearing as a Problem in the Community

(Key Informants, 2019)




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

### Top Concerns

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

#### Aging Population

> *Of our aging demographic, almost all need cataract surgery or some type of monthly ongoing ophthalmology-type care from a doctor who specializes in diseases of the eye, or surgical procedures of the eye. For this aging demographic, this requires travel and overnight stays away from our rural area. — Community Leader (Valley County)*
>
> *It's an elderly population. — Other Health Provider (Valley County)*

# Infectious Disease

Professional Research Consultants, Inc.

# HIV

## About HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

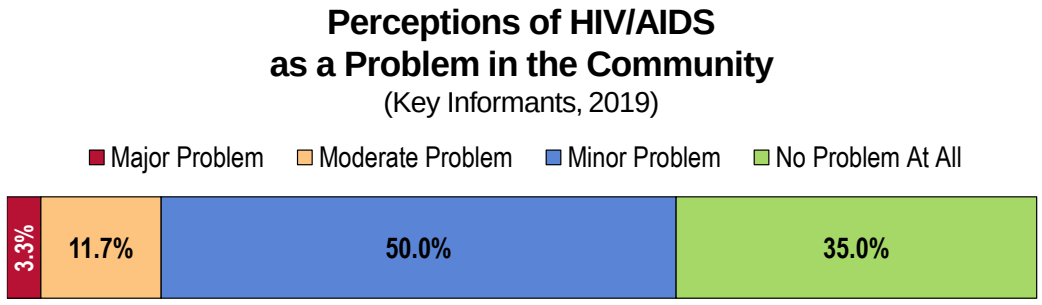
- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

- Healthy People 2020 (www.healthypeople.gov)

## Key Informant Input: HIV/AIDS

**Half of key informants taking part in an online survey characterized *HIV/AIDS* as a "minor problem" in the community.**




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a "major problem," the following reason was given:

#### Access to Care/Services

> *Lack of treatment options. — Other Health Provider (Valley County)*

# Sexually Transmitted Diseases

## About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

**Biological Factors.** STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs**. The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities**. Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities**. Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications**. Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

**Social, Economic, and Behavioral Factors.** The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

## Chlamydia & Gonorrhea

**In 2016, the chlamydia incidence rate in the Total Service Area was 650.3 cases per 100,000 population.**

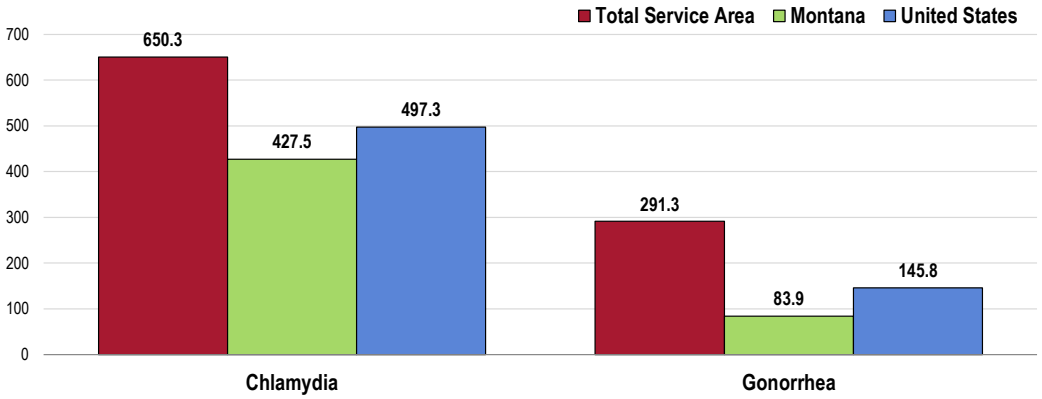
- Notably less favorable than the statewide and national incidence rates.

**The gonorrhea incidence rate in the service area was 291.3 cases per 100,000 population in 2016.**

- Notably less favorable than the statewide and national incidence rates.

## Chlamydia & Gonorrhea Incidence

(Incidence Rate per 100,000 Population, 2016)




Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

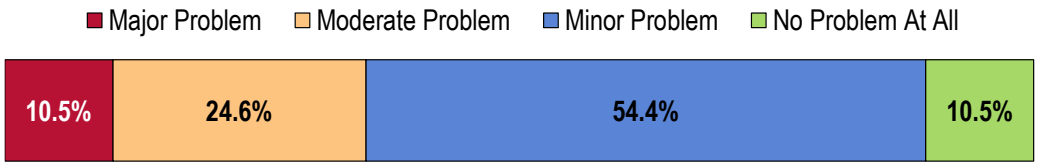
Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

## Key Informant Input: Sexually Transmitted Diseases

**Key informants taking part in an online survey most often characterized *Sexually Transmitted Diseases* as a "minor problem" in the community.**

## Perceptions of Sexually Transmitted Diseases as a Problem in the Community

(Key Informants, 2019)




Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

### Top Concerns

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

#### Prevalence/Incidence

> *We have seen a drastic increase in Valley County within the last year and half. — Public Health Representative (Valley County)*
>
> *It is everywhere. Rampant. Lack of education resources. — Other Health Provider (Valley County)*

#### Alcohol/Drug Abuse

> *Drug and alcohol abuse, sexual abuse, lack of education, mental health. — Other Health Provider (Roosevelt County)*

### Cultural Norms

> *Low standards of morality, drug and alcohol use, low self-esteem. — Other Health Provider (Roosevelt County)*

### Unprotected Sex

> *Unprotected sex and sex with multiple partners. — Community Leader (Roosevelt County)*

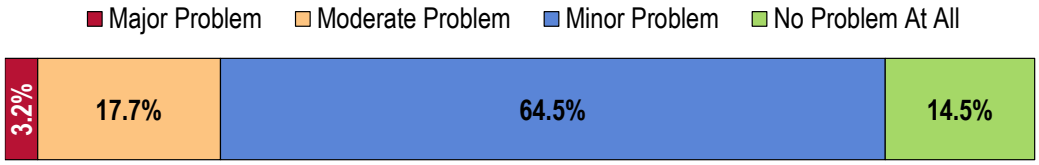
# Immunization & Infectious Diseases

## Key Informant Input: Immunization & Infectious Diseases

**More than six in ten key informants taking part in an online survey characterized *Immunization & Infectious Diseases* as a "minor problem" in the community.**

### Perceptions of Immunization and Infectious Diseases as a Problem in the Community

(Key Informants, 2019)




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a "major problem," the following reason was given:

**Screening**

> *Poor surveillance programs. — Other Health Provider (Valley County)*

# Births

Professional Research Consultants, Inc.

