

Executive Report

2015 Community Health Needs Assessment

Holy Rosary Healthcare Service Area

Carter, Custer, Dawson, Fallon, Garfield, McCone, Powder River,
Prairie, Rosebud and Treasure Counties, Montana

Prepared for:
Holy Rosary Healthcare

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Introduction



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 service area of Holy Rosary Healthcare. 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 Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

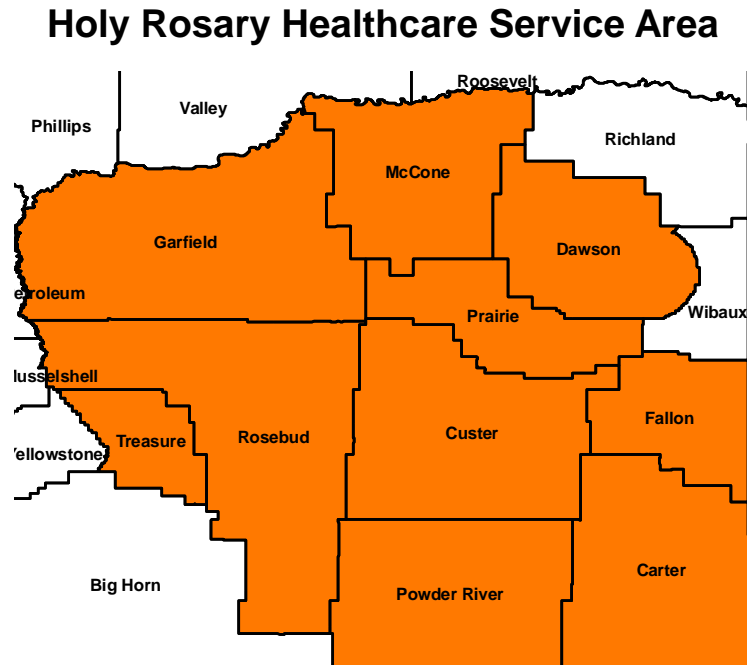
This assessment was conducted on behalf of Holy Rosary Healthcare by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United 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); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through the PRC Online Key Informant Survey.

Community Defined for This Assessment

The study area for this effort (referred to as the “Holy Rosary Healthcare Service Area” or “HRH Service Area” in this report) includes ten counties: Carter, Custer, Dawson, Fallon, Garfield, McCone, Powder River, Prairie, Rosebud, and Treasure. This community definition, determined based on the areas of residence of most recent patients of the Holy Rosary Healthcare System, 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 also implemented as part of this process. A list of recommended participants was provided by Holy Rosary Healthcare; 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, 56 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
Public Health Expert	35	15
Community Leader	50	15
Social Services Representative	31	14
Health Provider	33	12

Final participation included representatives of the organizations outlined below.

- Action for Eastern Montana
- Buckle Up Montana
- Chamber of Commerce
- Child and Family Services
- CHOICES - Compassionate Care Counseling Center
- CNADA
- Custer County Attorney
- Custer County Commissioner
- Custer County Council on Aging
- Custer County Sheriff's Office
- Dahl Memorial Healthcare Association, Inc.
- DEAP
- Department of Family Services
- Department of Public Assistance/ MT Casa
- Drug Task Force
- Eastern Montana Counseling and Consulting
- Eastern Montana Industries
- Fire and Ambulance Service
- First Presbyterian Church of Miles City
- Garfield Elementary School
- Garfield Public Health
- Glendive Medical Center
- Head Start/Action for Eastern Montana
- Holy Rosary Healthcare
- Home Care Services
- McCone County
- McCone County Health Center
- MidRivers Communications

- Miles City Job Service
- Miles City Unified School District
- Montana Health Network
- Montana State University Extension
- Montana Vocational Rehabilitation
- OneHealth
- Osco Pharmacy
- Powder River County
- Powder River Public Health
- Prairie Community Hospital
- Prairie County Montana
- Private Practice Psychologist
- Public Health and Human Services
- Rosebud Health Care Center
- RSVP
- Southeastern Montana Tobacco Use Prevention Program
- St. Labre Indian School
- Stein Chiropractic and Sports Clinic
- Traci Schell Insurance
- Veterans Affairs
- W. A. Mitchell Agency
- Wagner Chiropractic
- Yellowstone Anesthesia Associates

Through this process, input was gathered from several individuals whose organizations work with low-income, **minority populations** (including African-Americans, the Amish, Asians, Caribbean populations, children, Hispanics, the homeless, lesbian/gay/bisexual/transgender residents, low-income residents, the mentally ill, Native Americans, seniors, single parents, substance abusers, uninsured/underinsured residents, and women), or other **medically underserved populations** (including adolescents/young adults, the autistic population, children, the disabled, the elderly, ethnic minorities, the homeless, LGBT residents, low-income residents, Medicaid/Medicare recipients, the mentally ill, Native Americans, rural patients, single parents, uninsured/underinsured residents, and veterans).

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 be better 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 from participants regarding their opinions and perceptions of the health 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 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
- KIDS COUNT Data Center
- Montana Department of Public Health and Human Services
- 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

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.

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	See Report Page(s)
Part V Section B Line 1a <i>A definition of the community served by the hospital facility</i>	7
Part V Section B Line 1b <i>Demographics of the community</i>	25
Part V Section B Line 1c <i>Existing health care facilities and resources within the community that are available to respond to the health needs of the community</i>	121
Part V Section B Line 1d <i>How data was obtained</i>	6
Part V Section B Line 1f <i>Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups</i>	Addressed Throughout
Part V Section B Line 1g <i>The process for identifying and prioritizing community health needs and services to meet the community health needs</i>	16
Part V Section B Line 1h <i>The process for consulting with persons representing the community's interests</i>	7
Part V Section B Line 1i <i>Information gaps that limit the hospital facility's ability to assess the community's health needs</i>	10

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).

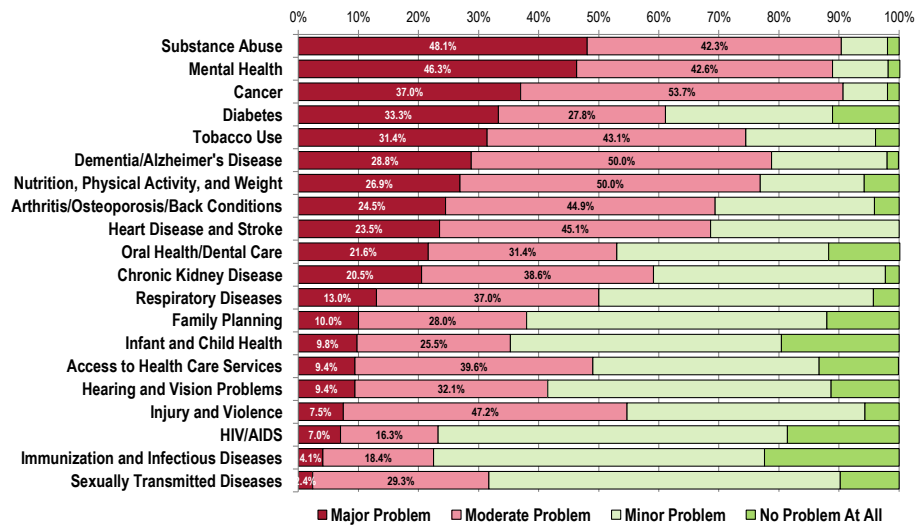
Areas of Opportunity	
Access to Healthcare Services	<ul style="list-style-type: none"> ● Lack of Health Insurance ● Primary Care Physician Ratio ● Health Professional Shortage Area Designation ● 9.4% of key informants rated Access to Healthcare as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Quality ○ Transportation
Cancer	<ul style="list-style-type: none"> ● Cancer Deaths ● Cancer Incidence <ul style="list-style-type: none"> ○ Including Prostate Cancer, Female Breast Cancer, Colorectal Cancer Incidence ● Female Breast Cancer Screening ● Cervical Cancer Screening ● Colorectal Cancer Screening ● 37.0% of key informants rated Cancer as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ High Incidence ○ Lack of Local Services
Dementia, Including Alzheimer's Disease	<ul style="list-style-type: none"> ● 28.8% of key informants rated Dementias/Alzheimer's Disease as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Aging Population ○ High Prevalence ○ Caregiving ○ Lack of Services
Diabetes	<ul style="list-style-type: none"> ● Diabetes Prevalence ● 33.3% of key informants rated Diabetes as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Lack of Education ○ Access to Primary Care & Medications ○ High Prevalence ○ Lack of Specialists & Services ○ Lack of Support ○ Weight Issues
Heart Disease & Stroke	<ul style="list-style-type: none"> ● Stroke Deaths ● 23.5% of key informants rated Heart Disease & Stroke as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Lack of Specialists ○ Poor Nutrition

<p>Infant Health & Family Planning</p>	<ul style="list-style-type: none"> • Infant Mortality • Teen Births • 9.8% of key informants rated <i>Infant & Child Health</i> as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Lack of Pediatric Providers & Services • 10.0% of key informants rated <i>Family Planning</i> as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Teen Pregnancy ○ Lack of Education & Family Planning Services
<p>Injury & Violence</p>	<ul style="list-style-type: none"> • Unintentional Injury Deaths <ul style="list-style-type: none"> ○ Including Motor Vehicle Crash Deaths • 7.5% of key informants rated <i>Injury & Violence</i> as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Prevalence of Violence
<p>Mental Health</p>	<ul style="list-style-type: none"> • Suicide Deaths • 46.3% of key informants rated <i>Mental Health</i> as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Lack of Access, Inadequate Services ○ Stigma ○ Lack of Education
<p>Nutrition, Physical Activity & Weight</p>	<ul style="list-style-type: none"> • Low Food Access • Obesity [Adults] • Leisure-Time Physical Activity • Access to Recreation/Fitness Facilities • 26.9% of key informants rated <i>Nutrition, Physical Activity & Weight</i> as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Lack of Facilities & Healthy Options ○ Lack of Motivation ○ Lack of Education
<p>Respiratory Diseases</p>	<ul style="list-style-type: none"> • Lung Disease Deaths • 13.0% of key informants rated <i>Respiratory Diseases</i> as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Tobacco Use
<p>Substance Abuse</p>	<ul style="list-style-type: none"> • 48.1% of key informants rated <i>Substance Abuse</i> as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Cultural Norms ○ Cost of Treatment ○ Lack of Services & Other Access Barriers ○ Lack of Willingness to Get Help ○ Stigma & Denial
<p>Tobacco Use</p>	<ul style="list-style-type: none"> • Montana has the 4th highest level of smokeless tobacco use among the 50 US states. • 31.4% of key informants rated <i>Tobacco Use</i> as a “major problem” in the community; their chief concerns include: <ul style="list-style-type: none"> ○ Cultural Norms ○ Persistent Use ○ Prevalence Among Teens

Key Informant Rankings

Through the PRC Online Key Informant Survey, community stakeholders were presented with 20 health topics and asked to rate each as a “major problem,” a “moderate problem,” a “minor problem,” or “not a problem at all” in their own community. In reviewing “major problem” responses, the following were ranked as top concerns for the HRH Service Area: substance abuse, mental health, cancer and diabetes.

Key Informants: Relative Position of Health Topics as Problems in the Community



Prioritization of Health Needs

On Monday, January 26, 2015, the Servant Leadership Team of Holy Rosary Healthcare met to evaluate, discuss and prioritize health issues for the community, based on findings of the 2014 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, attendees were provided worksheets that asked them to consider two criteria: 1) the **scope and severity** of each of the significant health needs presented; and 2) the ability of Holy Rosary Healthcare to have a significant **impact** on each. This exercise informed the dialogue that followed. Through discussion, a consensus was reached to establish the following as priorities for Holy Rosary Healthcare to include in its Implementation Strategy to address the top health needs of the community in the coming years:

1. Access to Healthcare Services

2. Mental Health

3. Tobacco Use

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.

- Cancer
- Dementias, Including Alzheimer's Disease
- Diabetes
- Heart Disease & Stroke
- Infant Health & Family Planning
- Injury & Violence
- Nutrition, Physical Activity & Weight
- Respiratory Diseases
- Substance Abuse
















Secondary Data Tables: Comparisons With Benchmark Data






The following tables provide an overview of secondary data indicators in the HRH 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 charts, HRH Service Area results are shown in the larger, blue column.
- The columns to the right of the HRH Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Symbols indicate whether the HRH 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	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Linguistically Isolated Population (%)	0.2	 0.4	 4.9	
Population in Poverty (%)	14.9	 14.8	 14.9	
Population Below 200% FPL (%)	35.4	 35.7	 33.6	
Children in Poverty (%)	21.2	 19.9	 20.8	
No High School Diploma (% Age 25+)	9.8	 8.1	 14.3	
Unemployment Rate (% Age 16+)	3.1	 3.8	 5.8	
		 better	 similar	 worse









Overall Health	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
"Fair/Poor" Overall Health (%)	16.0	 14.4	 16.2	
		 better	 similar	 worse












Access to Health Services	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Uninsured (% Age 18-64)	24.0	 25.2	 20.8	 0.0
Primary Care Doctors per 100,000	56.4	 76.5	 85.8	
Live in a Health Professional Shortage Area (%)	61.6	 46.3	 37.6	
		 better	 similar	 worse












Cancer	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)	187.2	 164.1	 174.1	 161.4
Prostate Cancer Incidence per 100,000	166.0	 155.2	 143.7	
Female Breast Cancer Incidence per 100,000	132.4	 124.0	 119.7	
Lung Cancer Incidence per 100,000	59.2	 61.8	 64.9	
Colorectal Cancer Incidence per 100,000	64.8	 44.7	 43.9	 41.6
Mammogram in Past 2 Years (% Medicare Women 67-69)	62.3	 66.8	 65.4	 81.1
Pap Test in Past 3 Years (% Women 18+)	66.9	 71.9	 77.6	 93.0
Sigmoidoscopy/Colonoscopy Ever (% Age 50+)	52.5	 58.3	 64.6	
		 better	 similar	 worse







Diabetes	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Diabetes Prevalence (%)	8.8	 7.5	 9.6	
		 better	 similar	 worse











Family Planning	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Teen Births per 1,000 (Age 15-19)	41.0	 34.8	 36.6	
		 better	 similar	 worse








Heart Disease & Stroke	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Diseases of the Heart (Age-Adjusted Death Rate)	164.1	 159.9	 184.6	
Stroke (Age-Adjusted Death Rate)	54.0	 39.6	 40.4	 34.8
		 better	 similar	 worse









Injury & Violence Prevention	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Unintentional Injury (Age-Adjusted Death Rate)	89.5	 58.0	 38.9	 36.4
Motor Vehicle Crashes (Age-Adjusted Death Rate)	39.3	 18.9	 7.6	 12.4
Violent Crime per 100,000	144.1	 272.2	 386.8	
		 better	 similar	 worse








Maternal, Infant & Child Health	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
No Prenatal Care in First Trimester (%)	21.5	 22.0		 22.1
Low Birthweight Births (%)	7.1	 7.3	 8.2	 7.8
Infant Death Rate	6.8	 6.2	 6.5	 6.0
		 better	 similar	 worse







Mental Health & Mental Disorders	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Suicide (Age-Adjusted Death Rate)	37.2	 21.1	 11.8	 10.2
		 better	 similar	 worse







Nutrition & Weight Status	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
<5 Fruits/Vegetables Per Day (%)	75.9	 74.8	 75.7	
Population With Low Food Access (%)	48.7	 26.9	 23.6	
Obese (% Age 20+)	26.5	 24.3	 27.3	 30.5
		 better	 similar	 worse

Physical Activity	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
No Leisure-Time Physical Activity (%)	26.7	 22.2	 23.4	
Recreation/Fitness Facilities per 100,000	4.9	 12.8	 9.4	
		 better	 similar	 worse

Respiratory Diseases	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Lung Disease (Age-Adjusted Death Rate)	58.2	 54.2	 42.7	
Pneumonia Vaccination (% 65+)	71.8	 71.2	 67.4	 90.0
		 better	 similar	 worse

Sexually Transmitted Diseases	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Gonorrhea Incidence per 100,000	12.3	 10.8	 107.5	
Chlamydia Incidence per 100,000	360.2	 383.4	 456.7	
		 better	 similar	 worse

Substance Abuse	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Excessive Drinking (%)	17.3	 18.8	 16.5	 25.4
		 better	 similar	 worse

Tobacco Use	HRH Service Area	HRH Service Area vs. Benchmarks		
		vs. MT	vs. US	vs. HP2020
Current Smoker (%)	16.6	 18.1	 17.8	 12.0
		 better	 similar	 worse



Community Description



Population Characteristics

Total Population

The Holy Rosary Healthcare (HRH) Service Area, the focus of this Community Health Needs Assessment, encompasses 29,449.31 square miles and houses a total population of 40,754 residents, according to latest census estimates.

Total Population
(Estimated Population, 2008-2012)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
HRH Service Area	40,754	29,449.31	1.38
Montana	990,785	145,507.56	6.81
United States	309,138,709	3,530,997.6	87.55

Sources: • U.S. Census Bureau American Community Survey 5-year estimates (2008-2012).
• Retrieved November 2014 from Community Commons at <http://www.chna.org>.

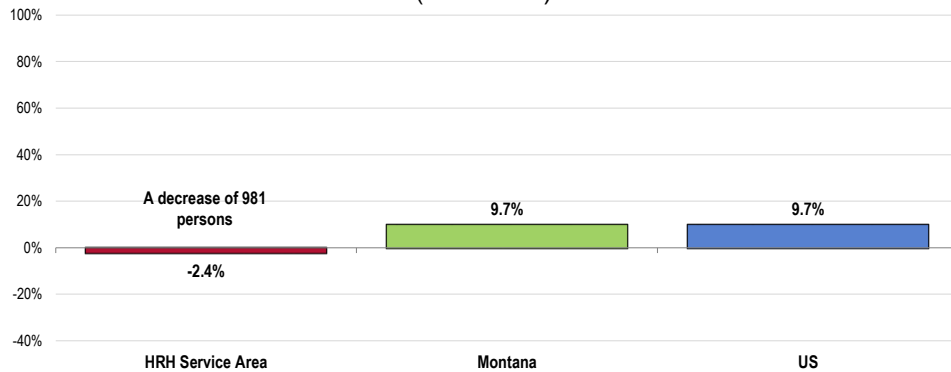
Population Change 2000-2010

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 HRH Service Area decreased by 981 persons, or 2.4%.

- A much greater proportional decrease than seen across the state of Montana.
- A much greater proportional decrease than seen nationwide.

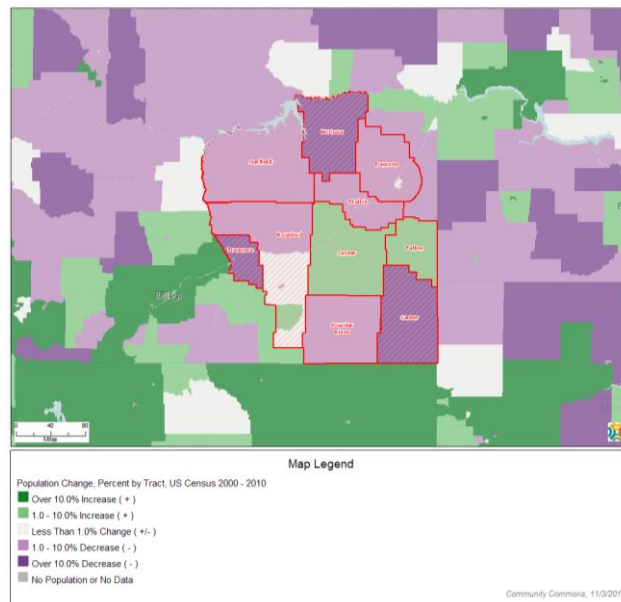
Change in Total Population, Percent (2000-2010)



Sources: • U.S. Census Bureau Decennial Census (2000-2010).
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.

Note that the greatest decreases occurred in Carter, McCone, and Treasure counties.

Population Change, Percent by Tract, US Census 2000-2010



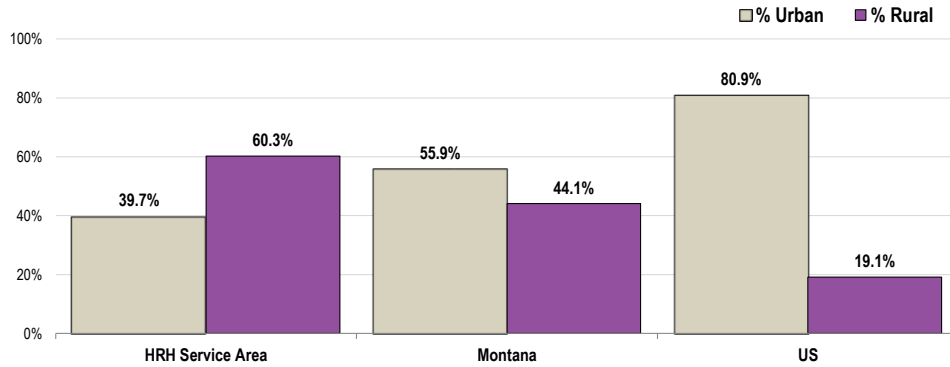
Urban/Rural Population

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 HRH Service Area is predominantly rural, with 60.3% of the population living in areas designated as rural.

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

Urban and Rural Population (2010)

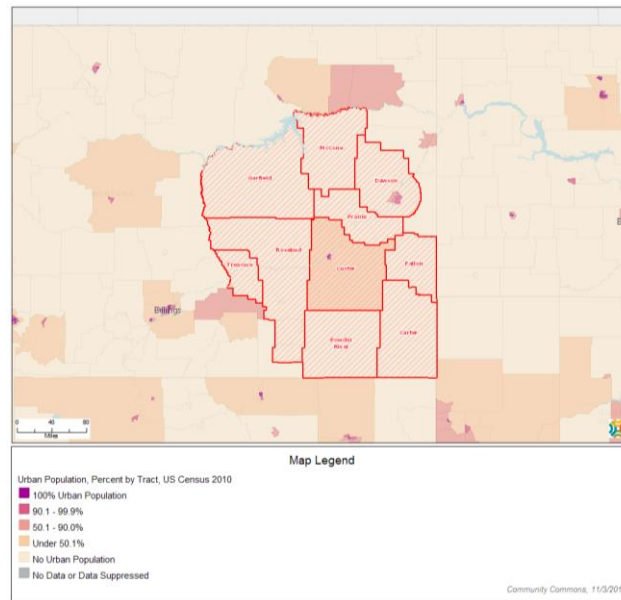


Sources:

- U.S. Census Bureau Decennial Census (2010).
- Retrieved November 2014 from Community Commons at <http://www.chna.org>.

- Note the following map outlining the urban population in the service area census tracts as of 2010.

Urban Population, Percent by Tract, US Census 2010



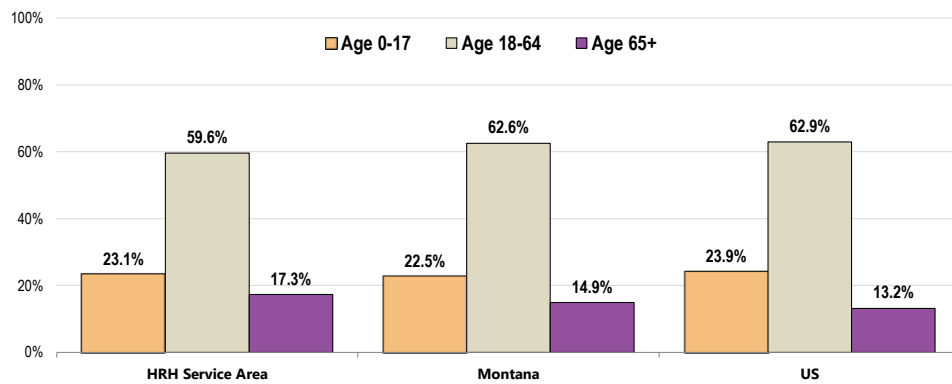
Age

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

In the HRH Service Area, 23.1% of the population are infants, children or adolescents (age 0-17); another 59.6% are age 18 to 64, while 17.3% are age 65 and older.

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

Total Population by Age Group
(2008-2012)

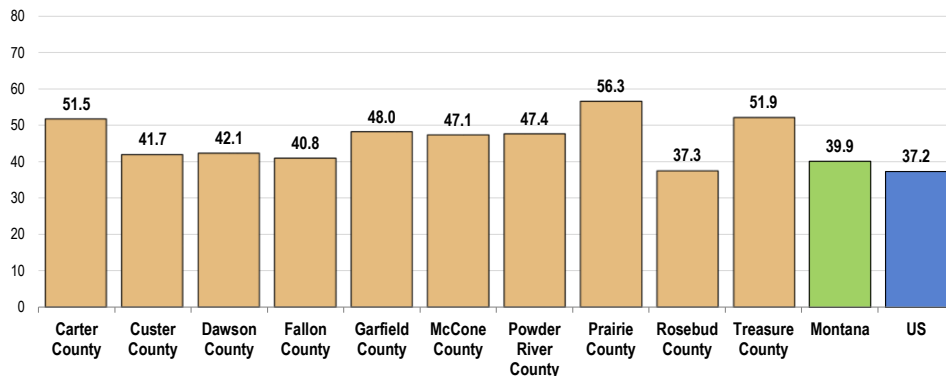


Sources: • U.S. Census Bureau American Community Survey 5-year estimates (2008-2012).
• Retrieved November 2014 from Community Commons at <http://www.chna.org>.

Median Age

The HRH Service Area is “older” than the state and the nation in that the median ages for nine out of the ten counties are all higher.

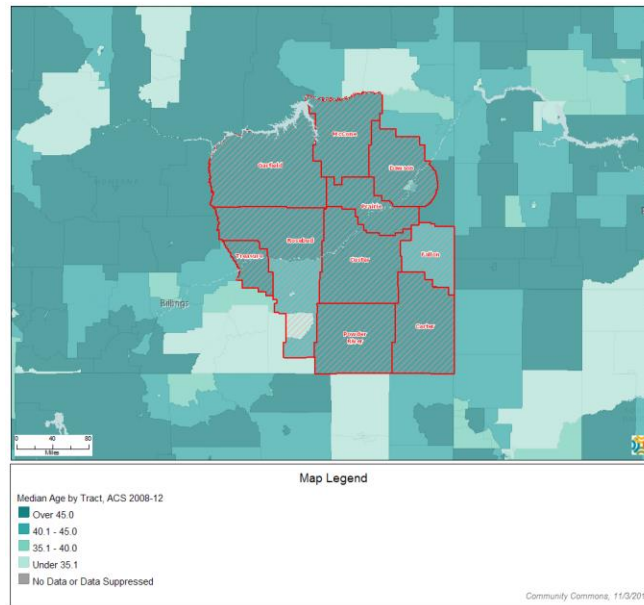
Median Age
(2008-2012)



Sources: • U.S. Census Bureau American Community Survey 5-year estimates (2008-2012).
• Retrieved November 2014 from Community Commons at <http://www.chna.org>.

- The following map provides an illustration of the median age in the service area, segmented by census tract.

Median Age, by Tract, ACS 2008-2012



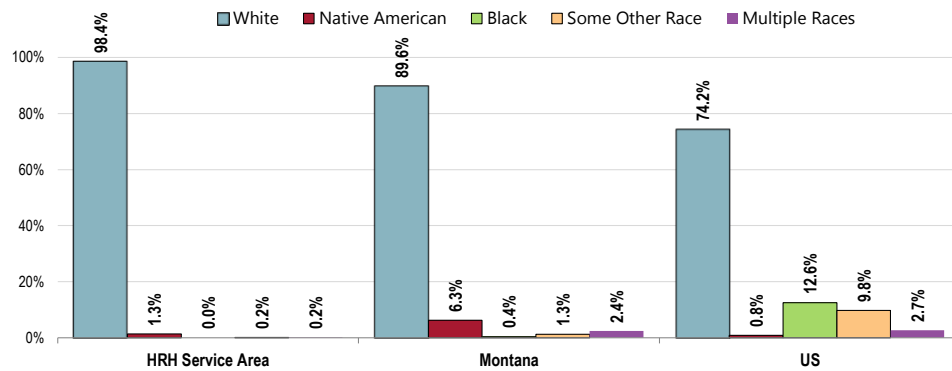
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 98.4% of residents of the HRH Service Area are White and 1.3% are Native American.

- Population across the state is slightly more racially diverse.
- Nationally, the US population is less White, more Black, and more “other” race.

Total Population by Race Alone, Percent (2008-2012)



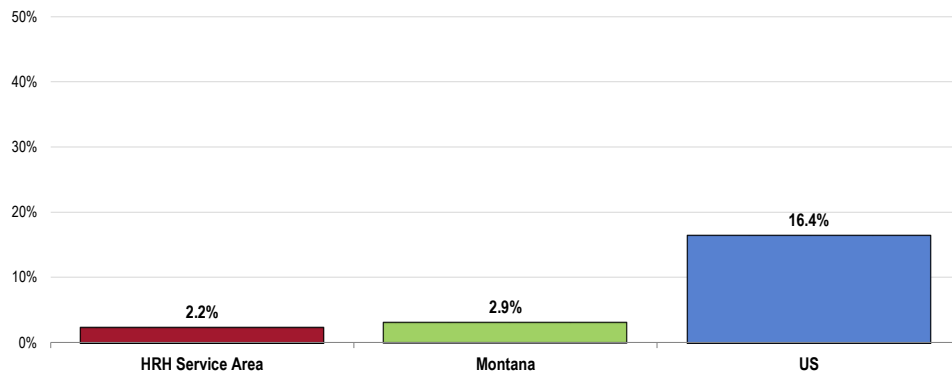
Sources: • U.S. Census Bureau American Community Survey 5-year estimates (2008-2012).
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.

Ethnicity

A total of 2.2% of service area residents are Hispanic or Latino.

- Lower than found statewide.
- Much lower than found nationally.

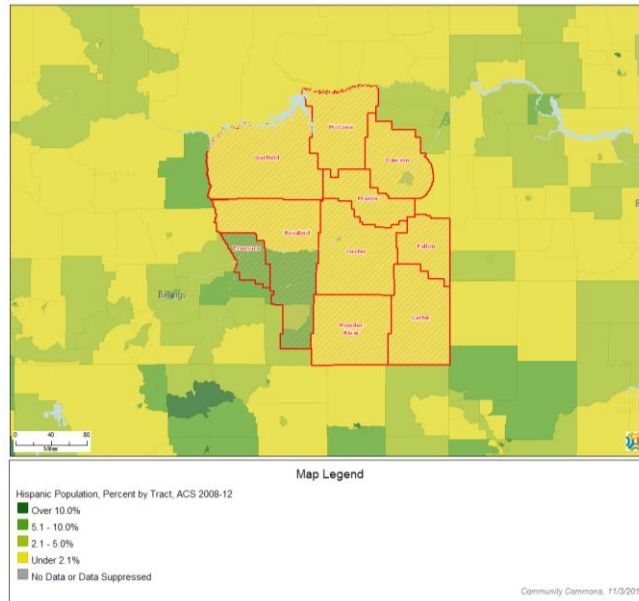
Percent Population Hispanic or Latino (2008-2012)



Sources: • U.S. Census Bureau American Community Survey 5-year estimates (2008-2012).
 • Retrieved November 2014 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.

- The Hispanic population appears to be most concentrated in Treasure County and southern Rosebud County.

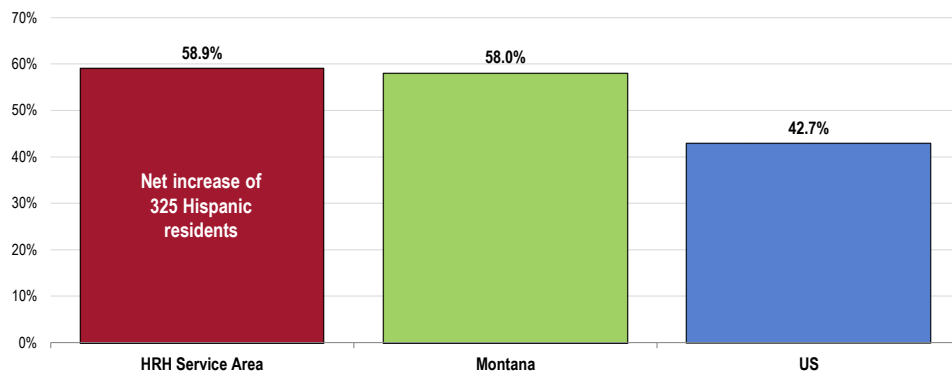
Population Hispanic or Latino, Percent by Tract, ACS 2008-2012



Between 2000 and 2010, the Hispanic population in the HRH Service Area increased by 325 residents or 58.9%.

- Similar to that found statewide.
- Higher (in terms of percentage growth) than found nationally.

Hispanic Population Change, Percent (2000-2010)



Sources: • U.S. Census Bureau Decennial Census (2000-2010).
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.

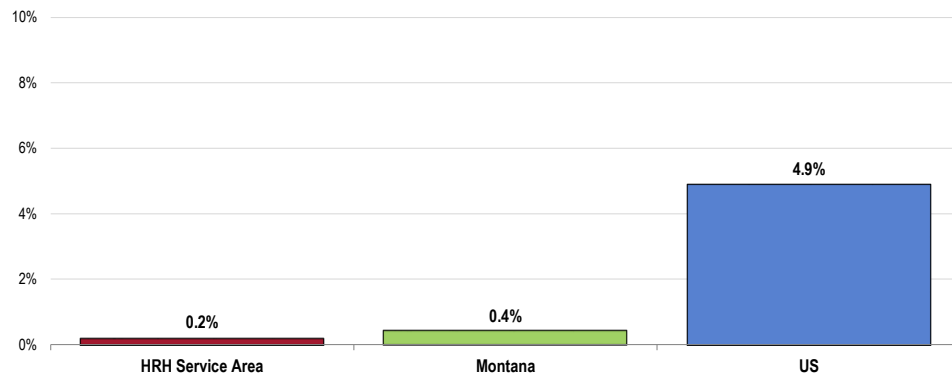
Linguistic Isolation

A low 0.2% of the HRH Service Area population age 5 and older live in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English “very well”).

- Lower than that found statewide.
- Lower than found nationally.

Linguistically Isolated Population

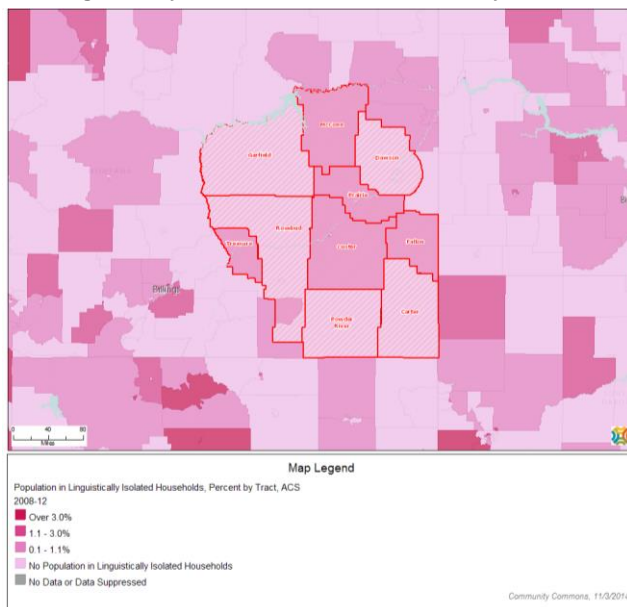
(2008-2012)



- Sources:
- U.S. Census Bureau American Community Survey 5-year estimates (2008-2012).
 - Retrieved November 2014 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator reports the percentage of the population aged 5 and older who live in a home in which no person 14 years old and over speaks only English, or in which no person 14 years old and over speaks a non-English language and speak English “very well.”

- Note the following map illustrating linguistic isolation in the service area.

Population in Linguistically Isolated Households, Percent by Tract, ACS 2008-2012



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.

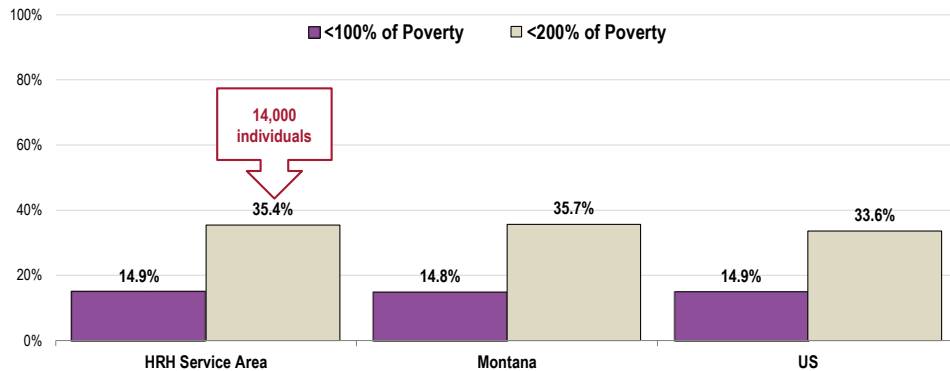
- Healthy People 2020 (www.healthypeople.gov)

Poverty

The latest census estimate shows **14.9%** of the HRH Service Area population living **below the federal poverty level**. In all, **35.4%** of service area residents (an estimated **14,000 individuals**) live **below 200% of the federal poverty level**.

- Similar to the proportion reported statewide.
- Similar to that found nationally.

Population in Poverty (2008-2012)



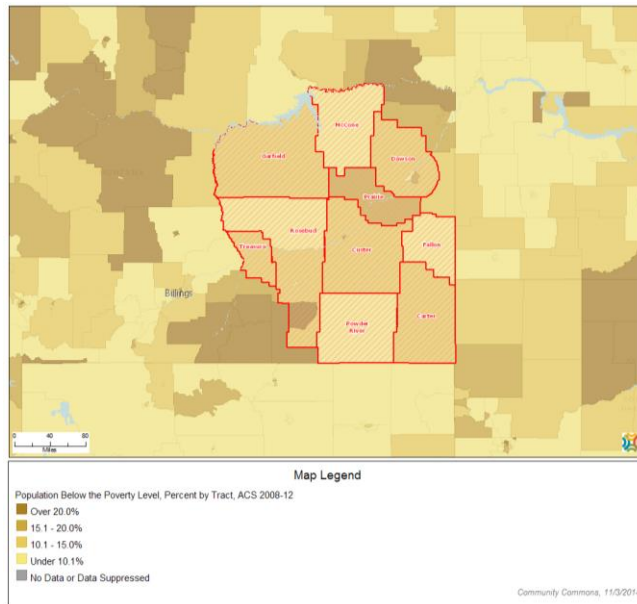
Sources: • U.S. Census Bureau American Community Survey 5-year estimates (2008-2012).

• Retrieved November 2014 from Community Commons at <http://www.chna.org>.