# Birth Outcomes & Risks

## About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

- Healthy People 2020 (www.healthypeople.gov)

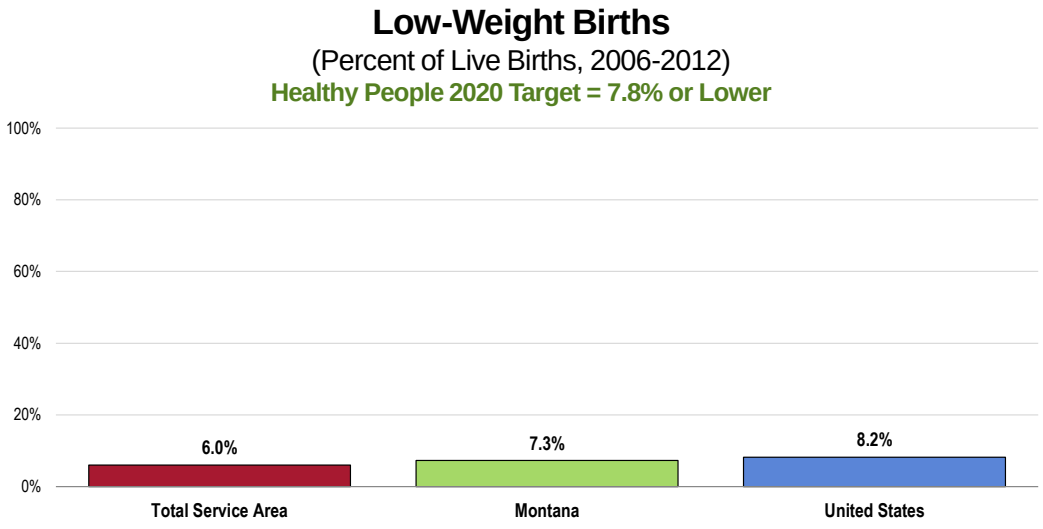
## Low-Weight Births

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

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

**Between 2006 and 2012, a total of 6.0% of births in the Total Service Area were low-weight.**

- Lower than the Montana and US proportions.
- Satisfies the Healthy People 2020 target (7.8% or lower).




Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2006-2012. Accessed using CDC WONDER.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

## Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

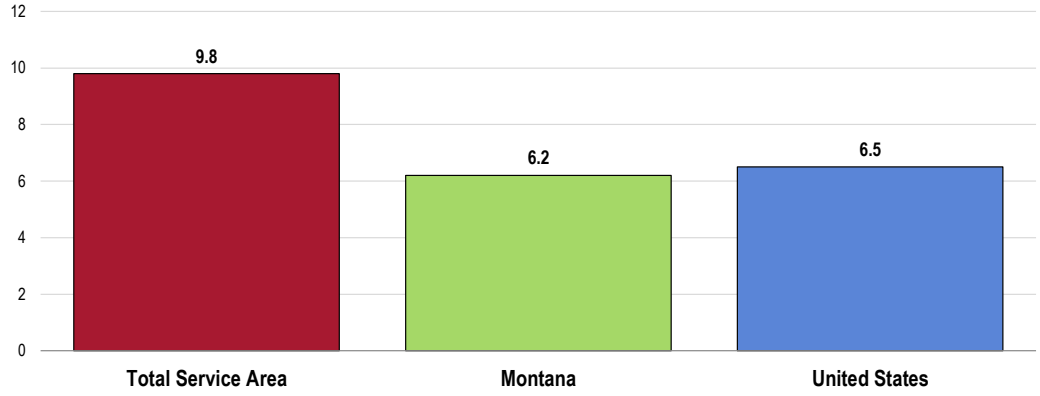
**Between 2006 and 2010, there was an annual average of 9.8 infant deaths per 1,000 live births.**

- Much less favorable than the Montana and national rates.
- Fails to satisfy the Healthy People 2020 target of 6.0 deaths or fewer per 1,000 live births.

### Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2006-2010)

**Healthy People 2020 Target = 6.0 or Lower**




Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, *Area Health Resource File*. Data extracted January 2019.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

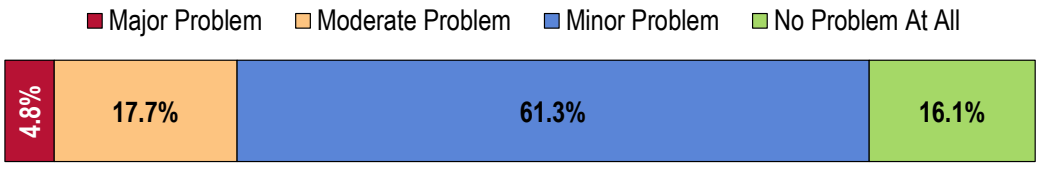
Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

## Key Informant Input: Infant & Child Health

**The majority of key informants taking part in an online survey characterized *Infant & Child Health* as a "minor problem" in the community.**

### Perceptions of Infant and Child Health as a Problem in the Community

(Key Informants, 2019)




Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

## Top Concerns

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

### Child Abuse Rates

> *High rates of abuse and neglect, children in foster care, poverty, unemployment, drug and alcohol abuse. — Other Health Provider (Roosevelt County)*

### Lack of Providers

> *There is no pediatrician.  There is a lack of access to care. — Other Health Provider (Valley County)*

# Family Planning

## Births to Teen Mothers

### About Teen Births

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

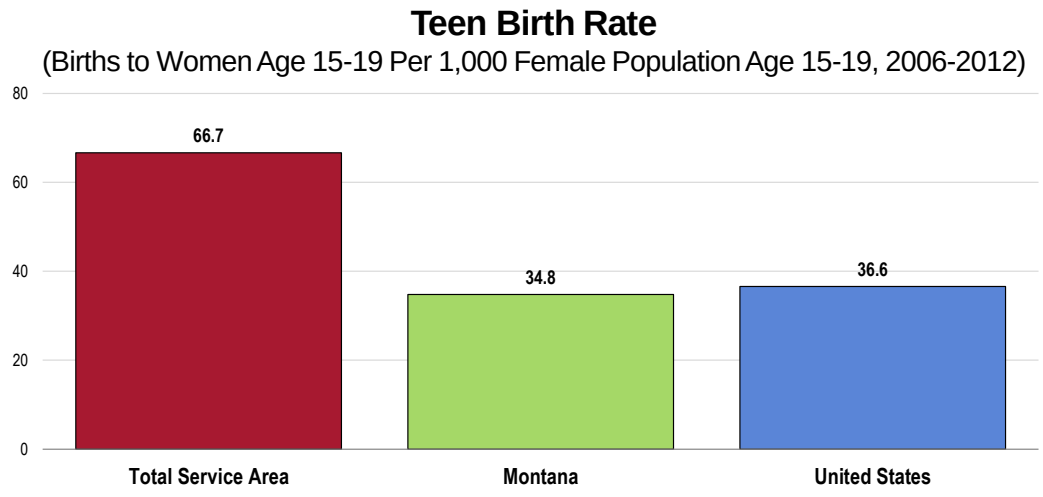
- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

- Healthy People 2020 (www.healthypeople.gov)

**Between 2006 and 2012, there were 66.7 births to women age 15 to 19 per 1,000 women age 15 to 19 in the Total Service Area.**

- Notably higher than the state and national rates.




Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
- Retrieved from Community Commons at http://www.chna.org.