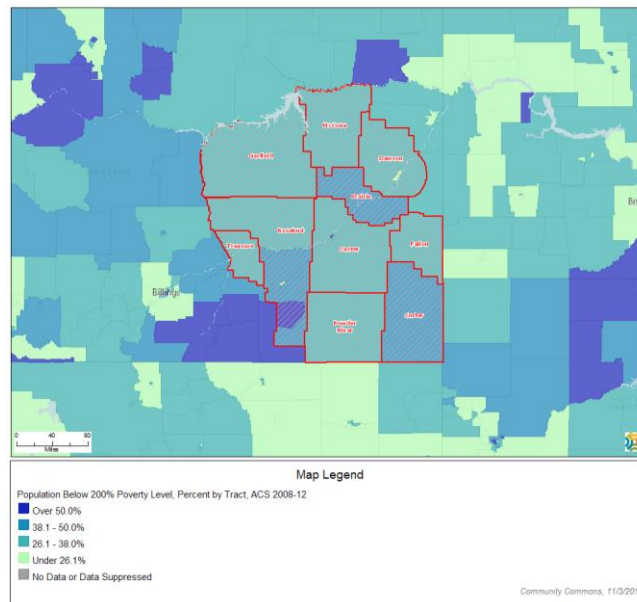
Notes: • The indicator reports the percent of individuals living in households with income below the Federal Poverty Level (FPL). Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

- Higher concentrations of poverty exist in census tracts in Prairie County and part of southern Rosebud County. A higher concentration of persons living below the 200% poverty threshold is found in Carter County, Prairie County, and part of southern Rosebud County, with part of southern Rosebud County showing the highest concentration.

Population Below the Poverty Level, Percent by Tract, ACS 2008-2012



Population Below 200% of Poverty, Percent by Tract, ACS 2008-2012

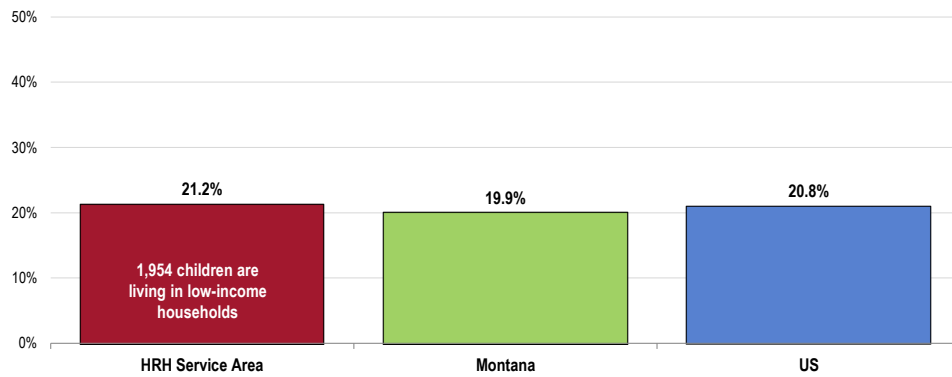


Children in Low-Income Households

Additionally, 21.2% of HRH Service Area children age 0-17 (representing an estimated 1,954 children) live below the poverty threshold.

- Slightly above the proportion found statewide.
- Close to the proportion found nationally.

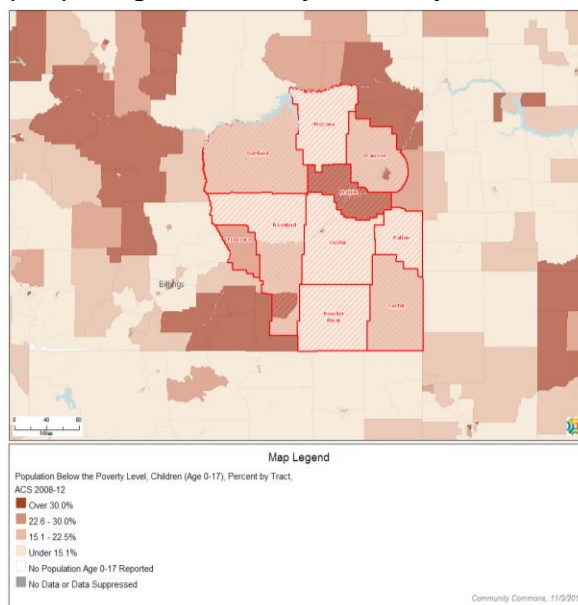
Percent of Children in Poverty
(2008-2012)



Sources: • U.S. Census Bureau American Community Survey 5-year estimates (2008-2012).
 • Retrieved November 2014 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 census tracts in Prairie and part of southern Rosebud counties.

Children (0-17) Living Below Poverty, Percent by Tract, ACS 2008-2012

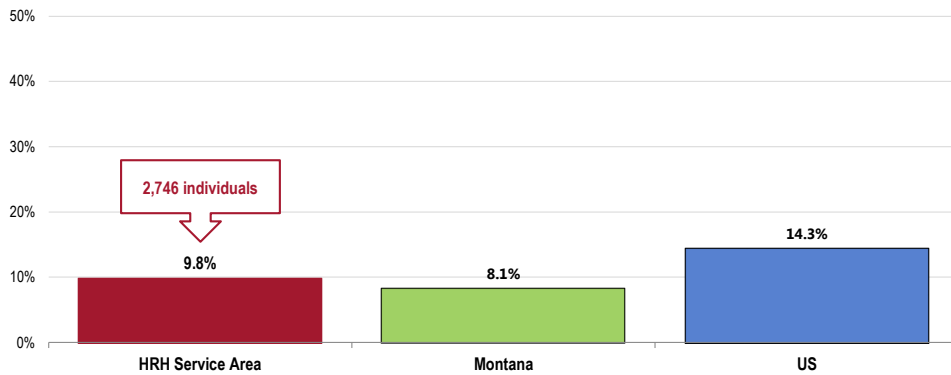


Education

Among the HRH Service Area population age 25 and older, an estimated 9.8% (over 2,746 individuals) do not have a high school diploma.

- Slightly less favorable than found statewide.
- Considerably more favorable than found nationally.

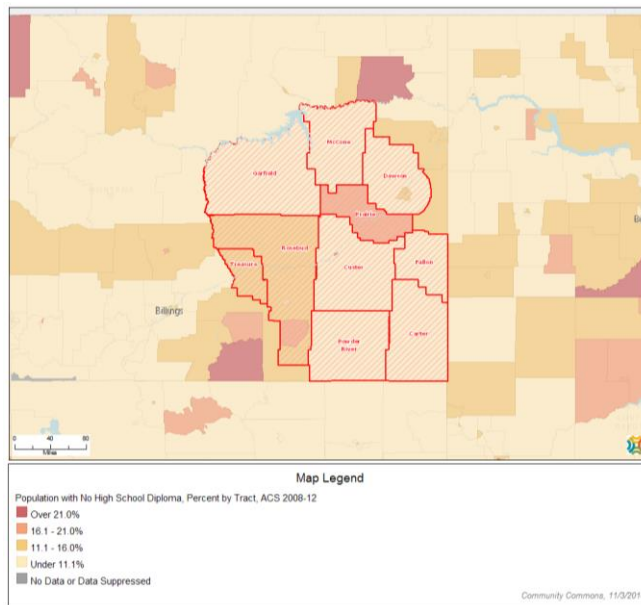
Population With No High School Diploma
(2008-2012)



Sources: • U.S. Census Bureau American Community Survey 5-year estimates (2008-2012).
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator reports the percent of individuals aged 25+ without a high school diploma (or equivalency) or higher. This indicator is relevant because educational attainment is linked to positive health outcomes.

- Geographically, this indicator is more concentrated in census tracts in Prairie and part of southern Rosebud counties.

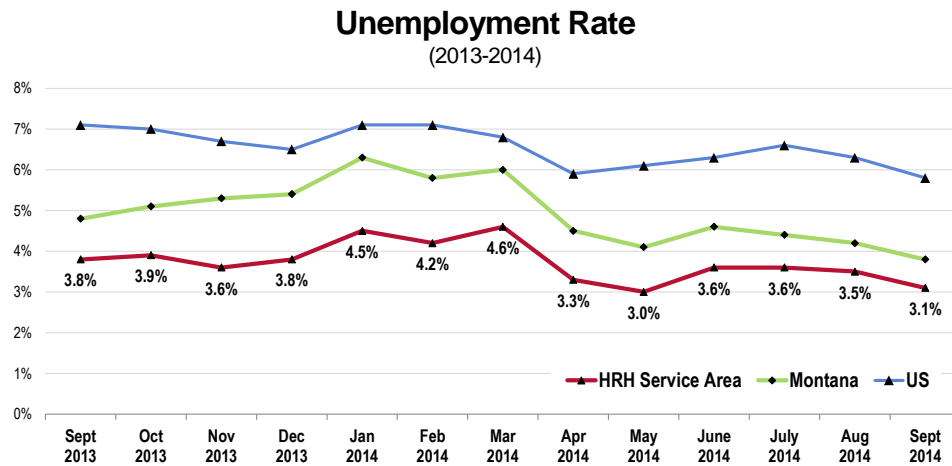
Population With No High School Diploma, Percent by Tract, ACS 2008-2012



Employment

According to data derived from the US Department of Labor, the unemployment rate in the HRH Service Area in September 2014 was 3.1%.

- More favorable than the statewide unemployment rate.
- More favorable than the national unemployment rate.
- TREND: Unemployment for the service area generally trended downward over the preceding year, echoing the state and national trends.



Sources:

- U.S. Department of Labor, Bureau of Labor Statistics.
- Retrieved November 2014 from Community Commons at <http://www.chna.org>.

Notes:

- This indicator reports monthly trends in the percent of the civilian non-institutionalized population aged 16+ who are unemployed (non-seasonally adjusted), 2013-2014. 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.

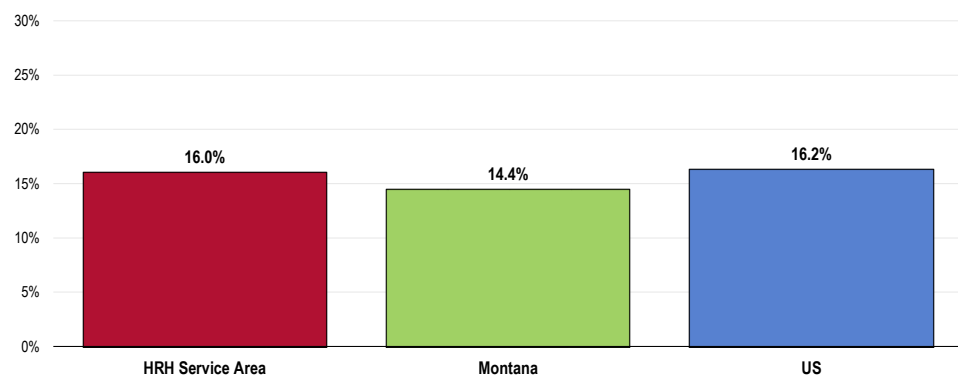
Overall Health Status

Self-Reported Health Status

A total of 16.0% of HRH Service Area adults rate their overall health as “fair” or “poor.”

- Less favorable than statewide findings.
- Similar to the national percentage.

Adults With Fair or Poor Health (2006-2012)



- Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2006-12). Accessed via the Health Indicators Warehouse.
 - Retrieved November 2014 from Community Commons at <http://www.chna.org>.
- Notes:
- Local, state and national data are simple averages
 - 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, 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

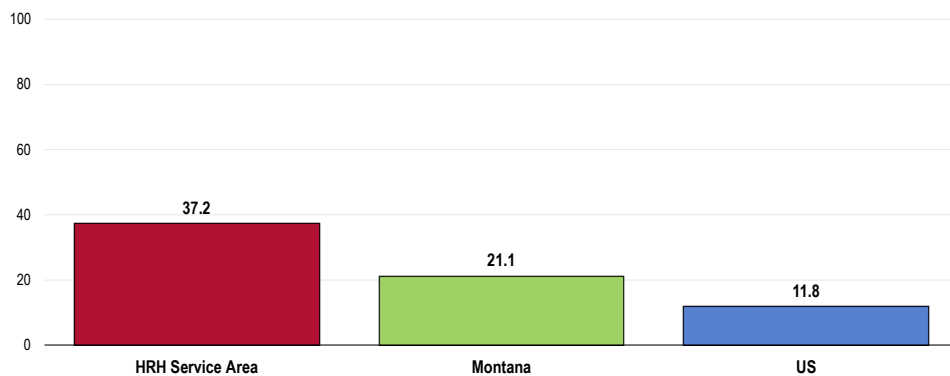
Between 2007 and 2011, there was an annual average age-adjusted suicide rate of 37.2 deaths per 100,000 population in the HRH Service Area.

- Much higher than the statewide rate.
- More than three times the national rate.
- Fails to satisfy the Healthy People 2020 target of 10.2 or lower.

Suicide: Age-Adjusted Mortality

(2007-2011)

Healthy People 2020 Target = 10.2 or Lower



Sources:

- Centers for Disease Control and Prevention, National Vital Statistics System: 2007-11. Accessed using CDC WONDER.
- Retrieved November 2014 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:

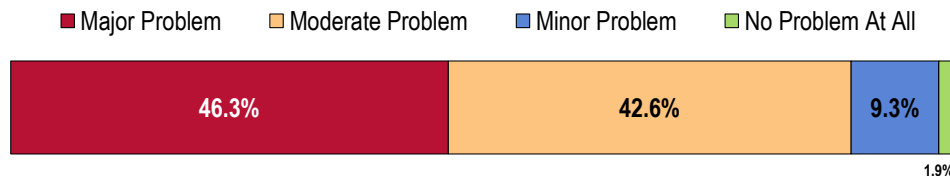
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple five-year averages.

Key Informant Input: Mental Health

The greatest share of 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, 2014)



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 frequently related to the following:

Lack of Access/Inadequate Services

Very limited physicians practicing in the area, counselors have limited access to their hospitalized patients. limited access to psychologists. Most available psychologists in Montana are not certified. - Public Health Expert

Not much mental health treatment, no long term care, no inpatient care locally. Limited outpatient care. - Community Leader

Not enough services for people with mental illness and no inpatient psych services at HRH; hasn't wanted to serve this population. - Public Health Expert

Access to services that are flexible to meet individual/family needs, insurance benefits that pay for evidenced-based services for both children and adults. Specialists to provide the services, psychiatrist, clinical psychologists, behavior-certified autism specialists; available clinical intervention and assessment services so don't have to go to Billings; crisis intervention options other than Billings and Warm Springs; early intervention for children and family members that are not just medication; ways to pay for needed medications and case management and education about the importance of taking medications as prescribed. - Public Health Expert

Lack of services. Many insurance companies will not pay for extended mental health treatment. Lack of providers. Lack of community awareness, or willingness to address the issue. No psychiatrist on staff at either clinic. - Social Services Representative

I feel that Miles City has been lacking in the care of the mentally ill in our community. I don't feel that there is enough care in the community to meet the needs and that many are left to their own devices. - Social Services Representative

Lack of access to trained, experienced and consistent providers, lack of public education about mental health issues. - Social Services Representative

Access to adequately trained behavioral health specialists. - Public Health Expert

Access to quality mental health services - Social Services Representative

Access to professional help. - Public Health Expert

Access to care and the stigma attached to mental illness. - Community Leader

Lack of affordable, reliable mental health services. Limited providers trained in evidence based practices such as Trauma Focused Cognitive Behavioral Therapy - Social Services Representative

Not enough help available to children and adults. Lack of services, very difficult to recruit mental health professionals into the community. A real lack of help available in the school system. Mental health issues are a huge concern in the educational environment and not enough support is available and it is extremely difficult to get children support, especially autism spectrum. - Community Leader

Getting quality care. - Community Leader

Stigma

There appears to be enough resources, however there continues to be a stigma associated with acknowledging and receiving mental health services in this community. - Health Provider

Considered a disgraceful condition in our community, not spoken about openly. Willing to acknowledge if person has heart disease or other medical condition. Not willing to say they struggle with depression, have thoughts of suicide. - Health Provider

Being labeled. Suicide is a large problem in the area. There are many counselors, but there is still a problem. Someone with more expertise in the area would be better able to address the challenges for those. - Social Services Representative

Lack of Education for Community Members

Education for community members regarding mental health issues. Continued access to services and medical treatment for clients. Advocacy for mental health clients. - Social Services Representative

"Cowboy Up" Mentality

A tendency to "Cowboy Up" when depression and anxiety are present. Good private mental health providers. Mental Health Center in the process of reorganization. - Health Provider

Reliance on Law Enforcement

Our biggest problem with the mental health is when we have people that are having an episode. If they have taken drugs or alcohol, the mental health worker will not respond. Yet when does an episode happen? Mostly when the person has been drinking and using drugs. Law enforcement must somehow keep this person safe and other people safe, yet he/she cannot be brought in our facility. We are not mental health workers...Nor do we pretend that we know what is going on. We can take them to Holy Rosary Hospital where they are refused because they do not have the mental health safe room anymore and they have been drinking and using drugs. Why is it up to law enforcement to cope with mental health problems when even the health and mental workers will not accept them? - Social Services Representative

People in Need Moving to the Area

We have many people moving into the area and many who have significant mental health needs - Social Services Representative

Death, Disease & Chronic Conditions



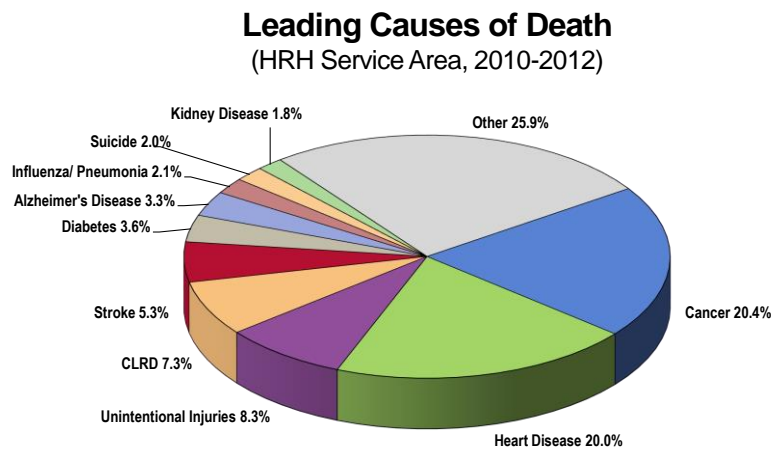
Professional Research Consultants, Inc.

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and *heart disease* are the leading causes of death in the HRH Service Area, accounting for approximately 40% of all deaths between 2010 and 2012.

These, in addition to *unintentional injury*, *chronic lower respiratory disease (CLRD)* and *stroke*, make up the top five leading causes of death.



- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted November 2014.
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - CLRD is chronic lower respiratory disease.

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).

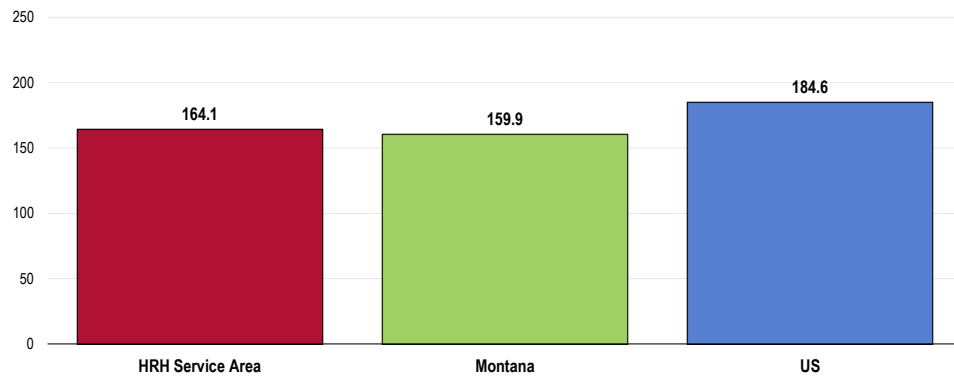
Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

Heart Disease Deaths

Between 2007 and 2011 there was an annual average age-adjusted heart disease mortality rate of 164.1 deaths per 100,000 population in the HRH Service Area.

- Similar to the statewide rate.
- More favorable than the national rate.

Heart Disease: Age-Adjusted Mortality (2007-2011)



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System (2007-11). Accessed using CDC WONDER.
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 Notes: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple averages

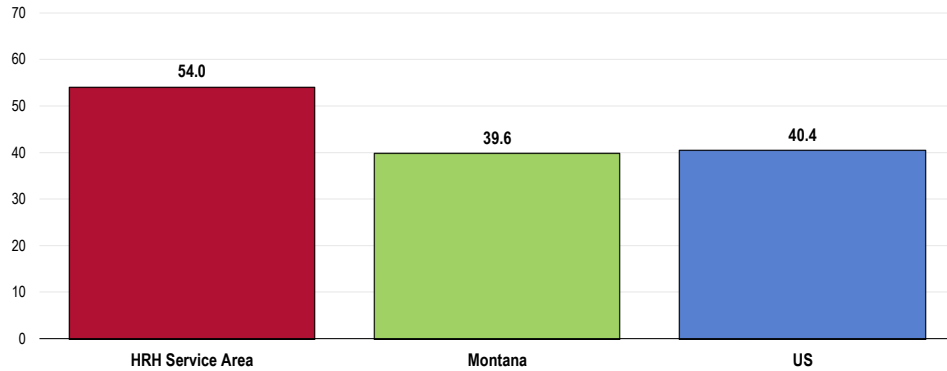
Stroke Deaths

Between 2007 and 2011, there was an annual average age-adjusted stroke mortality rate of 54.0 deaths per 100,000 population in the HRH Service Area.

- Much less favorable than the Montana rate.
- Much less favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target of 34.8 or lower.

Stroke: Age-Adjusted Mortality (2007-2011)

Healthy People 2020 Target = 34.8 or Lower



Sources:

- Centers for Disease Control and Prevention, National Vital Statistics System (2007-11). Accessed using CDC WONDER.
- Retrieved November 2014 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]

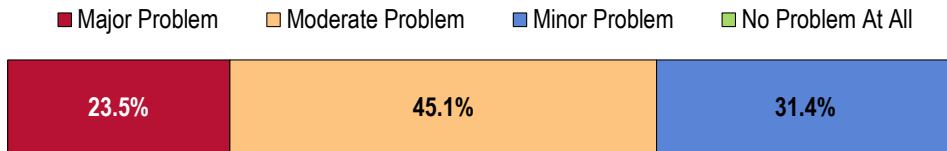
 Notes:

- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple averages

Key Informant Input: Heart Disease & Stroke

The greatest share of 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, 2014)



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 frequently related to the following:

Lack of Specialists

Lack of specialists within the community. - Social Services Representative

We do not have a permanent non-invasive or invasive cardiologist. We do not have cardiology oversight of the Stress lab at HRH. We do not have an ultrasound tech certified to do cardiac echo. We do not have a cath lab or angiography. Many acute patients presenting to the Emergency room will need to be shipped out of the community for management - Public Health Expert

Once again the limited access to cardiologists is a very big challenge for those in eastern Montana. - Health Provider

Poor Nutrition

Poor nutrition, lack of exercise, years of smoking. - Social Services Representative

Poor eating rituals, prevalence of low income, low educational level. Poor health choices. Passive approach to personal health. - Health Provider

Agricultural lifestyles often require late meals in busy seasons and the majority of jobs in town require sitting most of the day. There is also a great deal of stress evidenced in our community. - Community Leader

Elderly Population

Due to elderly population. - Health Provider

High Prevalence

We on a daily basis hear the ambulance being called for someone coming in with a heart attack or a stroke - Social Services Representative

Lack of Routine Check-Ups

Many individuals do not have a regular doctor and therefore do not go in for periodic checkups that may help prevent heart disease and stroke. The lack of a Medical Home for some patients is a problem. - Social Services Representative

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

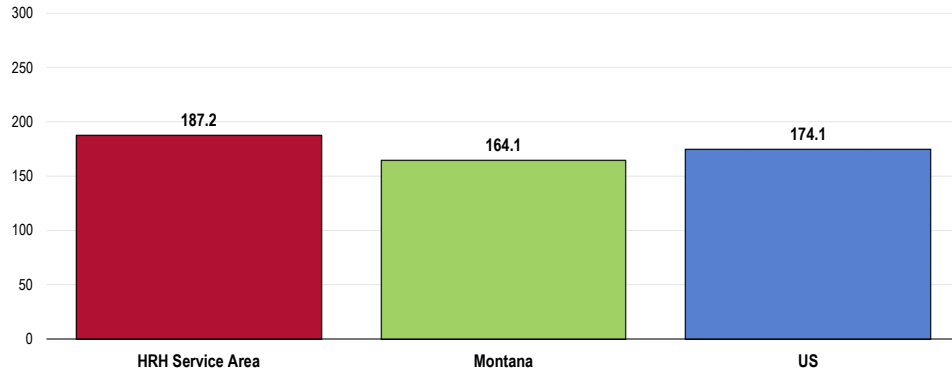
All Cancer Deaths

Between 2007 and 2011, there was an annual average age-adjusted cancer mortality rate of 187.2 deaths per 100,000 population in the HRH Service Area.

- Less favorable than the statewide rate.
- Less favorable than the national rate.
- Fails to satisfy the Healthy People 2020 target of 161.4 or lower.

Cancer: Age-Adjusted Mortality (2007-2011)

Healthy People 2020 Target = 161.4 or Lower



Sources:

- Centers for Disease Control and Prevention, National Vital Statistics System (2007-11). Accessed using CDC WONDER.
- Retrieved November 2014 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:

- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
- Local, state and national data are simple averages

Cancer Incidence

Incidence rates reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. Here, 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.

Between 2006 and 2010, the HRH Service Area had an annual average age-adjusted incidence rate of prostate cancer of 166.0 cases per 100,000 population.

- Well above the statewide incidence rate.
- Well above the national incidence rate.

There was an annual average age-adjusted incidence rate of 132.4 female breast cancer cases per 100,000 in the service area.

- Above the statewide incidence rate.
- Above the national incidence rate.

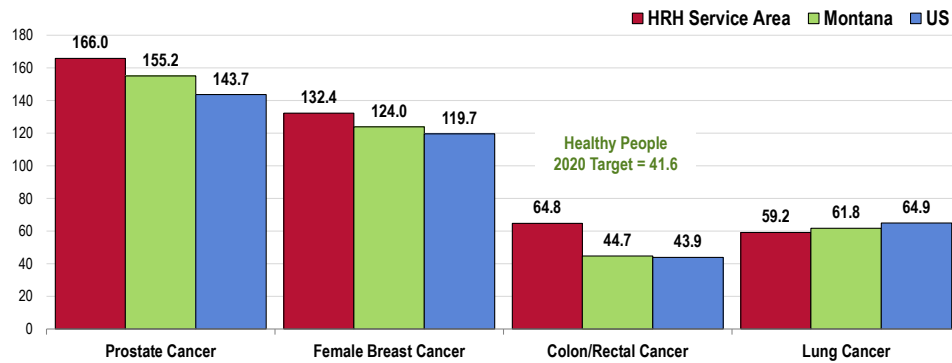
There was an annual average age-adjusted incidence rate of 64.8 colorectal cancer of 64.8 cases per 100,000 in the service area.

- Above the statewide incidence rate.
- Above the national incidence rate.
- Fails to satisfy the Healthy People 2020 target of 41.6 or lower.

There was an annual average age-adjusted incidence rate of 59.2 lung cancer cases per 100,000 in the service area.

- Close to the statewide incidence rate.
- Better than the national incidence rate.

Cancer Age-Adjusted Incidence Rates by Site (2006-2010)



- Sources:
- State Cancer Profiles (2006-10).
 - Retrieved November 2014 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 C-9]
- Notes:
- Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 - This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 U.S. 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, 62.3% had a mammogram within the past two years.

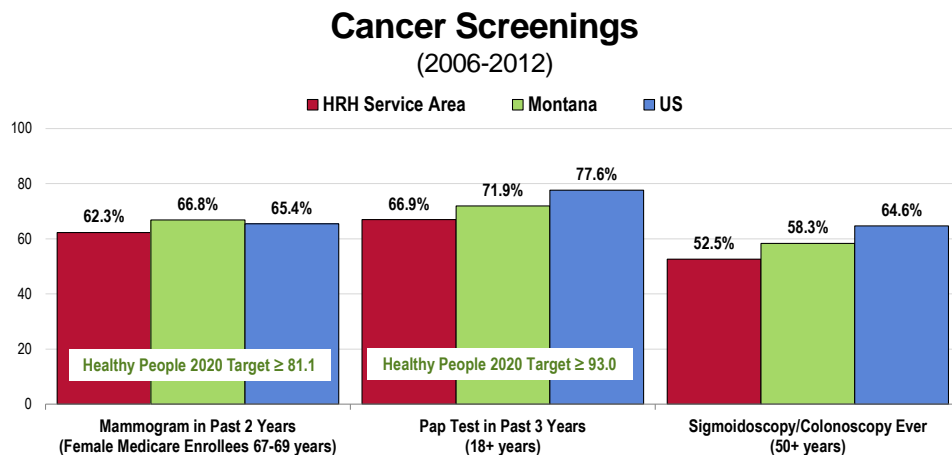
- Lower than statewide findings (which represent all women 67-69).
- Close to national findings.
- Fails to satisfy the Healthy People 2020 target (81.1% or higher).

Among all service area women age 18+, 66.9% had a Pap test within the past three years.

- Lower than Montana findings (which represents all women 18+).
- Lower than national findings.
- Fails to satisfy the Healthy People 2020 target (93% or higher).

Among all service area adults age 50+, 52.5% have ever had sigmoidoscopy/colonoscopy (lower endoscopy).

- Lower than statewide findings
- Lower than national findings.



Sources:

- Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care (2010).
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2006-12). Accessed via the Health Indicators Warehouse.
- Retrieved November 2014 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 C-15,16,17]

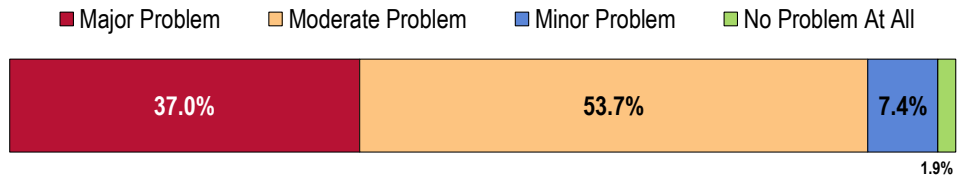
Notes:

- This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Key Informant Input: Cancer

Most key informants taking part in an online survey characterized **Cancer** as a “moderate problem” in the community.

Perceptions of Cancer as a Problem in the Community (Key Informants, 2014)



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 frequently related to the following:

High Incidence

I know several that are experiencing Cancer at this time. - Social Services Representative

The number of people diagnosed seems high. - Community Leader

There seems to be an exceptionally high number of residents who are diagnosed with cancer. Treatment often requires travel and lodging while away from home for long periods of time. - Community Leader

The number of cases I have witnessed and the difficulty in getting to treatment centers. - Public Health Expert

Cancer is everywhere. I understand that HRH has a wonderful program that offers chemo and other treatments so folks do not have to travel. But it seems that cancer has touched everyone in the community. And it is very expensive. - Social Services Representative

Isn't it a problem in every community. The frequency that it occurs in the community is frightening. - Social Services Representative

We read in the paper every day of fundraisers for cancer patients and this is only one avenue to learn of them. Relay for life participation also is an indication. - Health Provider

I believe that there is very few families that do not have one or more members dealing with cancer in one form or another. It may be due to us living longer and with more environmental pollutants. - Health Provider

Lack of Local Services

Many people are diagnosed yet access to some services means a 150 mile trip one way for treatment. Services available locally are very costly. - Social Services Representative

For patients diagnosed with cancer many have to travel to Billings for treatment. In the case of radiation therapy they are required to stay in Billings for several weeks. - Social Services Representative

We do not have a radiation treatment facility within 100 miles of here. - Public Health Expert

Majority of the time have to travel great distances to receive appropriate treatment. - Social Services Representative

More of a lack of local care for the cancer - Community Leader

Cancer treatments are somewhat limited. Oncologist must come from Billings, 145 miles away, and radiation therapy is not available in the community. An individual must go to Billings for radiation. - Social Services Representative

I realize there is access for chemotherapy here in Miles City but not radiation which causes a great hardship for those who must receive radiation therapy. I also feel that it is difficult for those in eastern Montana with the limited time that oncologists are here for appointments and otherwise must travel to Billings. - Health Provider

The nurses are subpar in the oncology clinic - Health Provider

Late-Stage Diagnoses

Many people are being newly diagnosed with cancer when it is further along. Stage 3 or 4 - Social Services Representative

Nutrition, Physical Activity & Weight

I think cancer is related to obesity, lack of exercise and poor nutritional choices. A lot of people are not educated on nutrition or have access to fresh produce. - Community Leader

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)

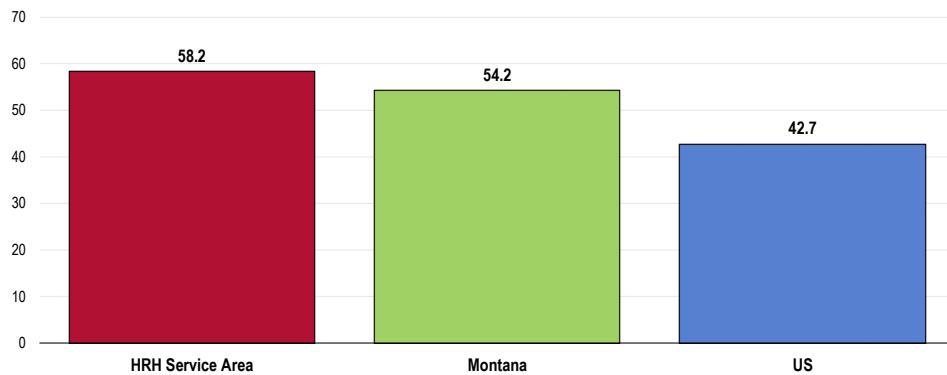
[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Age-Adjusted Lung Disease Deaths

Between 2007 and 2011, there was an annual average age-adjusted lung disease mortality rate of 58.2 deaths per 100,000 population in the HRH Service Area.

- Higher than found statewide.
- Much higher than the national rate.

Lung Disease: Age-Adjusted Mortality (2007-2011)

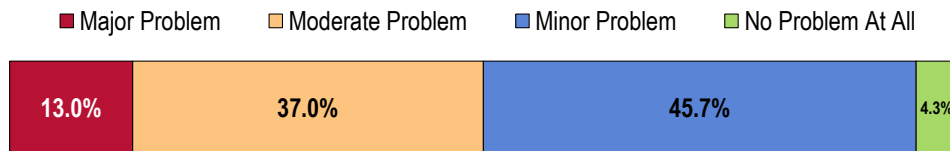


Sources: • Centers for Disease Control and Prevention, National Vital Statistics System (2007-11). Accessed using CDC WONDER.
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 Notes: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple averages

Key Informant Input: Respiratory Disease

The greatest share of key informants taking part in an online survey characterized *Respiratory Disease* as a “minor problem” in the community.

Perceptions of Respiratory Diseases as a Problem in the Community (Key Informants, 2014)



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 frequently related to the following:

Tobacco Use

Smoking - Public Health Expert

This is pretty evident from the amount of people that are using oxygen in the community. I have several friends that are quite ill with respiratory problems because of cigarette usage. - Social Services Representative

Tobacco use. - Health Provider

Today's elders often have a lifetime of smoking that has damaged their lungs. - Social Services Representative

Lack of Specialists

We do not have a pulmonologist or allergists in the area - Public Health Expert

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:

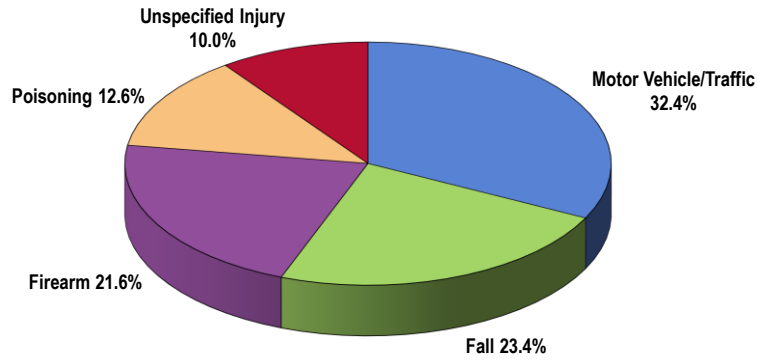
- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

- Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Motor vehicle accidents and falls accounted for more than one-half of accidental deaths in the HRH Service Area 2010-2012. Firearms and poisoning (including accidental drug overdoses) were also leading causes.

Leading Causes of Accidental Death (HRH Service Area, 2010-2012)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted November 2014.
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Unintentional Injury

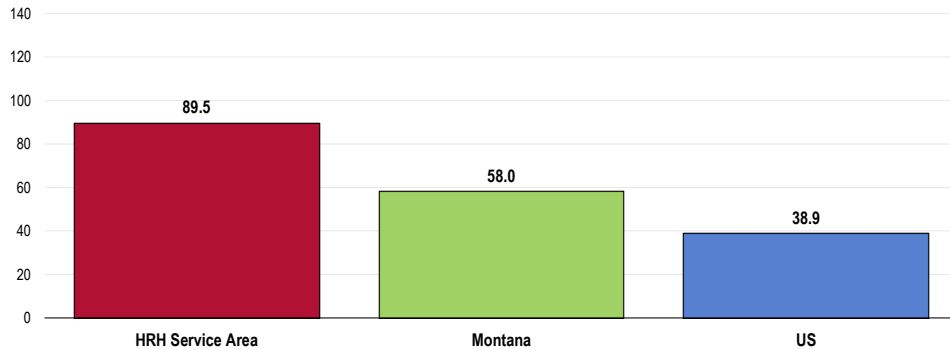
Age-Adjusted Unintentional Injury Deaths

Between 2007 and 2011, there was an annual average age-adjusted unintentional injury mortality rate of 89.5 deaths per 100,000 population in the HRH Service Area.

- Much less favorable than the Montana rate.
- More than twice the national rate.
- More than twice the Healthy People 2020 target of 36.4 or lower.

Unintentional Injuries: Age-Adjusted Mortality (2007-2011)

Healthy People 2020 Target = 36.4 or Lower



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System (2007-11). Accessed using CDC WONDER.
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>. Data extracted November 2014.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
 Notes: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.
 • Local, state and national data are simple averages
 • This indicator is relevant because accidents are a leading cause of death in the U.S.

Age-Adjusted Motor-Vehicle Related Deaths

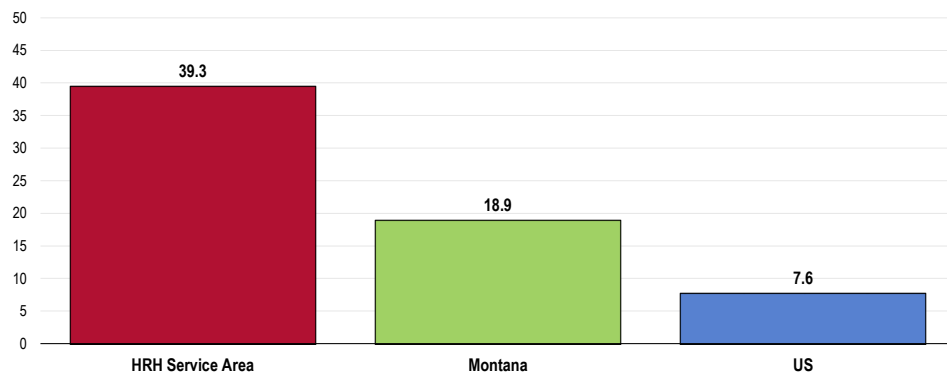
Between 2007 and 2011, there was an annual average age-adjusted motor vehicle crash mortality rate of 39.3 deaths per 100,000 population in the HRH Service Area.