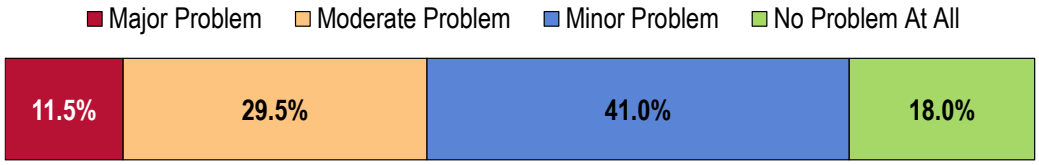
Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

## Key Informant Input: Family Planning

**Key informants taking part in an online survey frequently characterized *Family Planning* as a "minor problem" in the community.**

### Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2019)




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, 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

> *There is one OB/GYN for this entire area. There is no urologist. — Other Health Provider (Valley County)*
>
> *There doesn't seem to be the services at the Valley County Health Department that were once available for a low-cost. — Social Services Provider (Valley County)*
>
> *Access to a birthing facility and qualified personnel of < 100 miles distance. — Other Health Provider (Daniels County)*
>
> *Not sure if is a problem, I think there is none [services]. — Community Leader (Roosevelt County)*

#### Lack of Planning

> *Lack of planning. — Other Health Provider (Roosevelt County)*

# Modifiable Health Risks

Professional Research Consultants, Inc.

# Nutrition, Physical Activity & Weight

## Nutrition

### About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

**Social Determinants of Diet.** Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

**Physical Determinants of Diet.** Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

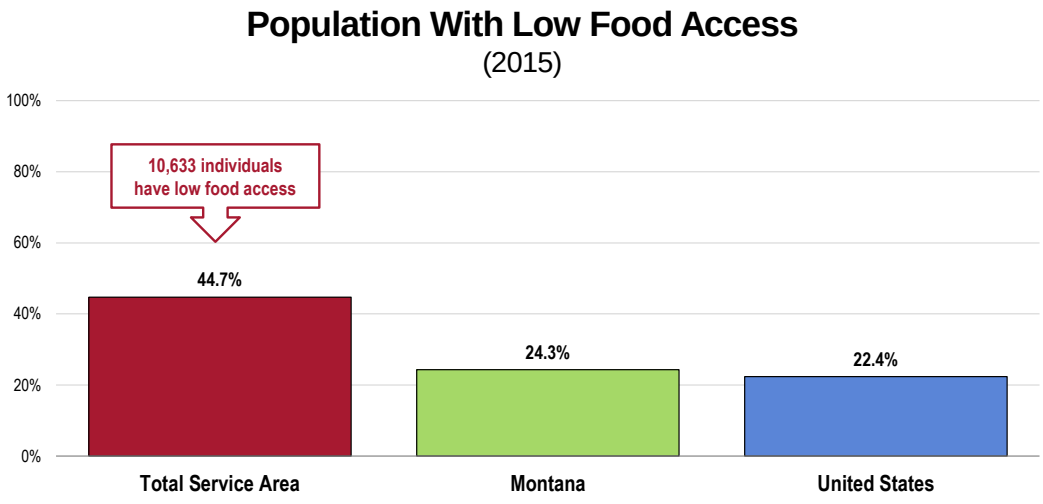
- Healthy People 2020 (www.healthypeople.gov)

## Low Food Access (Food Deserts)

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas.

**US Department of Agriculture data show that 44.7% of the Total Service Area population (representing approximately 10,633 residents) have low food access or live in a "food desert," meaning that they do not live near a supermarket or large grocery store.**

- Much higher than the Montana and US findings.




Sources:
- US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas (FARA).
- Retrieved April 2019 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of the population 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

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

- Healthy People 2020 (www.healthypeople.gov)

## Lack of 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.

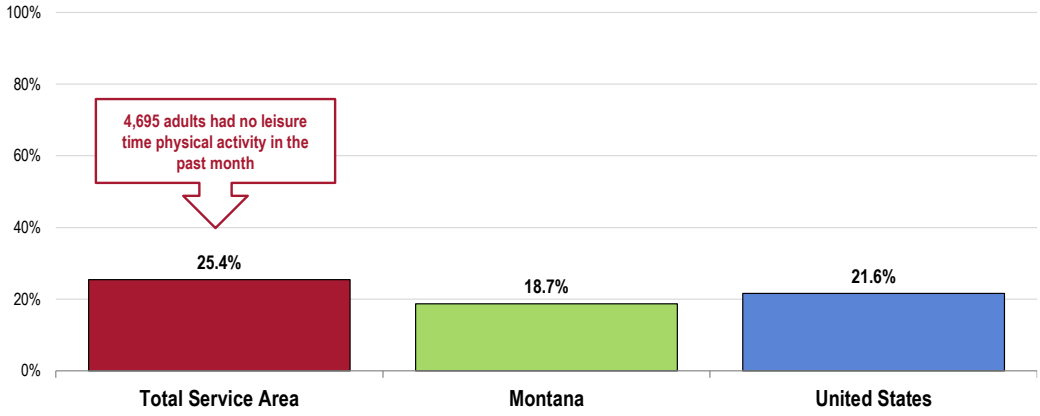
**A total of 25.4% of Total Service Area adults (representing almost 4,700 individuals) report no leisure-time physical activity in the past month.**

- Less favorable than statewide and national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).

### Adults Age 20+ Who Have No Leisure-Time Physical Activity in the Past Month

(2015)

**Healthy People 2020 Target = 32.6% or Lower**




Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1].

Notes:
- This indicator reports the percent of adults aged 20+, who self-report no leisure time for activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?". 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.

## Access to Physical Activity

**In 2016, there were <u>no</u> recreation/fitness facilities available in the Total Service Area.**

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

- Far lower than seen statewide and nationally (not shown).

# Weight Status

## About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

- Healthy People 2020 (www.healthypeople.gov)

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

**A total of 32.5% of Total Service Area adults age 20 and older (representing 5,758 individuals) are obese.**

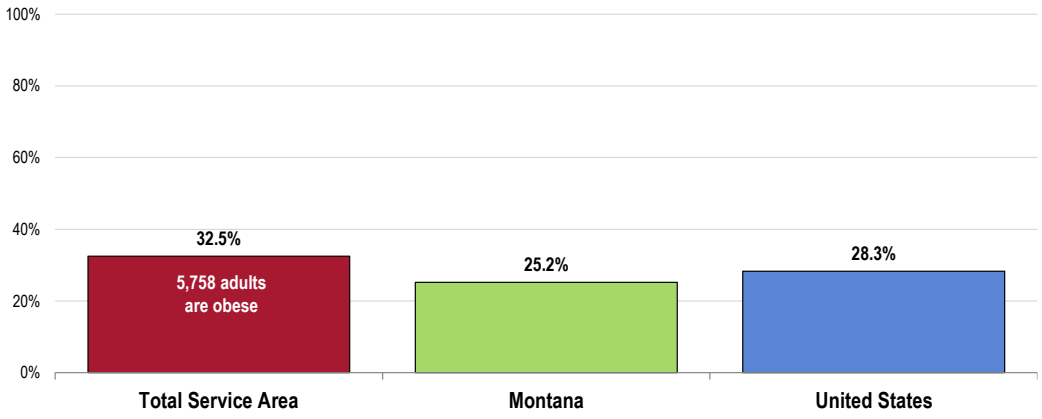
"Obese" includes respondents with a BMI value ≥30.0.

- Higher than Montana and US findings.
- Fails to satisfy the Healthy People 2020 target (30.5% or lower).