- Over twice that found statewide.
- Over five times the rate found nationally.
- Fails to satisfy the Healthy People 2020 target of 12.4 or lower.

Motor Vehicle Crashes: Age-Adjusted Mortality

(2007-2011)

Healthy People 2020 Target = 12.4 or Lower



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System (2007-11). Accessed using CDC WONDER.

• Retrieved November 2014 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-13.1]

Notes: • Rates are per 100,000 population, age-adjusted to the 2000 U.S. Standard Population.

• Local, state and national data are simple averages

• This indicator reports the rate of death due to motor vehicle crashes per 100,000 population, which include collisions with another motor vehicle, a non-motorist, a fixed object, and a non-fixed object, an overturn, and any other non-collision. This indicator is relevant because motor vehicle crash deaths are preventable, and they are a cause of premature death.

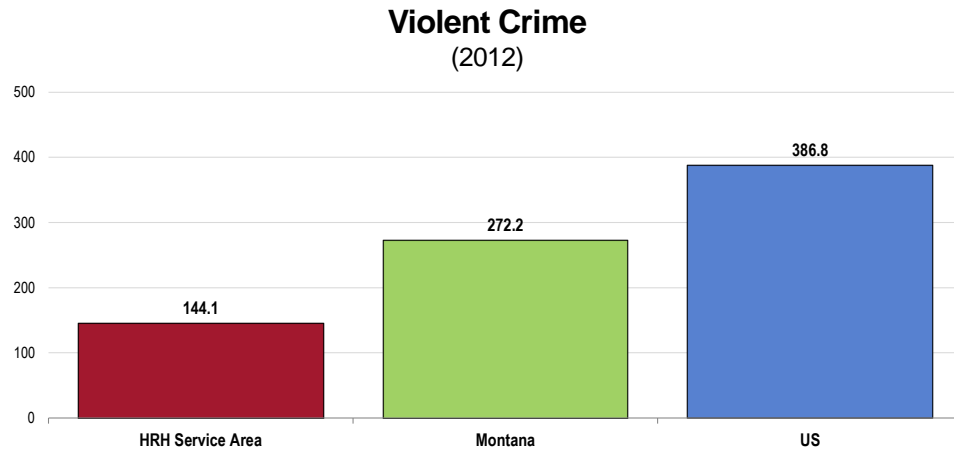
Violent Crime

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.

In 2012, there were a reported 144.1 violent crimes per 100,000 population in the HRH Service Area.

- Well below the Montana rate for the same period.
- Even further below the national rate.

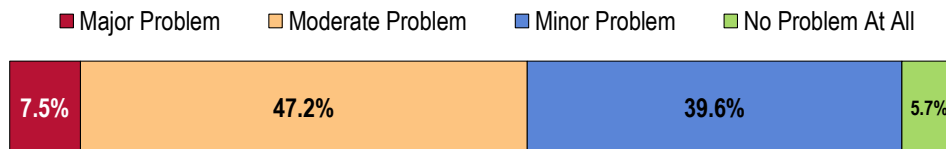


Sources: • Federal Bureau of Investigation, FBI Uniform Crime Reports (2012).
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. 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 largest share of key informants taking part in an online survey characterized *Injury & Violence* as a “moderate problem” in the community.

Perceptions of Injury and Violence as a Problem in the Community (Key Informants, 2014)



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 frequently related to the following:

Prevalence of Violence

See a lot of clients who have been victims or were the perpetrator - Social Services Representative
Domestic violence is on the upswing in part due to the nature of the labor force. - Health Provider

Lack of Providers

No active participation by the health care community in dealing with children who are victims of sexual assault. There needs to be providers trained, willing and able to conduct forensic exams of children additionally willing to participate in a child advocacy center team. - Social Services Representative

Social Determinants

Poverty and lack of affordable transportation lead to stress and depression, which can lead to injury and/or violence. - Social Services Representative

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.

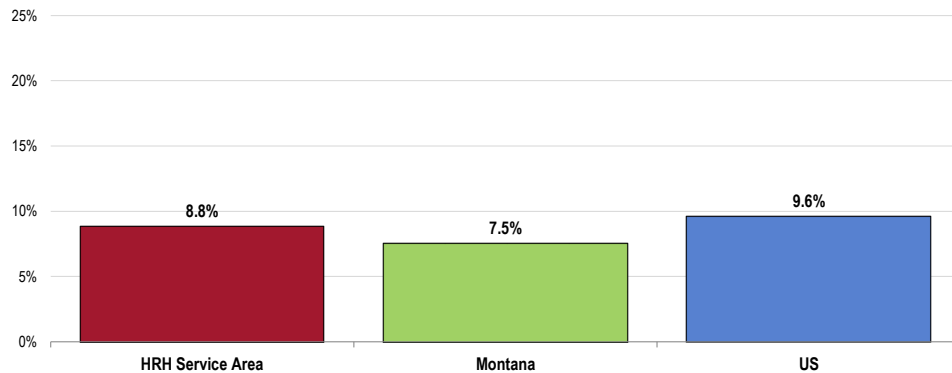
- Healthy People 2020 (www.healthypeople.gov)

Prevalence of Diabetes

A total of 8.8% of HRH Service Area adults have been diagnosed with diabetes.

- Greater than the statewide prevalence.
- Less than the national prevalence.

Adult Diabetes Prevalence (2010)



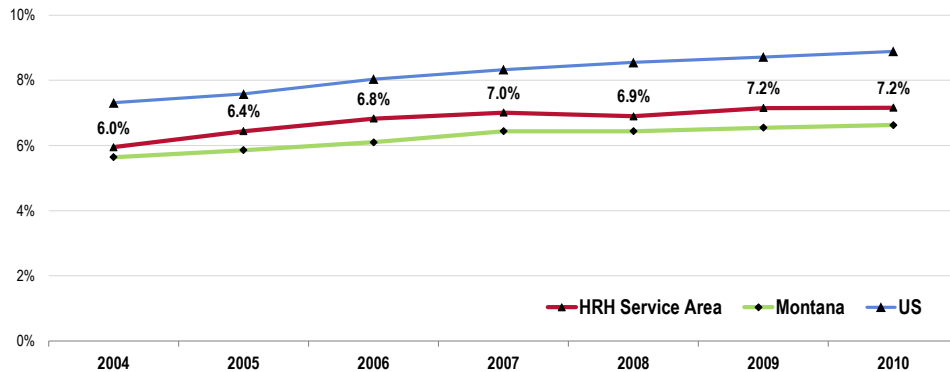
Sources: • Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas (2010).
• Retrieved November 2014 from Community Commons at <http://www.chna.org>.

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 U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

The graph below depicts the percent of adults diagnosed with diabetes between 2004 and 2010 in the HRH Service Area as compared against Montana and the nation. *Note that these rates are age-adjusted (unlike those presented in the previous chart).*

- From these data, an increase in diabetes prevalence is apparent locally, statewide and nationally.

Adults with Diagnosed Diabetes by Year, Age-Adjusted
(2004-2010)

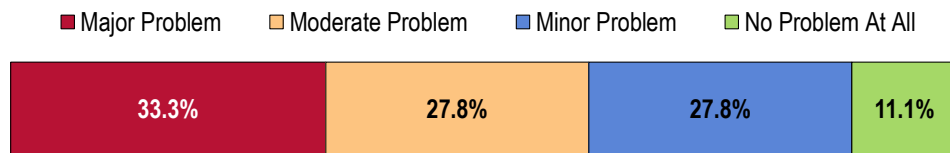


Sources: • Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas (2010).
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Key Informant Input: Diabetes

A plurality of key informants taking part in an online survey characterized *Diabetes* as a “major problem” in the community.

Perceptions of Diabetes as a Problem in the Community
(Key Informants, 2014)



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 frequently related to the following:

Lack of Education

Lack of education about nutrition and exercise. Would be nice if we had bike paths all around town or to the adjoining towns. - Community Leader

Access to nutrition counseling and support groups. - Public Health Expert

The knowledge of a proper diet to prevent diabetes and the lack of resources for that proper diet. - Health Provider

Education pertaining to diet which I think is probably the most important part of diabetes that can be somewhat controlled. - Health Provider

Education, follow up with long term health conditions caused by diabetes - Social Services Representative

Education about long term effects; access to knowledgeable primary and secondary providers who understand & have experience with diabetes and can provide consistent care intervention over time. More home-based services and funding options. - Public Health Expert

Access to Primary Care & Medications

Access to primary care. It takes a while to become comfortable with a physician and it seems they only last at GMC for one or two years. - Social Services Representative

Lack of consistency by medical providers. Turnover with primary care providers. - Health Provider

Affording the new medications that are on the market for diabetes. Being accountable for their disease. - Public Health Expert

High Prevalence

Like any other community we have an excess of diabetes. I work with several and I have several relatives that are affected by this disease. - Social Services Representative

There is a large number of people with diabetes in the area. I believe the health care, for those who take advice, is good. - Social Services Representative

Lack of Specialists & Services

Lack of specialists within the community - Social Services Representative

No dialysis centers - Health Provider

Lack of Support

There aren't any support groups. To participate in lifestyle classes, there is a fee. - Health Provider

Prevention and assistance after diagnosis. - Community Leader

Weight Issues

We have many obese people in our community. With that, often times you see diabetes and people not taking care of themselves. - Social Services Representative

Weight gain or weight loss. - Public Health Expert

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.

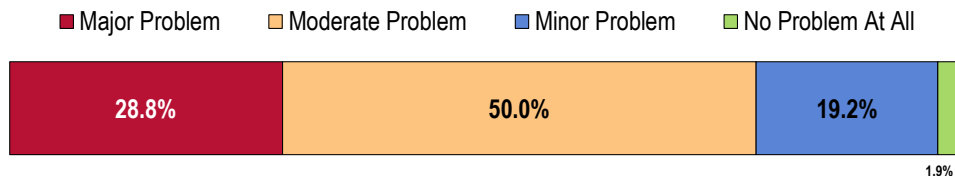
- Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Dementias, Including Alzheimer's Disease

Key informants taking part in an online survey are most likely to consider *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, 2014)



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 frequently related to the following:

Aging Population

Older population base and not much treatment available here only nursing homes that are shoddy - Community Leader

aging community. - Public Health Expert

Due to rapidly aging cohort. Fragmented services for this group. Too many changes in providers. - Health Provider

Lots of elderly people. - Social Services Representative

County population is aged and there are no facilities to deal with this. The only facility is the nursing home. It would be nice to have an assisted living unit as a step before full time nursing home care. -

Public Health Expert

We have an older and aging population - Social Services Representative

High Prevalence

We deal with dementia and Alzheimer's through the Sheriff's Office a lot. - Social Services Representative

Affects many community members; is occurring at younger and younger ages. Knowledge regarding preventative healthcare is essential. Development of necessary resources including respite for major caregivers is important. - Public Health Expert

Caregiving

Many spouses or family members provide care for patients at home and that can be a huge strain on the care giver. Placement in a Nursing Home can be cost prohibitive to individuals that do not have long term care insurance or Medicaid to cover the cost. - Social Services Representative

I do not feel that there is much in the way of treatment or support for those who are suffering from dementia/Alzheimer's or for their family members/caregivers. Many times these individuals must go to another community to be seen by a doctor or to reside in a residential home that specializes in dementia/Alzheimer's. - Health Provider

Lack of Services

Limited resources to families in dealing with this disease. - Social Services Representative

No real services available - Health Provider

When I see a patient that may be exhibiting dementia, I usually call their provider to discuss what they are seeing. After that, I don't know what steps to take to get that person help they need. It scares me to know that that person is driving around our community. I worry about their day to day activities and the conditions of their home. - Health Provider

Lack of Education

Lack of education for community members. - Health Provider

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.

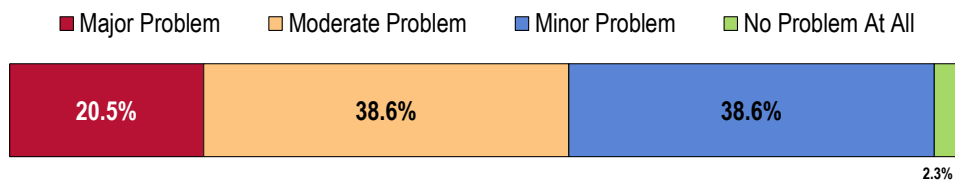
- Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Chronic Kidney Disease

Key informants taking part in an online survey generally characterized *Chronic Kidney Disease* as either a “moderate problem” or a “minor problem” in the community.

Perceptions of Chronic Kidney Disease as a Problem in the Community

(Key Informants, 2014)



- 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 frequently related to the following:

Lack of Dialysis Services

Lack of a Dialysis Unit is a major problem for eastern MT residents. They must travel or move to Billings or Dickinson, ND, for care. - Community Leader

Dialysis is not available - Health Provider

No dialysis options available. However I am not sure that there should be. It's just not available. It's one of the risks we take living in a small community - Health Provider

Specialty Care

We do not have a nephrologist and do not have dialysis - Public Health Expert

I know several people that have to see specialists - Community Leader

Education for Providers

Providers do not respond to abnormal lab values in this area when obtained from health fair labs and other screenings. Need improved education for providers now that we have no internal medicine specialists in the community. Holy Rosary chose not to offer. - Public Health Expert

Co-Morbidities

Co morbid conditions. - Public Health Expert

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.

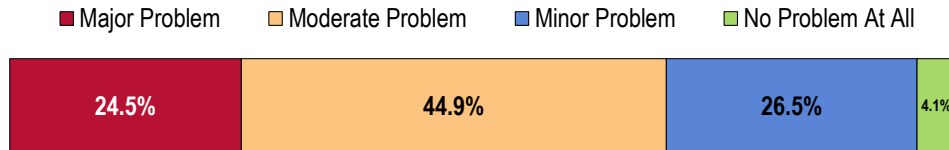
- Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

The greatest share of key informants taking part in an online survey 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, 2014)



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 frequently related to the following:

Aging Population

Aging population within the community - Social Services Representative

We have a lot of elderly people that are being crippled by this disease. Many ambulance calls are for people that are having pain in their hips and knees etc. You can also note when going to functions with older people the crippling effects of the disease. - Social Services Representative

On the average, most people in this community are elderly. - Community Leader

Population of our county is aged and this is a common affliction. - Public Health Expert

We are an aging community with an agricultural background. Heavy usage throughout one's lifetime contribute to arthritis, osteoporosis and back conditions. - Community Leader

We have an elderly population. There is not local Miles City access to physicians that specialize in these conditions so I feel that many go without the care they need because they don't have the funds or availability to travel to Billings for their care. - Social Services Representative

Occupational Health

I see a lot of patients who have been hard on themselves and working hard labor jobs for years and now have severe arthritis issues. Things like water aerobics and water therapy are very important to these patients, but we do not have availability to them. - Public Health Expert

In my profession as a Chiropractor, spinal issues are at the forefront of the patients we see each day. We are in a rural setting and the manual labor force is so large, we tend to see many patient dealing with injuries due to their professions. - Health Provider

People in our rural community abused their backs when younger. Arthritis is high in part because of low exercise levels. - Social Services Representative

High Prevalence

I see and talk to many people who have mentioned this as a problem and it seems that we have 4 or 5 chiropractors that must be busy. - Health Provider

I have talked to a lot of people that have arthritis and back pain. You can tell somewhat by the way they walk. Chiropractors are busy. - Public Health Expert

Falls

Winter weather causes slippage outdoors. Many people who fall break their pelvis and never recover. I also know many older residents who have degenerative bone loss/disease in their spines. - Community Leader

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)

Hearing Trouble

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.

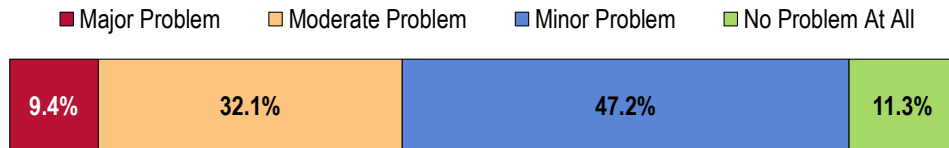
- Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Vision & Hearing

Nearly one-half of key informants taking part in an online survey characterized *Vision & Hearing* as a “minor problem” in the community.

Perceptions of Hearing and Vision as a Problem in the Community

(Key Informants, 2014)



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 frequently related to the following:

Lack of Services

We have no services for these health concerns in our community, and most offices that service these needs in surrounding communities are not in most health insurance networks. - Public Health Expert

Cost of Hearing Aids

Hearing is a problem because of the cost of hearing aids. - Health Provider

Occupational Health

A lot of farmers ruined their hearing years ago. - Social Services Representative

Infectious Disease



Professional Research Consultants, Inc.

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

- Healthy People 2020 (www.healthypeople.gov)

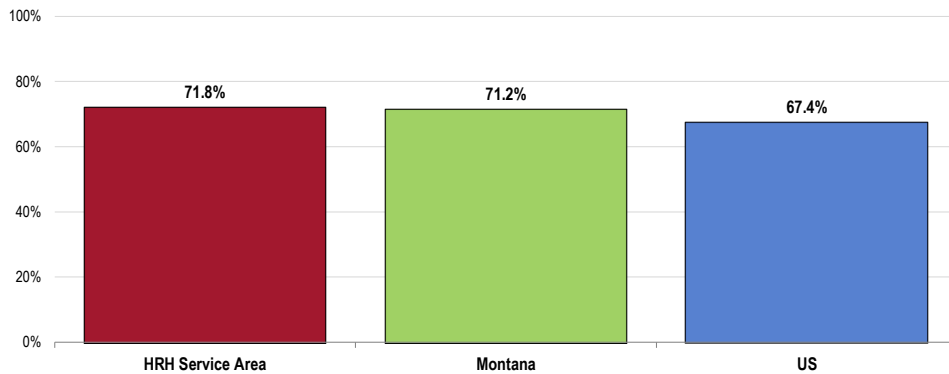
Pneumonia Vaccination

Among adults age 65 and older, 71.8% have received a pneumonia vaccination at some point in their lives.

- Comparable to the Montana finding.
- Better than the national finding.
- Fails to satisfy the Healthy People 2020 target of 90% or higher.

Adults 65 and Older With Pneumonia Vaccination, Percent (2006-2012)

Healthy People 2020 Target = 90.0 or Higher



- Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2006-12). Accessed via the Health Indicators Warehouse.
 - Retrieved November 2014 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 IID-13.1].

- Notes:
- This indicator reports the percentage of adults aged 65 and older who self-report that they have ever received a pneumonia vaccine. This indicator is relevant because engaging in preventive behaviors decreases the likelihood of developing future health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

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.

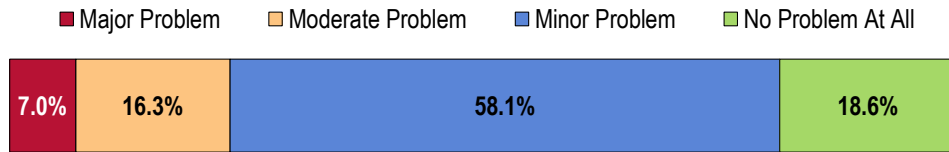
There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

- Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: HIV/AIDS

A majority of key informants taking part in an online survey characterized *HIV/AIDS* as a “minor problem” in the community.