### Adults Age 20 and Older Who Are Obese

(Body Mass Index ≥ 30.0; 2015)

**Healthy People 2020 Target = 30.5% or Lower**




Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9].

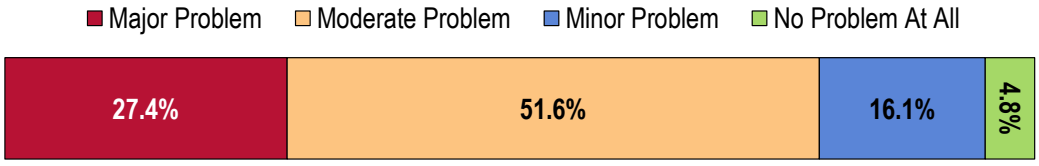
Notes:
- This indicator reports the percent of adults aged 20+ who self-report that they have a Body Mass Index (BMI) of 30.0 or greater (obese). This indicator is relevant because excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

## Key Informant Input: Nutrition, Physical Activity & Weight

**More than half of key informants taking part in an online survey characterized *Nutrition, Physical Activity & Weight* as a "moderate problem" in the community.**

### Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2019)




Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

## Top Concerns

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

### Affordable Healthy Food

*Cost of eating well, limited variety of fresh produce and items are shipped from long distances, community of farmers/ranchers where meat/potatoes are the meal, value of fruits and veggies not as high, overweight often seen as the norm, physical activity more difficult due to weather — Other Health Provider (Valley County)*

*High cost of fresh food, quality and availability of fresh foods, no walking or bike paths, lack of safety from scary people and dogs when walking. No wellness center. — Other Health Provider (Roosevelt County)*

*Price of healthy foods, weather, stress, work hours. — Other Health Provider (Roosevelt County)*

### Access to Physical Activity

*Tough one! Like the rest of America, we are getting fatter and more sedentary. We have few options for indoor exercise in the winter (which is essentially 9 months). And our indoor pool is very limited in availability. Plus, eating health is expensive. It is much cheaper to by processed, ready-to-eat foods. I see it all the time in the grocery stores, where people of limited means have their carts filled with frozen foods (pizzas, hot pockets, etc.), pastas and bread. Almost no, if any, fresh vegetables or meat. — Other Health Provider (Valley County)*

### Obesity

*A 2016 community assessment labeled obesity as a big problem. Many people feel Valley County does not have adequate physical activity resources (good sidewalks or enough parks), healthy food costs too much, or there are no healthy food options outside of home, or they are too busy to improve physical health. — Public Health Representative (Valley County)*

*Obesity is a big issue. Lack of exercise resources. — Other Health Provider (Valley County)*

### Access to Care/Services

*Eating disorder treatment or counselling, self-image/self-hurt counseling or treatment. Teenage mental health support is very to come by in our area. — Community Leader (Valley County)*

### Lifestyle

*Lack of motivation. How to balance your life. People are great about taking care of others, but do not do the same for themselves. — Community Leader (Valley County)*

### Nutrition

*Nutrition physical activity and weight control are large challenges in Valley County, due to the aging population, harsh winters, flood and otherwise difficult weather patterns. This makes it increasingly hard for people to maintain healthy habits. Most recreational activities are sedentary rather than physically demanding. Alcohol abuse and substance abuse do not help these people. Mental health access also limits pupils' compliance with exercise programs and appropriate nutrition. — Other Health Provider (Valley County)*

# Substance Abuse

## About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

- Healthy People 2020 (www.healthypeople.gov)

## Excessive Drinking

**A total of 24.8% of area adults drink alcohol excessively.**

This indicator reports the percentage of adults aged 18 and older who self-report:

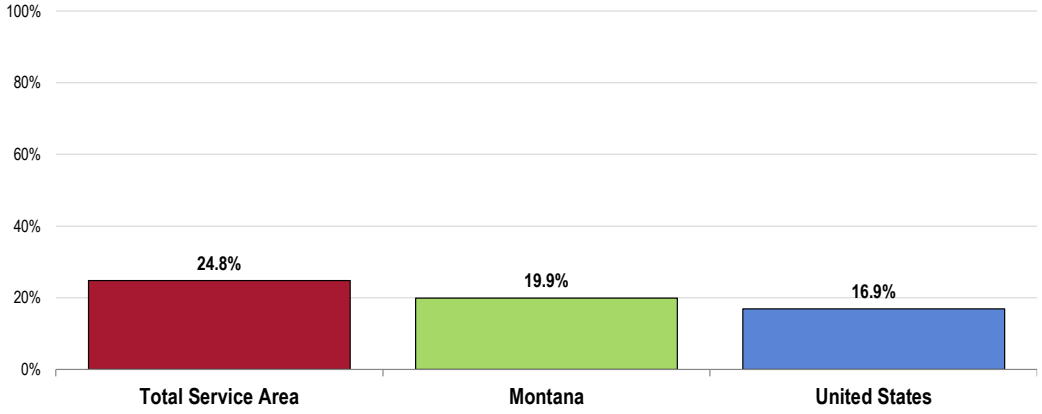
**heavy drinking** (defined as more than two drinks per day on average for men, and one drink per day on average for women)

or

**binge drinking** (5 or more drinks on a single occasion for men, 4 or more drinks on a single occasion for women).

- Less favorable than the statewide and national proportions.
- Statistically similar to the Healthy People 2020 target (25.4% or lower).

### Excessive Drinking
(2006-2012)
**Healthy People 2020 Target = 25.4% or Lower**



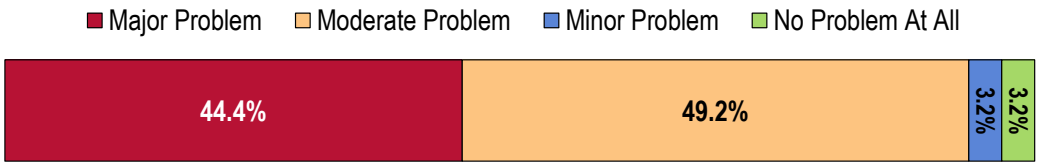

Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15].

Notes:
- This indicator reports the percentage of adults aged 18 and older who self-report heavy drinking (defined as more than two drinks per day on average for men and one drink per day on average for women).