Perceptions of HIV/AIDS as a Problem in the Community (Key Informants, 2014)



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 frequently related to the following:

Lack of Education

There is a low prevalence of HIV/AIDS in Montana and in particular, this community. There is limited education programs and limited regular screening. There is not an infectious disease program here - Public Health Expert

Increasing Nationally

This disease is increasing nationally and this community is way behind the times in marketing, educating and testing. - Health Provider

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

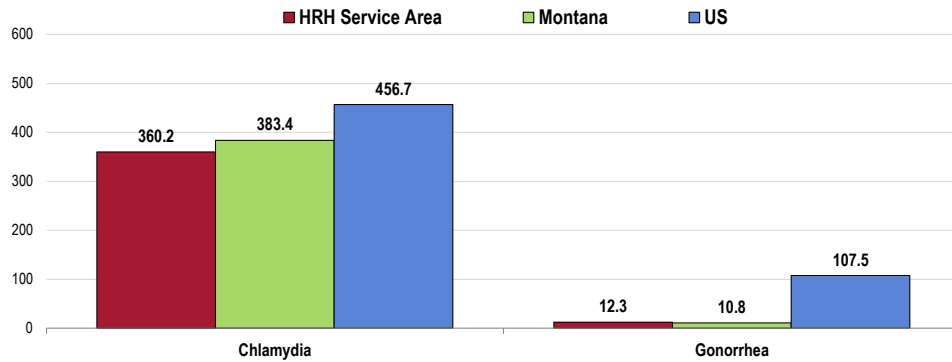
In 2012, the chlamydia incidence rate in the HRH Service Area was 360.2 cases per 100,000 population.

- Lower than the Montana incidence rate.
- Notably lower than the national incidence rate.

The gonorrhea incidence rate in the service area was 12.3 cases per 100,000 population in 2012.

- Just above the statewide incidence rate.
- Notably lower than the national incidence rate.

Chlamydia & Gonorrhea Incidence (2012)



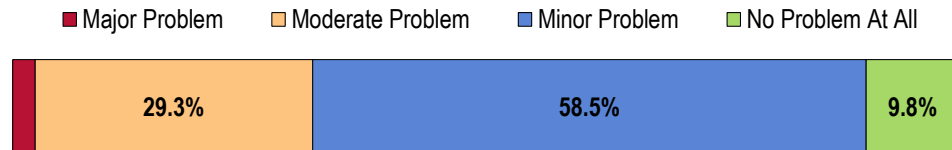
Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (2012).
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator reports incidence rate of chlamydia cases per 100,000 population. This 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

Most key informants taking part in an online survey characterized *Sexually Transmitted Diseases* as a “minor problem” in the community.

Perceptions of Sexually Transmitted Diseases as a Problem in the Community

(Key Informants, 2014)



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

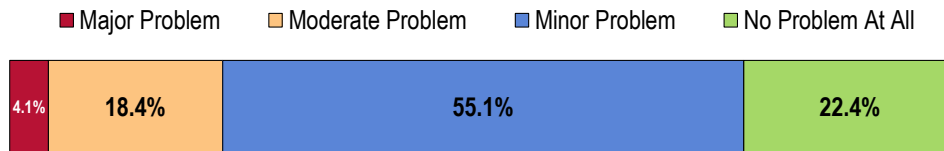
Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

A majority of 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, 2014)



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 frequently related to the following:

Lack of Services

No infectious disease program in eastern Montana - Public Health Expert

With Ebola and other infectious diseases now becoming an issue, we are a small community and do not have this type of service available to us. - Health Provider

Births



Professional Research Consultants, Inc.

Prenatal Care

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)

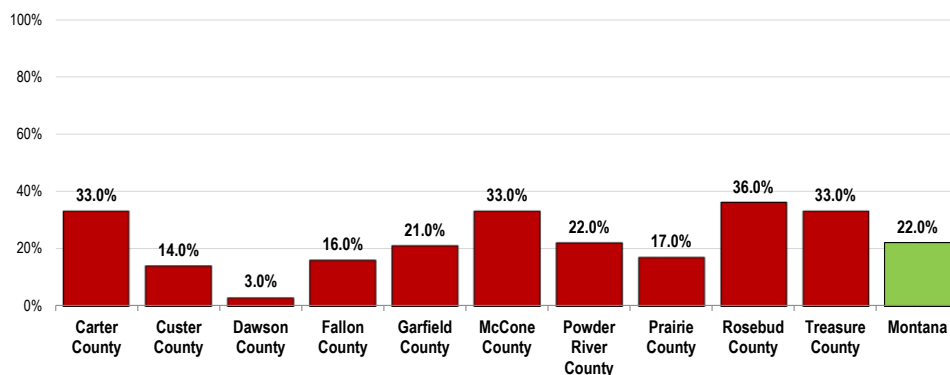
Early and continuous prenatal care is the best assurance of infant health.

Lack of prenatal care in the HRH Service Area varied quite widely, ranging from 3% in Dawson County to over 30% in Carter, McCone, Rosebud, and Treasure counties.

- In five counties, less favorable or equal to the Montana proportion.
- In four counties, fails to satisfy the Healthy People 2020 target (22.1% or lower).

Lack of Prenatal Care in the First Trimester (2009)

Healthy People 2020 Target = 22.1% or Lower



- Sources:
- KIDS COUNT Data Center. Data retrieved November 2014 from www.datacenter.kidscount.org
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]
- Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester (months 1 through 3) of pregnancy, as percent of all births. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

Birth Outcomes & Risks

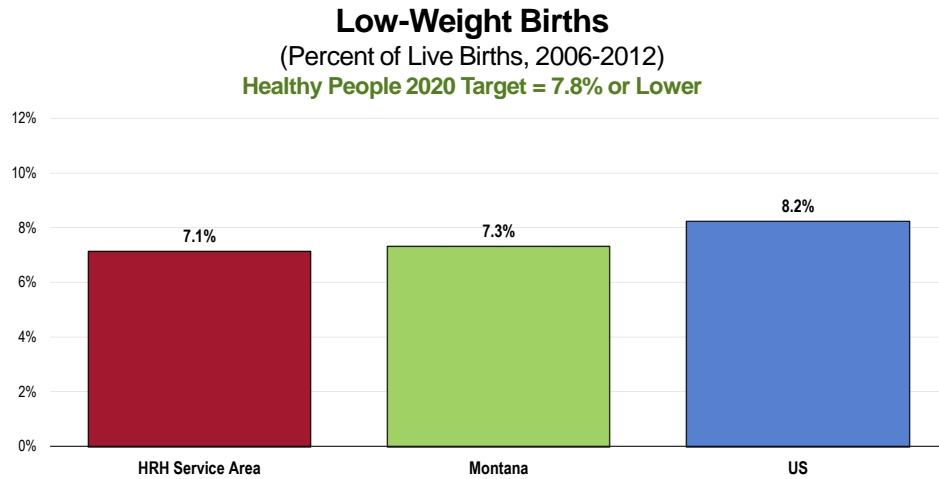
Low-Weight Births

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.

A total of 7.1% of 2006-2012 HRH Service Area births were low-weight.

- Almost identical to the Montana proportion.
- Slightly better than the national proportion.
- Satisfies the Healthy People 2020 target (7.8% or lower).



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System (2006-12). Accessed via the Health Indicators Warehouse.
 • Retrieved November 2014 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.

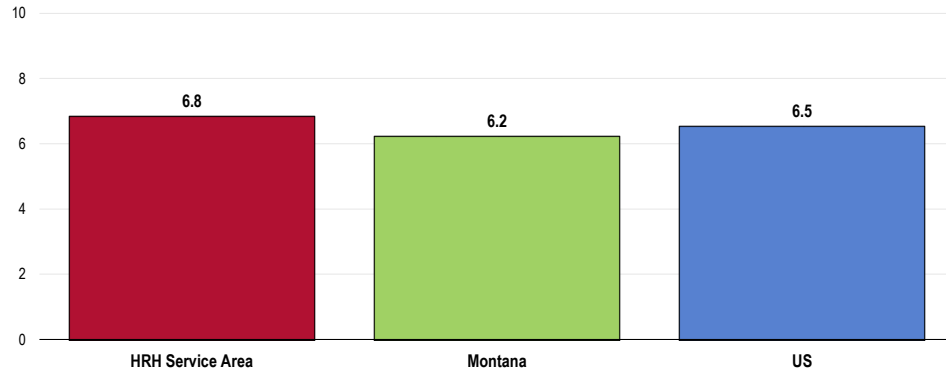
Between 2006 and 2010, there was an annual average of 6.8 infant deaths per 1,000 live births.

- Just above the Montana rate.
- Similar to the national rate.
- Fails to satisfy the Healthy People 2020 target of 6.0 per 1,000 live births.

Infant Mortality Rate

(2006-2010)

Healthy People 2020 Target = 6.0 or Lower



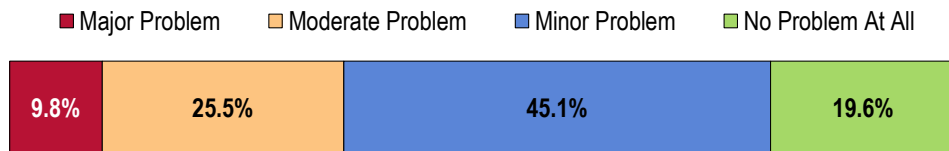
- Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File (2006-10).
 - Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
- Notes:
- Infant deaths include deaths of children under 1 year old per 1,000 births.
 - 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

Key informants taking part in an online survey most often 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, 2014)



- 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 frequently related to the following:

Lack of Providers & Services

Limited pediatric providers in the community. Generally not a pediatric physician available on emergent basis. - Social Services Representative

Less of a problem now that we have two pediatricians. - Health Provider

Lack of Critical Care for newborns or Intensive Care for newborns. - Community Leader

I don't know if it is a problem or just a need for more resources. - Social Services Representative

High Prevalence of Pre-Term and Teen Births

Children are the future of our community. High % of pre-term and teen births, more and more children diagnosed with special needs including mental health/autism. Many families still do not have consistent funding/insurance options that pay for preventative care. Access of preventative mental health services. Waiting lists for special services for children with disabilities. Need for affordable specialized services such as speech therapy, physical therapy. More home based options. Collaborative services among private and public service providers. Continued public education regarding health prevention, healthy lifestyles. - Public Health Expert

Family Planning

Births to Teen Mothers

About Teen Births

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

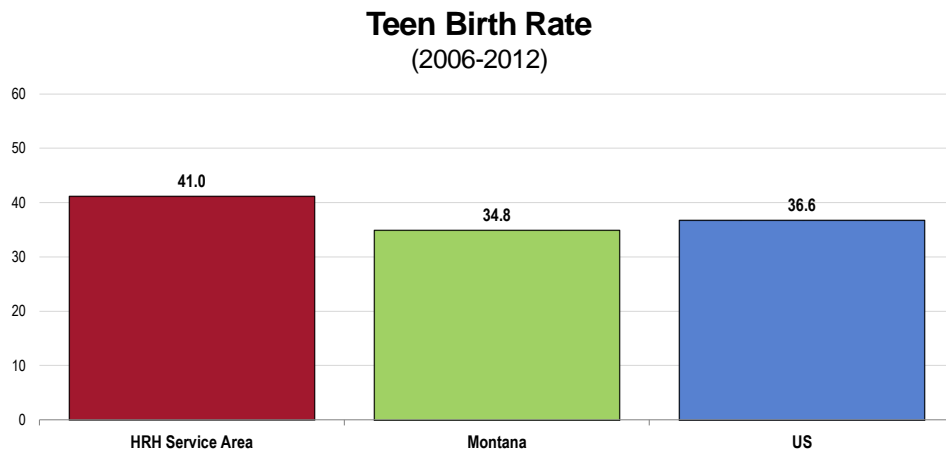
- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

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 was an annual average of 41.0 births to women age 15-19 per 1,000 population in that age group.

- Higher than the Montana proportion.
- Higher than the national proportion.



Sources:

- Centers for Disease Control and Prevention, National Vital Statistics System (2006-12). Accessed via the Health Indicators Warehouse.
- Retrieved November 2014 from Community Commons at <http://www.chna.org>.

Notes:

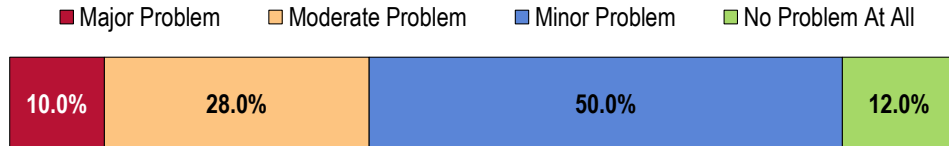
- This indicator reports the rate of total births to women under the age of 15 - 19 per 1,000 female population age 15 - 19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate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

Key Informant Input: Family Planning

Key informants taking part in an online survey largely characterized *Family Planning* as a “minor problem” in the community.

Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2014)



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 frequently related to the following:

Teen Pregnancies

I work with youth and from what I've seen there are too many teen pregnancies. - Social Services Representative

Pregnant teens and young women. - Social Services Representative

Teen pregnancy. – Community Leader

Lack of Education & Family Planning Services

Lack of proper education. - Health Provider

We have no program in the our community that offers family planning. - Public Health Expert

Modifiable Health Risks



Professional Research Consultants, Inc.

Actual Causes of Death

About Contributors to Mortality

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

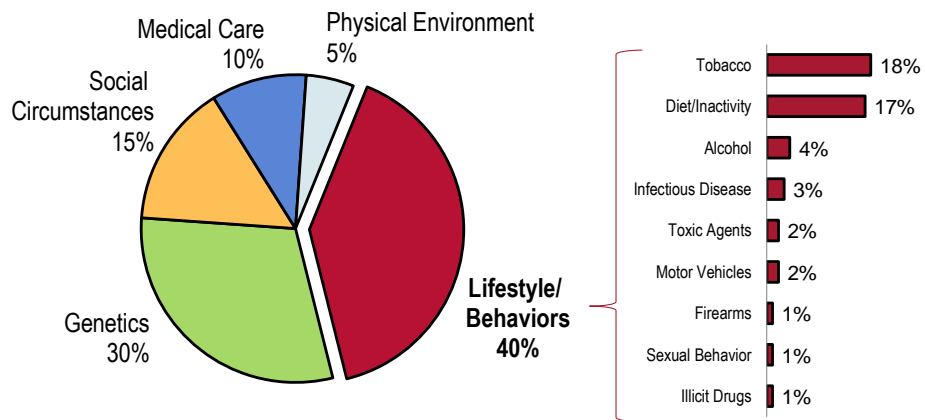
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual behavior** (20,000), and **illicit use of drugs** (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

- Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Factors Contributing to Premature Deaths in the United States



Sources: • "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. No. 2. March/April 2002.
 "Actual Causes of Death in the United States"; (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH.) JAMA. 291 (2000) 1238-1245.

Leading Causes of Death	Underlying Risk Factors (Actual Causes of Death)	
Cardiovascular Disease	Tobacco use Elevated serum cholesterol High blood pressure	Obesity Diabetes Sedentary lifestyle
Cancer	Tobacco use Improper diet	Alcohol Occupational/environmental exposures
Cerebrovascular Disease	High blood pressure Tobacco use	Elevated serum cholesterol
Accidental Injuries	Safety belt noncompliance Alcohol/substance abuse Reckless driving	Occupational hazards Stress/fatigue
Chronic Lung Disease	Tobacco use	Occupational/environmental exposures

Source: National Center for Health Statistics/US Department of Health and Human Services, Health United States: 1987. DHHS Pub. No. (PHS) 88-1232.

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.

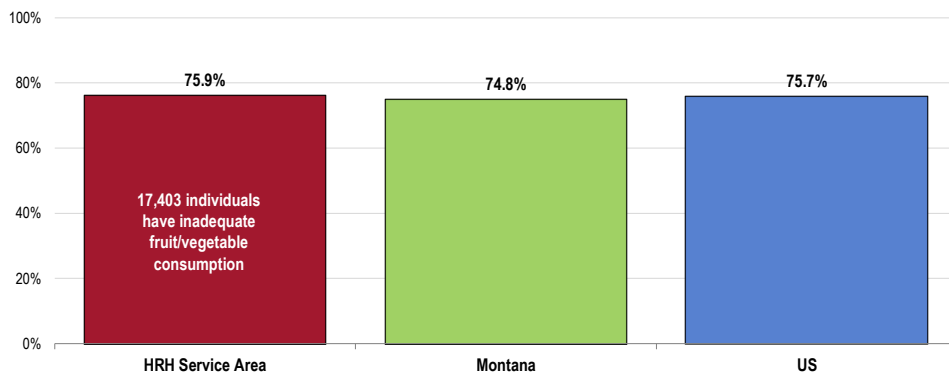
- Healthy People 2020 (www.healthypeople.gov)

Fruits/Vegetable Consumption

Three-fourths (75.9%) of HRH Service Area adults (representing over 17,000 individuals) get less than the recommended five servings of fruits and/or vegetables per day.

- Comparable to statewide findings
- Nearly identical to national findings.

Less Than 5 Servings of Fruits and Vegetables Each Day (2005-2009)



Sources: • Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2005-09). Accessed via the Health Indicators Warehouse.
• Retrieved November 2014 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percent of adults age 18+ who are consuming less than 5 servings of fruits and vegetables each day. This indicator is relevant because current behaviors are determinants of future health, and because unhealthy eating habits may cause of significant health issues, such as obesity and diabetes.

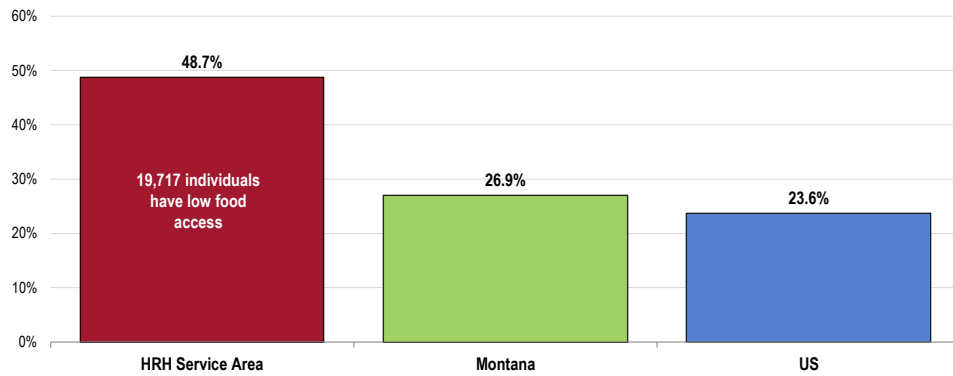
Low Food Access (Food Deserts)

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 48.7% of the HRH Service Area population (representing nearly 20,000 residents) have low food access or live in a "food desert," meaning that they do not live near a supermarket or large grocery store.

- Less favorable than statewide findings.
- Notably less favorable than national findings.

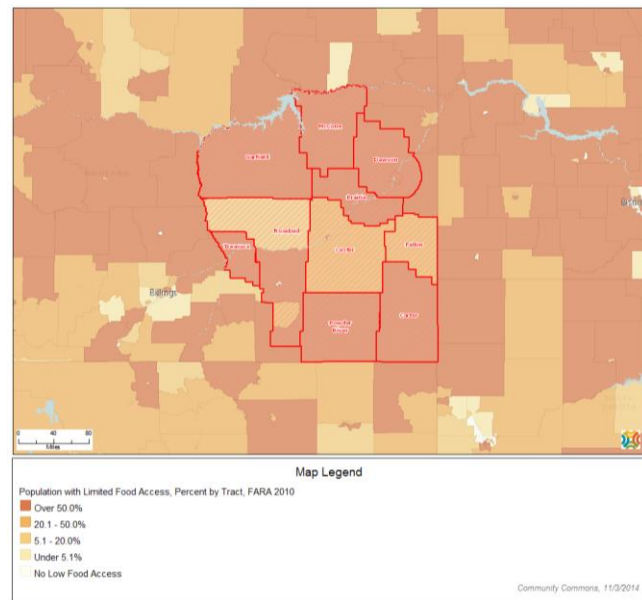
Population With Low Food Access (2010)



Sources: • U.S. Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA); 2010.
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas 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. This indicator is relevant because it highlights populations and geographies facing food insecurity.

- The following map provides an illustration of food deserts by census tract. Geographically, food deserts are prevalent throughout most of the service area, with lowest food access evident in census tracts in Carter, Dawson, Garfield, McCone, Powder River, Prairie, southern Rosebud, and Treasure counties.

Population With Limited Food Access, Percent by Tract, FARA 2010



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 and older 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

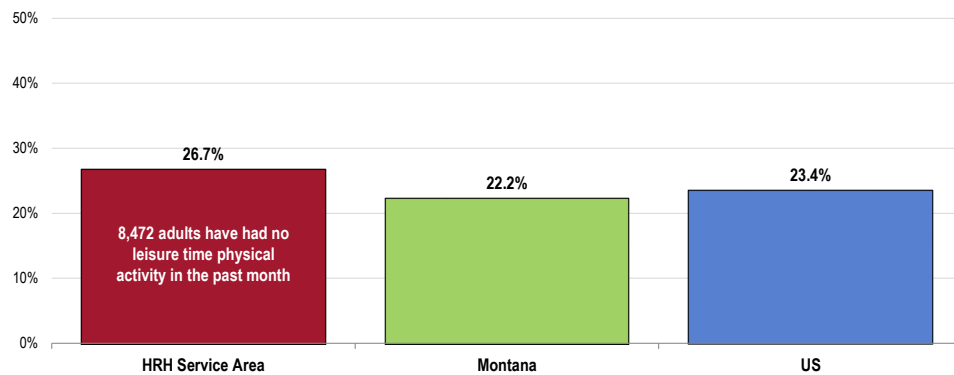
A total of 26.7% of HRH Service Area adults (representing 8,472 individuals) report no leisure-time physical activity in the past month.

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.

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

No Leisure-Time Physical Activity in the Past Month (2010)

Healthy People 2020 Target = 32.6 or Lower



Sources:

- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas (2010).
- Retrieved November 2014 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 Recreation & Fitness Facilities

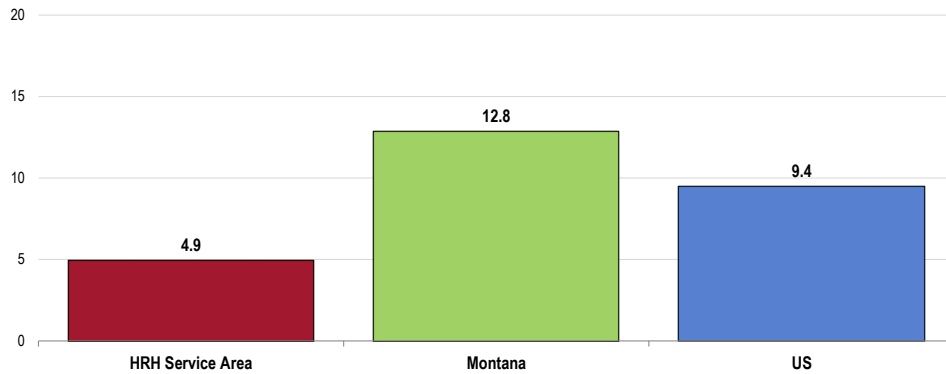
In 2012, there were 4.9 recreation/fitness facilities for every 100,000 population in the HRH Service Area.

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.

- Notable lower than what is found statewide.
- Lower than what is found nationally.

Population With Recreation & Fitness Facility Access
(2012)



- Sources:
- U.S. Census Bureau, County Business Patterns (2012). Additional data analysis by CARES.
 - Retrieved November 2014 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator reports the number per 100,000 population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940, which 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. This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

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: $[\text{weight (pounds)}/\text{height squared (inches}^2)] \times 703$.

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 26.5% of HRH Service Area adults age 20 and older (representing 8,020 individuals) are obese.

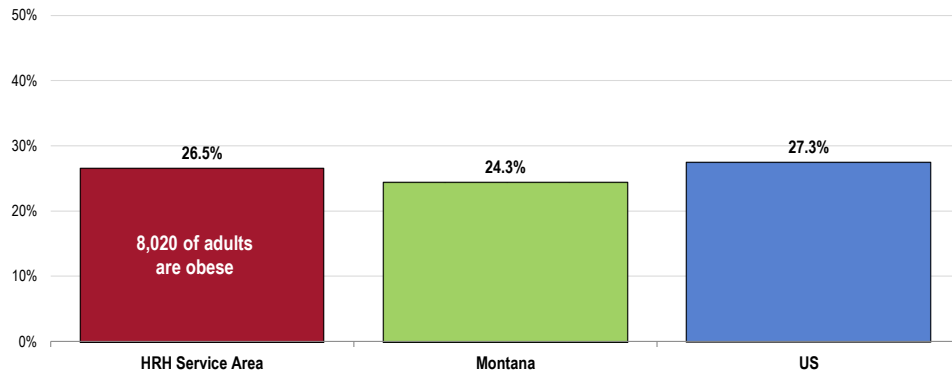
“Obese” includes respondents with a BMI value ≥ 30 .

- Less favorable than Montana findings.
- Similar to US findings.
- Below the Healthy People 2020 target (30.5% or lower).

Adults Age 20 and Older Who Are Obese

(Body Mass Index ≥ 30 ; 2010)

Healthy People 2020 Target = 30.5 or Lower



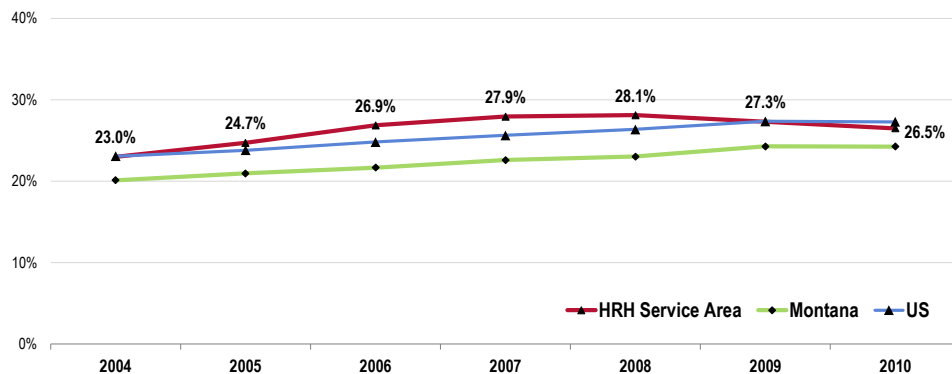
Sources: • Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas (2010).
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <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.

- Note that obesity increased between 2004 and 2008, but has since dropped.

Trend in Adults 20+ Who Are Obese

(Body Mass Index ≥ 30)

Healthy People 2020 Target = 30.5 or Lower

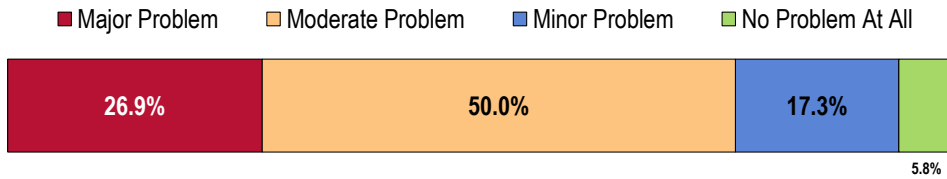


Sources: • Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas (2010).
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 Notes: • This indicator reports the percent of adults aged 20+ who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) in the report area. 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

One-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, 2014)



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 frequently related to the following:

Lack of Facilities & Healthy Options

No inside place to walk at 5:30AM when the weather is bad. I used to be able to walk at Holy Rosary early mornings, but it is not open until 7AM, which does not work into my schedule. Nutrition — lack of awareness of what is healthy eating. Weight, I've observed many people eating and they just don't seem to care what they put in their mouths. For those of us in healthy lifestyles, it would be great to continue to weigh in and have meetings for more than a year. - Social Services Representative

There are no fitness facilities available at all, or healthy eating programs that are in person, i.e. Curves, Weight Watchers. - Public Health Expert

No place to go, no way to get there, no money to spend. Restaurants don't offer many healthy choices, grocery stores have difficulty stocking fresh fruits and vegetables and or offering them at reasonable prices, independent thinking. - Social Services Representative

The nation's food production companies and their lack of care to provide health foods. They are not out to give the consumer a healthy product, but one they can make a buck with and get them addicted to. - Health Provider

Long winter! Limited resources for health and wellness in the community - Public Health Expert

Lack of Motivation

Continued public education, support for healthy lifestyles, sustainable support - Public Health Expert

Motivation to change life-long habits. - Community Leader

Being overweight is more accepted. - Health Provider

There are many overweight folks in our community and many refuse to take care of themselves and their situation. There are also nutrition needs with children - parents not taking the time to fix appropriate meals. And just hungry kids in general who go to school hungry. I know of instances where the teachers in our local schools have food in their classrooms and desks to provide to children who don't have food at home and their only food for the day is the school lunch program. - Social Services Representative

Lack of Education

Education - Community Leader

Education for residents in a neutral environment and access to nutritional education for all residents - Social Services Representative

Overall low emphasis on wellness, healthy activities, etc. Not a common value in many Miles City households. Also, due to low education level and high number of low-income families, people struggle with accessing healthy food options, exercise activities. - Health Provider

Nutrition

Nutritious meals for our lower income families, especially those with children. - Community Leader

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 17.3% of area adults drink alcohol excessively.

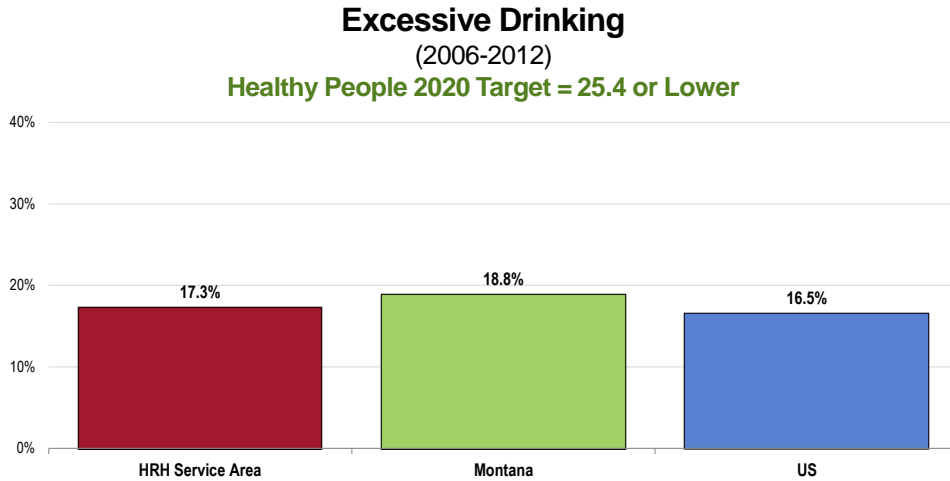
This indicator reports the percentage of adults aged 18 and older who self-report:

- **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).

- More favorable than the statewide proportion.
- Close to the national proportion.

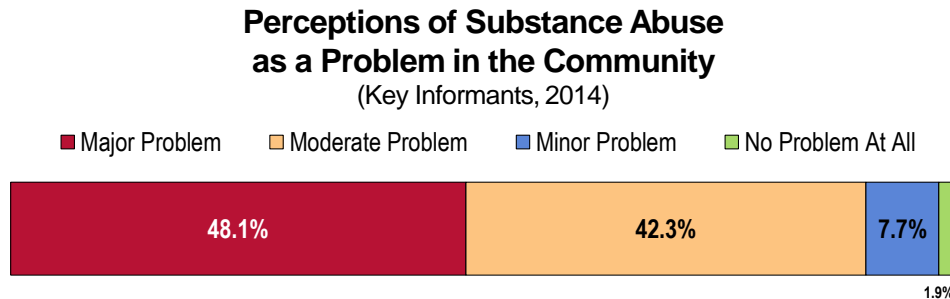


Sources: • Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2006-12). Accessed via the Health Indicators Warehouse.
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.
 • US Department of Health and Human Services. Healthy People 2020. December 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) or binge drinking (5 or more drinks on a single occasion for men, 4 or more drinks on a single occasion for women). This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as cirrhosis, cancers, and untreated mental and behavioral health needs.

Key Informant Input: Substance Abuse

The greatest share of key informants taking part in an online survey characterized **Substance Abuse** as a “major 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 frequently related to the following:

Cultural Norms

The majority of substance abuse in our community is due to alcohol abuse. It's a general problem that starts in high school, so needs to be addressed in grade school. The community has always tolerated drinking, almost to the point of celebrating. - Community Leader

Drinking is accepted as a normal and social activity. Other drugs are not deemed appropriate. - Health Provider

Cultural acceptance of alcohol use. Prescription drugs are also a problem. - Health Provider

Again, substance abuse is a huge issue in our communities. It seems there is easy access to drugs here. And alcohol is everywhere and seems to be very acceptable behavior. There are too many bars/casinos in our communities. - Social Services Representative

Lack of insurance coverage for substance abuse - Social Services Representative

Cost of Treatment

Cost of treatment, especially more long term residential care. Lack of understanding, acceptance of the nature of the problem by the substance abuser and family members. - Social Services Representative

Cost - Social Services Representative

Cost, distance to those centers, reluctance to seek help. - Public Health Expert

Lack of access to treatment facilities, treatment is not affordable to many families. Follow up treatment in Miles City and the surrounding areas is not adequate. - Social Services Representative

Lack of Services & Other Access Barriers

Access near their homes. We do not have any inpatient facilities here to help and no "detox" units. - Public Health Expert

Distance to treatment centers and programs. - Community Leader

Attitude, services not easily accessible; not enough effective emphasis on prevention; flexible treatment options; rural nature of community/county - Public Health Expert

Local medical providers will not refer them, and treatment facilities are very far away from our facility. - Public Health Expert

Only one place in the area to gain the treatment and it is outpatient only - Social Services Representative

Lack of Willingness to Get Help

Subjects willingness to want to help him/herself. They wait until they are caught and then help can be available but only if they are willing to take it. Doctors have been found to buy into the substance abuse by prescribing unneeded pills, and subject will be hooked on these drugs and it becomes a vicious circle and they can't get it from one doctor, they will try until they find another doctor that will prescribe. - Social Services Representative

People do not always want to receive treatment and not willing to change their behaviors. Maybe they do not see the destruction that is happening around them. - Social Services Representative

Lack of motivation. - Community Leader

Stigma & Denial

Being labeled, no support from family friends and lack of desire to help themselves. - Social Services Representative

Denial of a problem. Fear of the financial burden of a program. - Community Leader

They don't want to go - Community Leader

Shame, no desire to quit. Non admittance that a problem exists. Perceptions on cost, perception that no local resources exist. - Health Provider

Improper Care

Too many doctors treating chronic pain and mental health issues without proper training or diagnosis. Several doctors over prescribing - Community Leader

Seniors

A big concern for the COA is what, if anything, can be done and would be effective in treating alcoholism in elders. - Social Services Representative

Most Problematic Substances

Key informants (who rated Substance Abuse as a “major problem”) most often identified *alcohol, methamphetamine* and *prescription medications* as the most problematic substances abused in the community. *Marijuana* and *heroin/opioids* were mentioned less frequently.

	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Alcohol	73.7%	17.6%	5.9%	18
Methamphetamines or Other Amphetamines	26.3%	29.4%	35.3%	16
Prescription Medications	0.0%	29.4%	47.1%	13
Marijuana	0.0%	17.6%	11.8%	5
Heroin or Other Opioids	0.0%	5.9%	0.0%	1
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	0.0%	0.0%	0
Cocaine or Crack	0.0%	0.0%	0.0%	0
Hallucinogens or Dissociative Drugs (e.g. Ketamine, PCP, LSD, DXM)	0.0%	0.0%	0.0%	0
Inhalants	0.0%	0.0%	0.0%	0
Over-The-Counter Medications	0.0%	0.0%	0.0%	0
Steroids	0.0%	0.0%	0.0%	0
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	0.0%	0.0%	0

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.

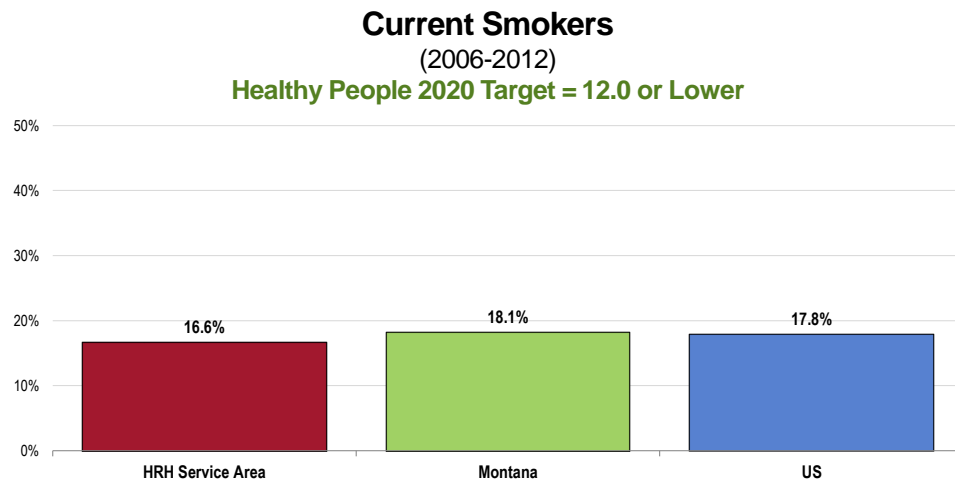
- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 16.6% of HRH Service Area adults currently smoke cigarettes, either regularly or occasionally.

- More favorable than statewide findings.
- More favorable than national findings.
- Fails to satisfy the Healthy People 2020 target (12% or lower).



Sources: • Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2006-12). Accessed via the Health Indicators Warehouse.
• Retrieved November 2014 from Community Commons at <http://www.chna.org>.

Notes: • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1].
• This indicator reports the percent of adults aged 18+ who self-report currently smoking cigarettes some days or every day. This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.

Smokeless Tobacco

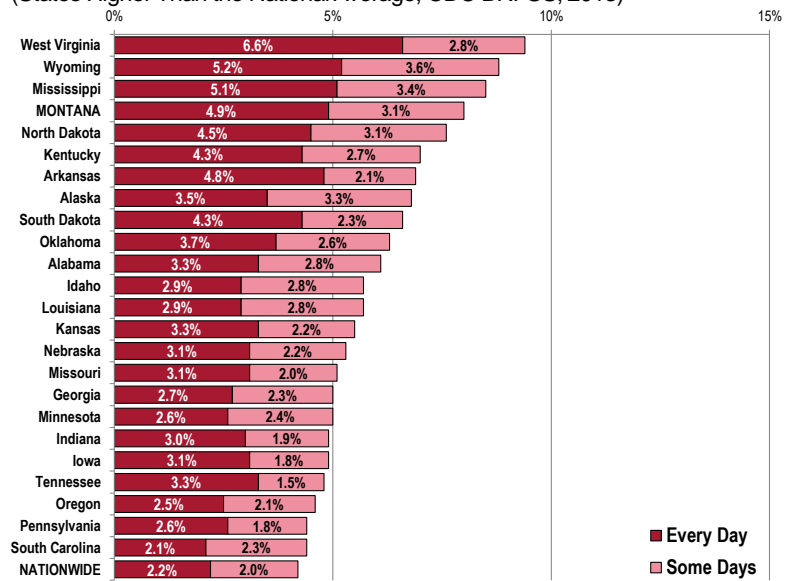
In 2013, Montana ranked 4th among the 50 states in terms of the prevalence of smokeless tobacco use.