## Key Informant Input: Substance Abuse

**Key informants taking part in an online survey characterized *Substance Abuse* as a "moderate problem" slightly more often than a "major problem" in the community.**

### Perceptions of Substance Abuse as a Problem in the Community
(Key Informants, 2019)




Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

## Barriers to Treatment

Among those rating this issue as a "major problem," the greatest barriers to accessing substance abuse treatment are viewed as:

### Access to Care/Services

*We have no adequate facility, and the people that currently work at our treatment facility only have a certification. They are not degreed in addiction counseling and do not have the ability to dispense meds if needed. Many of these patients do not have transportation. — Other Health Provider (Roosevelt County)*

*Alcohol and drug abuse treatment and counseling is also difficult to attain when you are four hours driving distance from specialists with this focus of care and treatment. — Community Leader (Valley County)*

*The rural nature of Glasgow predisposes residents to substance abuse, specifically alcohol. The lack of treatment programs 12-step programs does not aid in their ability to fight this abuse cycle. — Other Health Provider (Valley County)*

*I believe there should be resources for those who have drinking and addictive gambling issues within the community. — Other Health Provider (Valley County)*

*We have limited access to LAC's. The mental health center cannot meet the demand for the community. — Public Health Representative (Valley County)*

*Mental health and appropriate rehab facility access. — Other Health Provider (Valley County)*

*Availability of quality support and assistance. — Social Services Provider (Valley County)*

### Denial/Stigma

*Again, most folks who are addicted to alcohol or other drugs don't tend to want help. Drinking is so accepted here, as is marijuana use. — Community/Business Leader (Daniels County)*

*I'm not sure what the barriers are beyond personal barriers, and possibly family planning. — Other Health Provider (Valley County)*

*Noncompliance, transportation, lack of resources. — Other Health Provider (Roosevelt County)*

### Prevalence/Incidence

*Substance abuse is a huge issue in our community. There aren't enough resources to meet the needs. — Social Services Provider (Valley County)*

*2016 community assessment identified illegal drug use and prescription drug use, as well as high alcohol consumption as big problems in Valley County. — Public Health Representative (Valley County)*

*Lots of street drug use; this includes marijuana and meth, several alcoholic problems. Lack of resources to stop use. No substance abuse programs. — Other Health Provider (Valley County)*

### Government/Policies

*Known drug dealers aren't handled by law enforcement or let go. Too easy to obtain illegal substances. Are we asking our patients about the alcohol use and if so, taking steps/offering resources if alcohol is a daily intake. — Other Health Provider (Valley County)*

*Dealer not being punished. — Community Leader (Roosevelt County)*

### Affordable Care/Services

*Cost, expertise, and education of people attempting to provide the services through the Tribe. — Other Health Provider (Roosevelt County)*

### Easy Access

*Access to the drugs, and limited counselors available. — Community Leader (Valley County)*

## Most Problematic Substances

Key informants (who rated this as a "major problem") identified **alcohol** as the most problematic substance abused in the community, followed by **methamphetamine/other amphetamines**.

| Problematic Substances | | | | |
|---|---|---|---|---|
| | Most Problematic | Second-Most Problematic | Third-Most Problematic | **Total Mentions** |
| Alcohol | 66.7% | 16.7% | 13.0% | **23** |
| Methamphetamines or Other Amphetamines | 33.3% | 41.7% | 13.0% | **21** |
| Prescription Medications | 0.0% | 25.0% | 30.4% | **13** |
| Marijuana | 0.0% | 12.5% | 21.7% | **8** |
| Over-The-Counter Medications | 0.0% | 0.0% | 13.0% | **3** |
| Heroin or Other Opioids | 0.0% | 4.2% | 4.3% | **2** |
| Synthetic Drugs (e.g. Bath Salts, K2/Spice) | 0.0% | 0.0% | 4.3% | **1** |

# Tobacco Use

## About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes: cancer; heart disease; lung diseases (including emphysema, bronchitis, and chronic airway obstruction); and premature birth, low birth weight, stillbirth, and infant death.

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

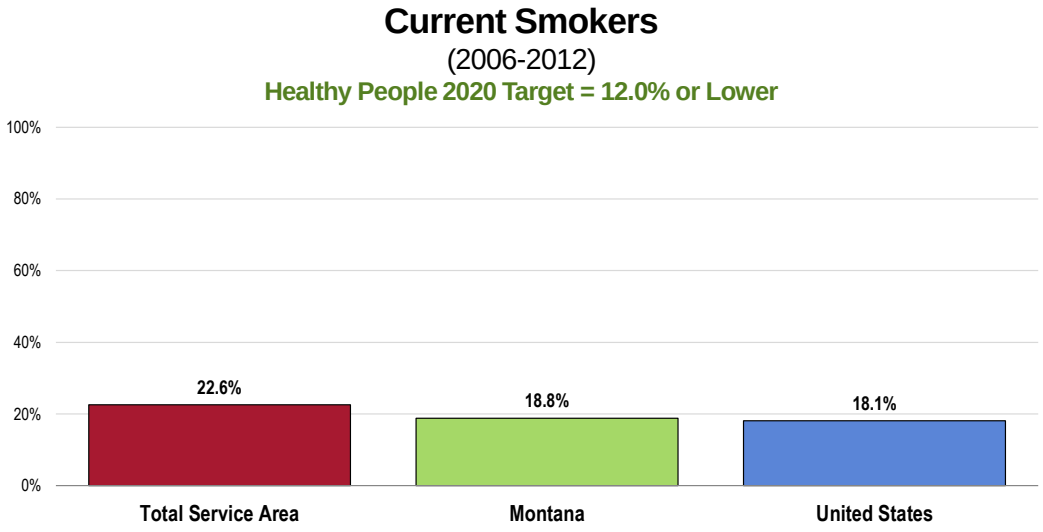
Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

- Healthy People 2020 (www.healthypeople.gov)

## Cigarette Smoking Prevalence

**A total of 22.6% of Total Service Area adults currently smoke cigarettes, either regularly or occasionally.**

- Higher than statewide and national findings.
- Fails to satisfy the Healthy People 2020 target (12.0% or lower).




Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

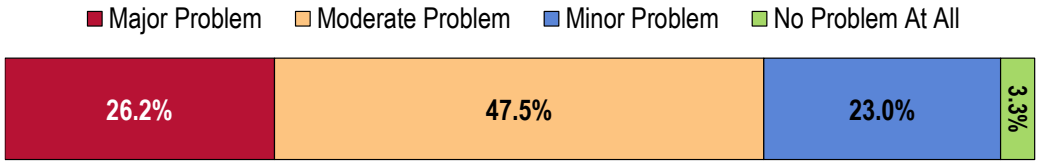
Notes:
- This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

## Key Informant Input: Tobacco Use

**Key informants taking part in an online survey most often characterized *Tobacco Use* as a "moderate problem" in the community.**

### Perceptions of Tobacco Use as a Problem in the Community

(Key Informants, 2019)




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

### Top Concerns

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

#### Prevalence/Incidence

*Heavy smoking population and chewing tobacco. Lots of pulmonary issues related to this. Lack of quitting resources. — Other Health Provider (Valley County)*

*Many people continue its use, despite known risks and diseases associated with its use. I believe use is much higher than the national average. — Other Health Provider (Valley County)*

*I see folks standing outside near the local taverns smoking. Many of the folks here are chew users, as well. — Community/Business Leader (Daniels County)*

*I don't think that this is a major problem in a sense that our community isn't dealing with it appropriately. I think that it is just a common use that is leading to the other major health issues. — Other Health Provider (Valley County)*

*Too many kids and adults are smoking. — Other Health Provider (Roosevelt County)*

#### Vaping

*Vaping has really taken off in adolescents. The full dangers of vaping is still vague. Cigarettes and chew/snuff are big in young and older adults. — Public Health Representative (Valley County)*

*Schools within Valley County have seen a rise in students using e-cigarettes, smokeless tobacco, as well as cigarettes. — Public Health Representative (Valley County)*

#### Co-Occurrences

*Mental health, weather, and poly-substance abuse predispose residents' tobacco abuse. While I do believe this is improving, it does continue to be a major problem. — Other Health Provider (Valley County)*

#### Rural Community

*Rural/ranching community leads to high smokeless tobacco use. — Other Health Provider (Roosevelt County)*

#### Tobacco Use

*Smokers. — Community Leader (Roosevelt County)*

# Access to Health Services

Professional Research Consultants, Inc.

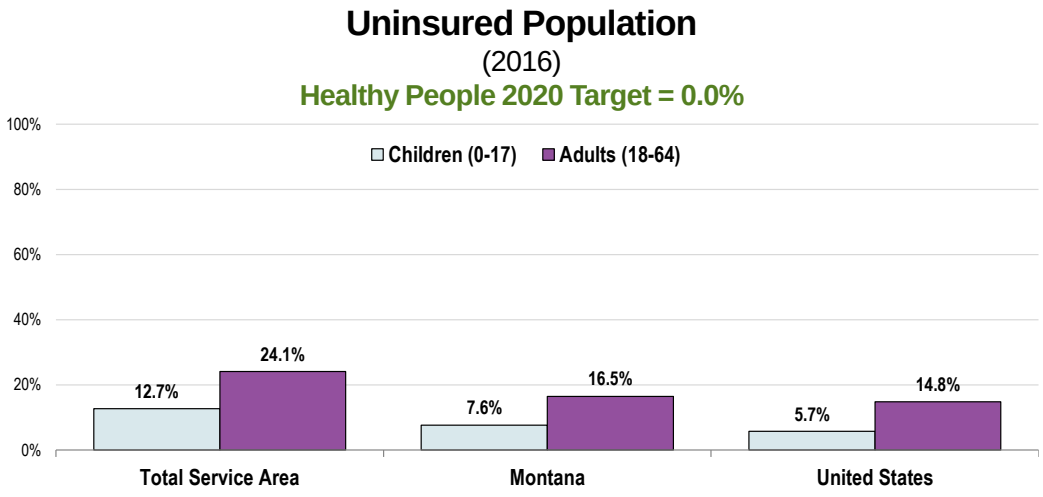
# Lack of Health Insurance Coverage

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 healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

**Among adults age 18 to 64 in the Total Service Area, 24.1% report having no insurance coverage for healthcare expenses.**

**Additionally, among children age 0 to 17 in the Total Service Area, 12.7% have no insurance coverage for healthcare expenses.**

- Each is worse than their respective state and national findings.
- The Healthy People 2020 target is universal coverage (0.0% uninsured).




Sources:
- US Census Bureau, Small Area Health Insurance Estimates. & American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1.1].

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.

# Difficulties Accessing Healthcare

## About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

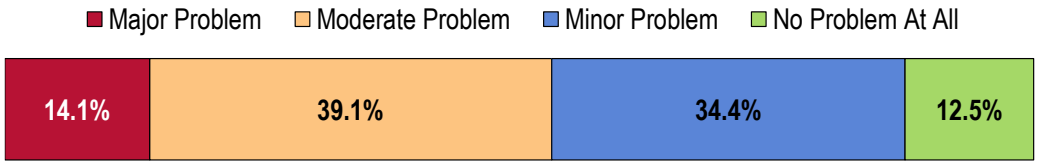
- Healthy People 2020 (www.healthypeople.gov)

## Key Informant Input: Access to Healthcare Services

**The largest share of key informants taking part in an online survey characterized *Access to Healthcare Services* as a "moderate problem" in the community.**

### Perceptions of Access to Healthcare Services as a Problem in the Community

(Key Informants, 2019)




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, 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

*We cover hundreds/thousands of square miles. The hours that are available for preventative health care are inadequate. The hours for walk-in care are inadequate. We need more Family Practice physicians and more acute care availability in the Glasgow Clinic. — Other Health Provider (Valley County)*

*Having these [primary care] visits occur at the ER is a poor use of ER resources (time, money, personnel, everything). Access to mental health services is also a major problem — Other Health Provider (Valley County)*

*Provider availability and consistency. — Other Health Provider (Valley County)*

#### Lack of Providers

*Lack of primary care options, lack of pediatric care, lack of necessary surgical care, i.e. non-invasive general surgery options, large case gynecology, large case orthopedics. Huge need for GOOD Mental Health assistance, both psychiatry with the ability to manage medications as well as solid counseling services and substance abuse support. Huge issue with sexual abuse in this community that needs medical community support to end the stigma and get appropriate treatment for victims. — Other Health Provider (Valley County)*

> *Not enough access to providers, including primary care providers and surgeons. Difficulty recruiting and retaining providers. It is difficult to get providers to move to the middle of nowhere. — Other Health Provider (Valley County)*
>
> *Only two doctors in the entire county. No access to specialists. Unable to get an appointment in a reasonable time. Only access to the Emergency Room on weekends. Cost is very high. — Other Health Provider (Roosevelt County)*

### Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") most often identified **mental health care** as the most difficult to access in the community.

**Medical Care Difficult to Access Locally**

| | Most Difficult to Access | Second-Most Difficult to Access | Third-Most Difficult to Access | **Total Mentions** |
|---|---|---|---|---|
| Mental Health Care | 85.7% | 0.0% | 0.0% | **6** |
| Primary Care | 0.0% | 12.5% | 37.5% | **4** |
| Substance Abuse Treatment | 14.3% | 12.5% | 12.5% | **3** |
| Specialty Care | 0.0% | 37.5% | 0.0% | **3** |
| Urgent Care | 0.0% | 12.5% | 12.5% | **2** |
| Chronic Disease Care | 0.0% | 12.5% | 0.0% | **1** |
| Hospice Care | 0.0% | 12.5% | 0.0% | **1** |
| Dental Care | 0.0% | 0.0% | 12.5% | **1** |
| Elder Care | 0.0% | 0.0% | 12.5% | **1** |
| Pain Management | 0.0% | 0.0% | 12.5% | **1** |

# Primary Care Services

## About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

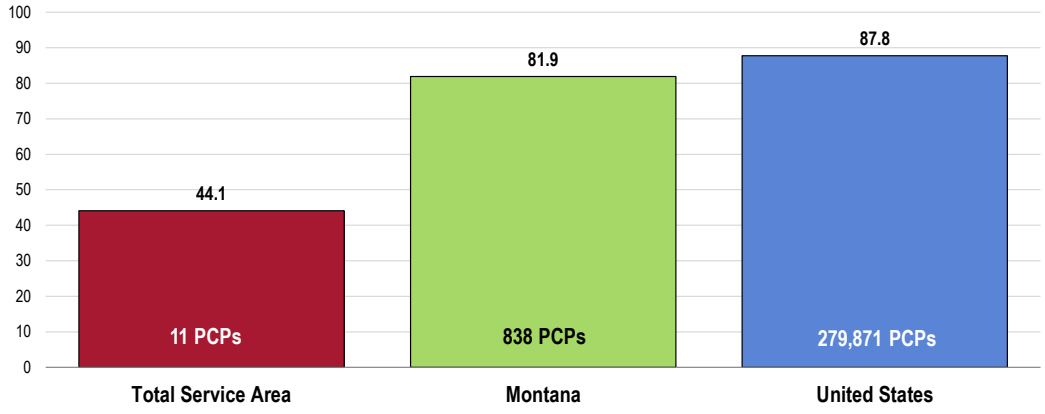
## Access to Primary Care

**In the Total Service Area in 2014, there were 11 primary care physicians, translating to a rate of 44.1 primary care physicians per 100,000 population.**

- Well below what is found statewide and nationally.

### Access to Primary Care

(Number of Primary Care Physicians [PCPs] per 100,000 Population, 2014)




Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

# Oral Health

## About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use; excessive alcohol use;** and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

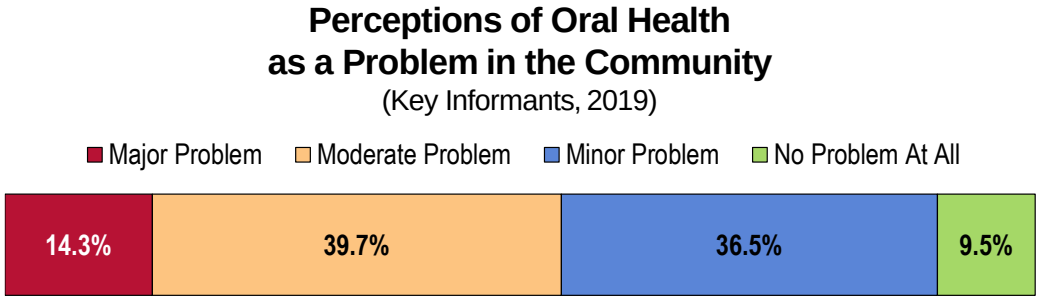
Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

- Healthy People 2020 (www.healthypeople.gov)

## Key Informant Input: Oral Health

**Key informants taking part in an online survey characterized *Oral Health* as a "moderate problem" slightly more often than a "minor problem" in the community.**




Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

## Top Concerns

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

### Insurance Issues

> *No Montana CHIP/insurance access for youths for dental care. The health department has an infant-toddler program that helps with preventative measures. — Community Leader (Valley County)*
>
> *Limited providers accepting Medicaid. Cost of services. Limited services for young children. — Other Health Provider (Valley County)*
>
> *No provider in Glasgow will take Medicaid. — Other Health Provider (Valley County)*

### Access to Care/Services

> *Oral health services. Our dentists accept limited insurance and ages. Younger children are often missed and have damaged teeth and cavities before they are seen as adolescents. Valley County Health Department sees children for a fluoride varnish application and an assessment of mouth in children age 6 months to 6 years. This service is only funded by a yearly grant. Public health oral health services are not reimbursed by insurances, even with dental coverage. — Public Health Representative (Valley County)*
>
> *No reliable dental practice. — Other Health Provider (Roosevelt County)*

### Prevention

> *Lack of hygiene, drug abuse, high sugar foods. — Other Health Provider (Roosevelt County)*

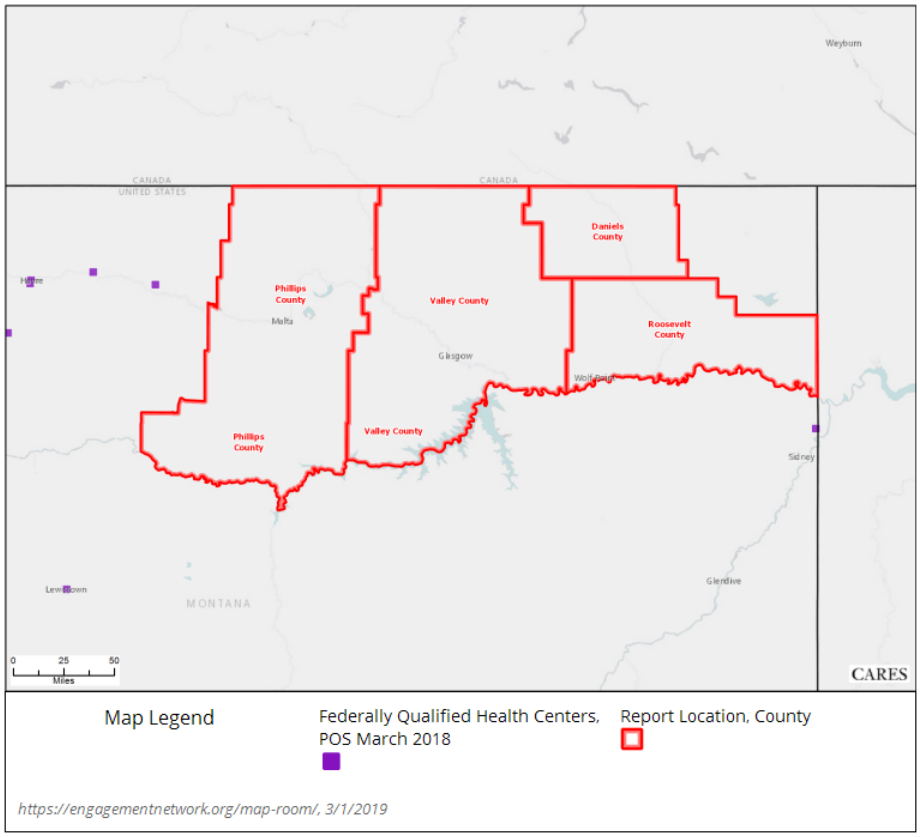
# Local Resources

Professional Research Consultants, Inc.

# Healthcare Resources & Facilities

## Federally Qualified Health Centers (FQHCs)

**As of March 2018, there were no Federally Qualified Health Centers (FQHCs) within the Total Service Area.**



# Resources Available to Address the Significant Health Needs

Incorporating input from community stakeholders taking part in the Online Key Informant Survey, the following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

### Access to Healthcare Services

*Doctor's Offices*
*Frances Mahon Deaconess Hospital*
*Glasgow Clinic*
*Mental Health Services*
*Northeast Montana Health Services*
*VA Clinic*

### Arthritis, Osteoporosis & Chronic Back Conditions

*Frances Mahon Deaconess Hospital*
*Glasgow Clinic*
*Hospital Clinic*
*Massage Services*

### Cancer

*AA/NA*
*Daniels County Public Health*
*Daniels Memorial Healthcare Center*
*Frances Mahon Deaconess Hospital*
*Glasgow Clinic*
*Glasgow Hospital*
*Health Department*
*Indian Health Services*
*Relay for Life*

### Dementias, Including Alzheimer's Disease

*Council on Aging*
*Doctor's Offices*
*Frances Mahon Deaconess Hospital*
*Home Care Services*
*Hospitals*

### Diabetes

*Bountiful Baskets*
*Daniels Memorial Healthcare Center*
*Diabetes Program*
*Doctor's Offices*
*Frances Mahon Deaconess Hospital*
*Glasgow Clinic*
*Health Department*
*Hospitals*
*Northeast Montana Health Services*
*Nutrition Services*
*Pharmacists*
*Roosevelt County Health Department*
*Roosevelt Medical Center*
*Telemed*

### Family Planning

*Churches*
*Community Health Nurse*
*Doctor's Offices*
*Health Education*

### Heart Disease & Stroke

*Cardiac Rehab*
*Daniels County Public Health*
*Daniels Memorial Healthcare Center*
*Doctor's Offices*
*Frances Mahon Deaconess Hospital*
*Glasgow Clinic*
*Northeast Montana Health Services*
*Parks and Recreation*
*Roosevelt Medical Center*
*Smoking Cessation Programs*

### Immunization & Infectious Disease

*Frances Mahon Deaconess Hospital*

### Infant & Child Health

*BIA Social Services*
*Montana Child Protective Services*

### Injury & Violence

*Frances Mahon Deaconess Hospital*

- *Hospitals*
- *Indian Health Services*
- *Love Should Not Hurt*
- *Mental Health Services*
- *School System*
- *Spotted Bull Treatment Center*

### Kidney Disease

- *Diabetes Program*
- *Dialysis*
- *Doctor's Offices*
- *Telemed*

### Mental Health

- *AA/NA*
- *Churches*
- *Counselors*
- *County Mental Health*
- *Daniels Memorial Healthcare Center*
- *Doctor's Offices*
- *Eastern Montana Community Mental Health Center*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Hospitals*
- *Indian Health Services*
- *Lifecoach*
- *Mental Health Center*
- *Mental Health Services*
- *Northeast Montana Community Mental Health*
- *Peer Recovery Coach*
- *School System*
- *State Mental Hospital*
- *Teaming Together Counseling*
- *Telehealth*
- *The Answer Within Counseling*
- *Valley County Mental Health*

### Nutrition, Physical Activity & Weight

- *Civic Center*
- *Daniel Plan Program*
- *Food Co-op*
- *Fort Peck Tribes*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Glasgow Recreation Center*
- *Hospitals*
- *Just for Kicks*
- *Kraze Fitness Center*
- *Parks and Recreation*
- *Recreation Center*
- *Roosevelt County Health Department*
- *Telemed*
- *Weight Watchers*
- *Wellness Center*
- *Wolf Point High School Track*

### Oral Health

- *Budde Family Dentistry*
- *Dentist's Offices*
- *Doctor's Offices*
- *Gentle Dental*
- *Health Department*
- *Indian Health Services*
- *Rimrock Pediatric Dentistry*

### Respiratory Diseases

- *Doctor's Offices*
- *Home Oxygen*

### Sexually Transmitted Diseases

- *Churches*
- *Community Health Nurse*
- *Doctor's Offices*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Indian Health Services*
- *Roosevelt County Health Department*
- *School System*

### Substance Abuse

- *AA/NA*
- *Daniels Memorial Healthcare Center*
- *Doctor's Offices*
- *Eastern Montana Community Mental Health Center*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Glasgow Police Department*
- *Indian Health Services*
- *Mental Health Center*
- *Mental Health Services*
- *Ministerial Resources*
- *Peer Recovery Coach*
- *Spotted Bull Treatment Center*
- *Substance Abuse Counselors*
- *Teaming Together Counseling*
- *Valley County Mental Health*
- *Valley County Sheriff's Department*

### Tobacco Use

*1-800-Quit-Line*

*Daniels Memorial Healthcare Center*

*Doctor's Offices*

*Fort Peck Tobacco Prevention Coordinator*

*Frances Mahon Deaconess Hospital*

*Glasgow Clinic*

*Mental Health Services*

*Montana Quit Line*

*Montana Tobacco Use Prevention Program, Valley County Health Department*

*Nutrition Services*

*Roosevelt County Tobacco Prevention Coordinator*

*Smoking Cessation Programs*

# Appendix

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# Evaluation of Past Activities

## CHNA Action Update – Nutrition, Weight, and Physical Activity

Goal: To improve the health of our community by implementing and supporting evidence based approaches to impact behaviors related to nutrition, weight and physical activity thereby having a positive impact on a multitude of health conditions.

Strategy 1 and Strategy 2 are under discussion.

Strategy 3: FMDH has continued the wellness program for employees. FMDH has begun communication with a company called WellRight. WellRight is a corporate wellness platform that allows FMDH to run an online board that reaches out to our employees via smart phone, computer, or tablet. The employees can track their own health habits as well as participate in; health coaching, custom activities, personal challenges, group challenges, and much more. WellRight was appealing to FMDH with the hopes of being able to implement WellRight services at FMDH and then bundle these services out to other community businesses for promotion of employee wellness and a revenue return. FMDH is still working out the contract with WellRight. As of now FMDH is looking at a one year contract with WellRight. Once the contract is finished an update on investment and cost will be able to be reported.

Anticipated Impact: With regards to all objectives the goal is to impact employee and community compliance with physical activity recommendations and improve the overall health status of the Glasgow community and surrounding areas.

## January, 2017

| | | |
|---|---|---|
| Bi-weekly Facebook Posts | 6-30-18 | Fitness ads |
| Bi-weekly ads in the Buzz and the Courier | 6-30-18 | Fitness ads |
| KLTZ/KLAN radio ads, weekly | 6-30-18 | Fitness ads |
| Billboard on Hwy 2 East of Glasgow | 6-30-18 | Fitness ad |
| Health Fair | 10-24-18 | |
| Community Resource Fitness List | | Community Directory |

## January, 2018

| | | |
|---|---|---|
| Smoke Free Movie Night | 2-19-18 | We are doing a tobacco-free movie night geared towards teens in conjunction with reACT. |
| Red Thumb Day | 4-10-18 | Red Thumb Day raises awareness of the risks of texting and driving. We are co-sponsoring this community event, and will also have information about the risks of using tobacco as well. |
| Bi-weekly Facebook Posts | | Anti-tobacco ads |
| Bi-weekly ads in the Buzz and the Courier | | Anti-tobacco ads |
| KLTZ/KLAN radio ads, weekly | | Anti-Tobacco ads |
| Billboard on Hwy 2 East of Glasgow | | Anti-tobacco ad |

## October, 2018

**Billboard**

We continue to run our billboard on Highway 2. I have had good feedback from people that it has been capturing their attention.


**FMDH Health & Wellness Fair**

Our annual FMDH Health & Wellness Fair is Saturday, October 27th. We will be hosting over 27 booths from our own facility, as well as community organizations and businesses. The spotlight this year will be our MEGA Heart – an inflatable heart that provides a highly interactive and educational experience that increases people's awareness about heart disease. Visitors can tour inside the human heart, learn about cardiovascular function, observe examples of various types of heart disease, and see displays of some of the latest medical treatments for heart problems. Tours will be open to the public during the Health & Wellness fair, and we are offering private school tours on Friday, October 26th. The private tours have been offered county-wide to schools as well as home school groups.


## January, 2019

**Fruit & Veggie Program**

We continue to sponsor the Fruit & Veggie Program at the Glasgow Schools. Every day the "Glasgow Scottie School Food" Facebook page shares what the FMDH sponsored snack is. (Some of the past few weeks options have been broccoli, bananas, blood oranges, grapes, kiwis, apples, and snap peas). The posts generally get good response and feedback. See a sample of one of their posts below.

They have been able to stretch the money for the program fairly far, as we provide funds for grade K-6 students but they are able to offer the snack program for the grade 7-12 students as well. This program goes through the entire school year.

**2019 CHNA Assessment**

We are currently working with Professional Research Consultants, Inc (PRC) to conduct our 2019 CHNA assessment. This is the same company that we worked three years ago to do the last study. The assessment will take place spring of 2019.