A total of 8.0% of Montana residents used chewing tobacco, snuff or snus in 2013 (4.9% every day, and 3.1% on some days).

- Nationally, only 4.2% of adults use smokeless tobacco products.

Currently Use Chewing Tobacco, Snuff or Snus

(States Higher Than the National Average, CDC BRFSS, 2013)

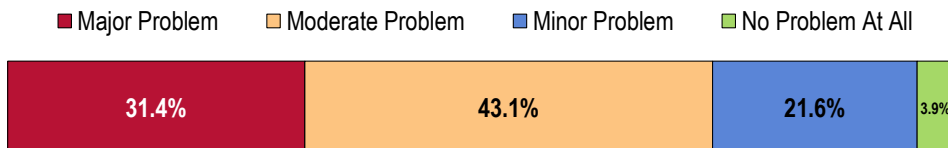


Key Informant Input: Tobacco Use

The greatest share of key informants taking part in an online survey characterized Tobacco Use as a “moderate problem” in the community.

Perceptions of Tobacco Use as a Problem in the Community

(Key Informants, 2014)



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 frequently related to the following:

Cultural Norms

Again, tobacco use is accepted as normal. - Health Provider

An accepted behavior. Low income, low education level support at risk behaviors. - Health Provider

It seems to be an acceptable habit. Chewing tobacco may be more of a problem than smoking, although both are a problem. - Community Leader

I feel that tobacco use throughout Montana is a huge issue. It is a cultural thing and many smoke or chew because it is the “thing”. Many young people smoke and have easy access to the products even though there is an age limit. - Social Services Representative

Persistent Use

Too many residents still smoke and are dealing with the negative effects of this — cancer, COPD, asthma. - Public Health Expert

Persistent use among vulnerable populations at both ends of the age scale. - Health Provider

Sales of tobacco products continue to rise, in spite of cessation campaigns; ease of obtaining help. - Community Leader

I see youth smoking. I also see many adults, and a great deal of those adults in the medical profession smoking. If the medical profession isn't assisting their staff with this problem it does not set a good example for the rest of the community. - Social Services Representative

Prevalence Among Teens

Smokeless tobacco and Smoking are very prevalent among teens and young adults. - Social Services Representative

Tobacco use in our teens is prevalent, seen by the many Tobacco Underage citations that are written. Also drive by the high school before noon and after school, our youth are using it frequently. - Social Services Representative

High number of users, younger population using, acceptable status, easy access, - Public Health Expert

Chewing Tobacco

There is a lot of chewing tobacco use. - Social Services Representative

Access to Health Services



Professional Research Consultants, Inc.

Lack of Health Insurance Coverage

Among adults age 18 to 64 in the HRH Service Area, 24.0% report having no insurance coverage for healthcare expenses.

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).

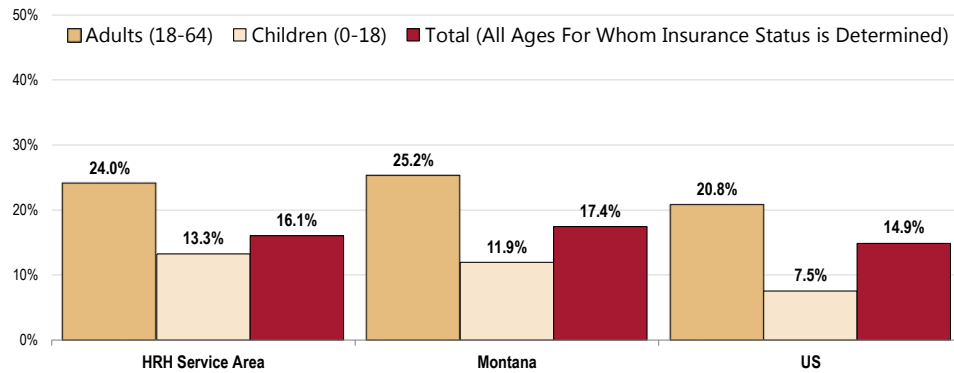
- Similar to the state finding.
- Worse than the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).

Additionally, among children age 0 to 17 in the Service Area, 13.3% have no insurance coverage for healthcare expenses.

Uninsured Population

(2008-2012)

Healthy People 2020 Target = 0



Sources:

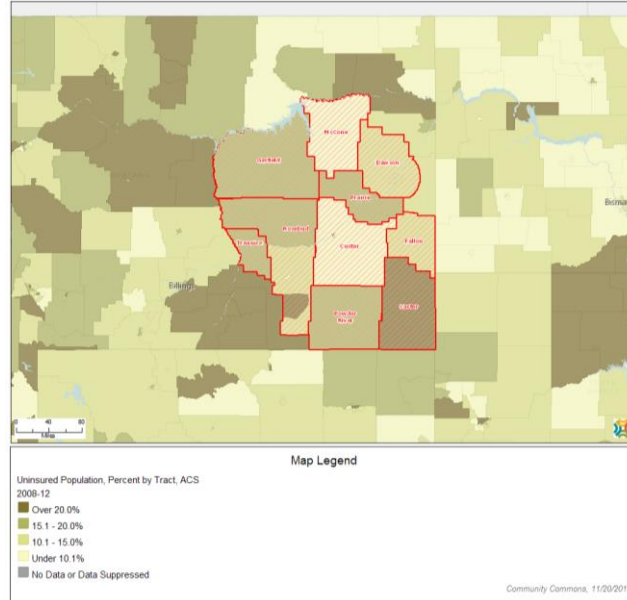
- U.S. Census Bureau, Small Area Health Insurance Estimates (2012), & American Community Survey 5-year estimates (2008-2012).
- Retrieved November 2014 from Community Commons at <http://www.chna.org>.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [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.

- Lack of health insurance is highest in Carter County and in parts of southern Rosebud County.

Uninsured Population, Percent by Tract, ACS 2008-2012



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.

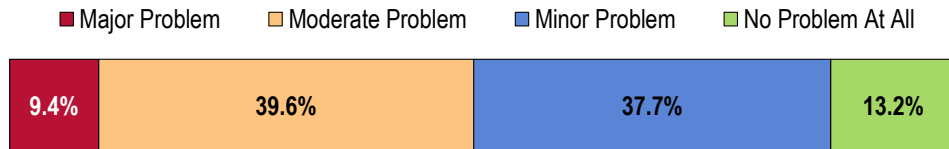
Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider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

- Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Access to Healthcare Services

Key informants taking part in an online survey generally characterized **Access to Healthcare Services** as either a “moderate problem” or a “minor problem” in the community.

Perceptions of Access to Healthcare Services as a Problem in the Community (Key Informants, 2014)



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 frequently related to the following:

Quality

Access to quality providers in our community and the distance needed to travel to see a specialist. - Public Health Expert

Can never keep a good doctor on staff - Public Health Expert

Turnover of qualified physicians because of lack of continuity. - Health Provider

Transportation

The need to travel long distances to cover all health care needs. Local hospitals cover a great deal, but not all. - Social Services Representative

Transportation. - Social Services Representative

Appointment Availability

The wait to see a health care professional is too long, both to schedule an appointment and while there. How can other areas be addressed until access to care is your major problem. - Health Provider

Cost

Too expensive - Public Health Expert

Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) most often identified specialty care and dental care as the most difficult to access in the community. Elder care, hospice care and mental health care were also mentioned.

	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Specialty Care	66.7%	0.0%	0.0%	2
Dental Care	0.0%	50.0%	50.0%	2
Elder Care	0.0%	0.0%	50.0%	1
Hospice Care	0.0%	50.0%	0.0%	1
Mental Health Care	33.3%	0.0%	0.0%	1
Chronic Disease	0.0%	0.0%	0.0%	0
Pain Management	0.0%	0.0%	0.0%	0
Palliative Care	0.0%	0.0%	0.0%	0
Prenatal Care	0.0%	0.0%	0.0%	0
Primary Care	0.0%	0.0%	0.0%	0
Substance Abuse Treatment	0.0%	0.0%	0.0%	0
Urgent Care	0.0%	0.0%	0.0%	0

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

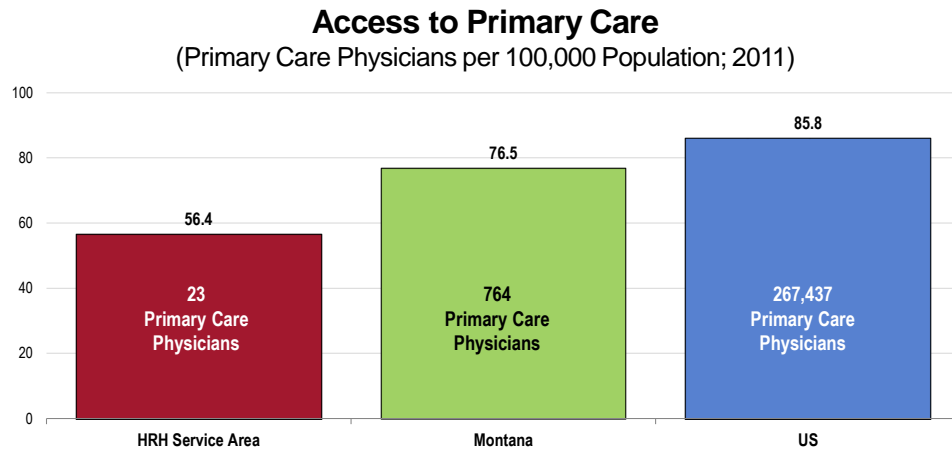
Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease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

- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

In the HRH Service Area in 2011, there were 23 primary care physicians, translating to a rate of 56.4 primary care physicians per 100,000 population.

- Well below the primary care physician-to-population ratio found statewide.
- Well below the ratio found nationally.



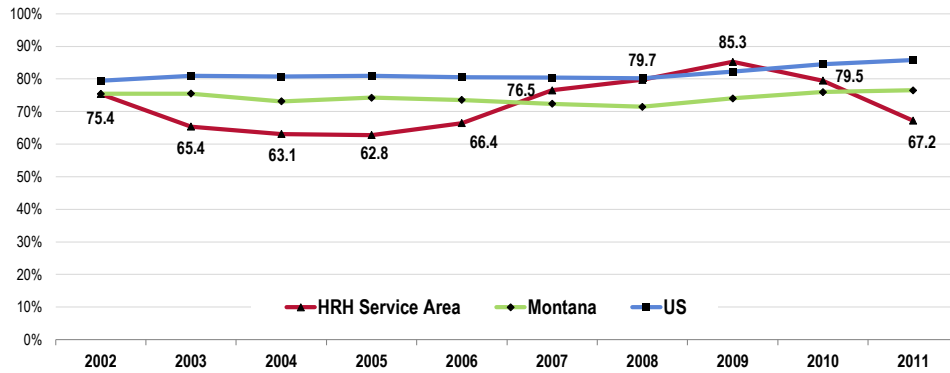
Sources: • U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File (2011).

• Retrieved November 2014 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the number of primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

- In recent years, this has fluctuated above and below state/national ratios.

Access to Primary Care (2002-2011)



Sources:

- U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File (2011).
- Retrieved November 2014 from Community Commons at <http://www.chna.org>.

Notes:

- This indicator reports trends in the number of primary care physicians per 100,000 population between 2002 and 2011 in the report area. 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.

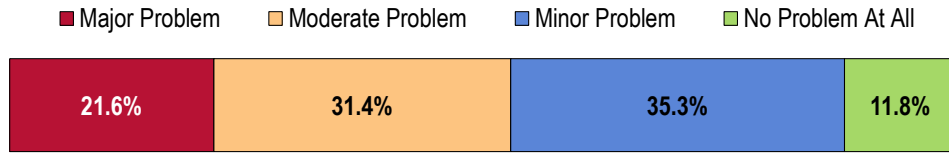
- Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a “minor problem” in the community (although over one-half said it was either a “major” or “moderate problem”).

Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2014)



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 frequently related to the following:

Lack of Services/Coordinated Care

We have no dentist in our community. It is very hard to get an appointment in the outlying areas in a decent time frame. Usually you are scheduled 3-4 months out. Is not very good if you have a bad tooth or abscessed tooth. - Public Health Expert

We have no services offered in our community and limited offered in the surrounding areas. - Public Health Expert

Same as the rest of Montana. There is no cohesive plan for delivering quality service. Hundreds of fiefdoms without any coordination of services. - Public Health Expert

Cost of Care/Lack of Insurance

Lack of affordable dental health care coverage. - Social Services Representative

Insurance access and scheduling. - Public Health Expert

Lack of insurance for youth that covers dental care. - Social Services Representative

Access for the Medicaid Populations

Limited providers who accept Medicaid. - Social Services Representative

Essential for overall health, nutrition. Lack of providers who accept Medicaid and have time to do preventative intervention and education. - Public Health Expert

Seniors on Medicaid have to go out of town for dental treatment. VA seems to deny some veterans dental services, needing dentures, for example. - Social Services Representative

Drug Use

Being in law enforcement, the first thing that they list is teeth problems and this is due to the high use of meth and other drugs in our community. - Social Services Representative

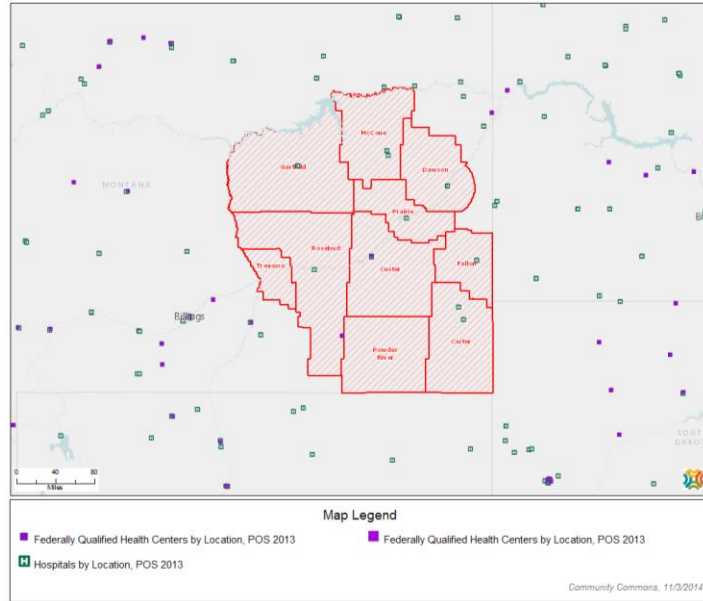
Local Resources

Healthcare Resources & Facilities

Hospitals & Federally Qualified Health Centers (FQHCs)

As of 2013, there were multiple hospitals and 2 Federally Qualified Health Centers (FQHCs) within the HRH Service Area.

Hospitals & Federally Qualified Health Centers, POS 2013



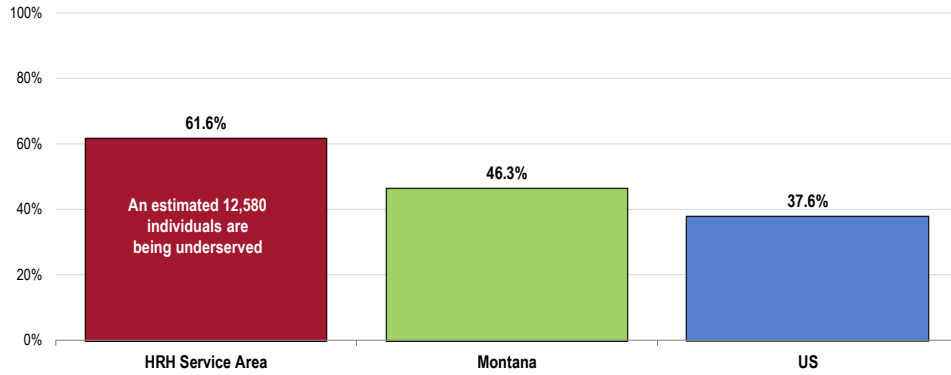
Health Professional Shortage Areas (HPSAs)

As of 2014, 61.6% of the HRH Service Area population were living in a Health Professional Shortage Area (HPSA). Consequently, an estimated 12,580 residents are underserved.

A "health professional shortage area" (HPSA) is defined as having a shortage of primary medical care, dental or mental health professionals.

- Notably less favorable than statewide findings.
- Notably less favorable than national findings.

Population Living in a Health Professional Shortage Area (HPSA) (2014)

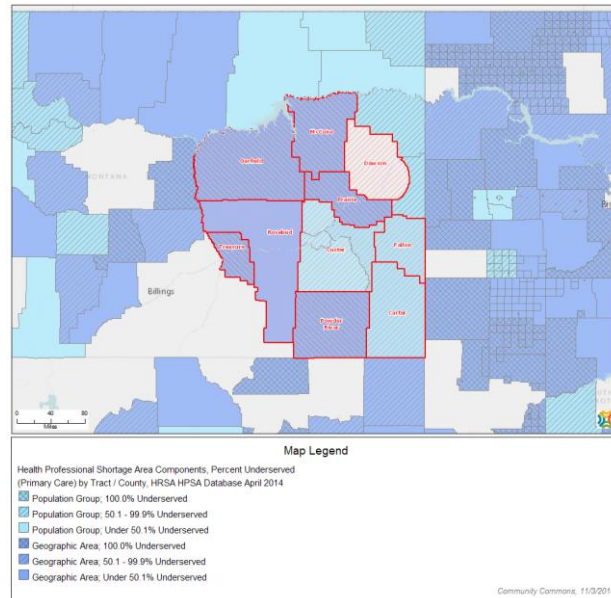


Sources: • U.S. Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas (April 2014).
 • Retrieved November 2014 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

- As shown in the following map, many of counties comprising the HRH Service Area have been designated by the US Department of Health and Human Services as health professional shortage areas (HPSAs).

Population Living in a HPSA, Percent, HRSA HPSA Database April 2014



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant 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

- Badlands Taxi Reduced Fares for Seniors*
- Billings Clinic*
- County Transportation*
- OneHealth Community Health Center*
- State Workers Health Clinic*
- VA Health Center*

Arthritis, Osteoporosis & Chronic Back Conditions

- Arthritis Exercise Program by Tara Andrews*
- Arthritis Foundation*
- Billings Clinic*
- Door 804*
- Glendive Medical Center*
- Holy Rosary Healthcare*
- Local Doctors*
- Local Insurance Companies*
- Local Massage Therapists*
- Local Physical Therapy Services*
- McCone County Health Center*
- Miles Community College Recreation Center*
- OneHealth*
- Powder River Medical Clinic*
- Strong Women Exercise Program by Tara Andrews*
- Taylor Spines Chiropractic*

Cancer

- American Cancer Society*
- Billings Clinic*
- County Transportation*
- Glendive Medical Center*
- Holy Rosary Healthcare*
- Local Funds*
- Local Health Facilities*

Local Health Food Stores
Local Hospice
Local Insurance Companies
Local Physicians
Local Schools
Local Support Groups
Medicaid Travel Reimbursement
OneHealth
St. Vincent Oncology
Telemedicine Services
Wake Up and Lace

Chronic Kidney Disease

AHEC
Billings Clinic
Holy Rosary Healthcare
Holy Rosary Medical Arts Building
HRH Outreach Clinics
Local Physicians
OneHealth
VA Medical Center

Dementias, Including Alzheimer's Disease

Billings Clinic
Council on Aging
DEAP
Friendship Villa
Holy Rosary Healthcare
Holy Rosary Nursing Home
Local Alzheimer's Support Groups
Local Counselors
Local In-Home Nursing Care
Local Mental Health Center
Local Nursing Homes
Local Senior and Long-Term Care Services
OneHealth
Secured Unit for Advanced Dementia
Senior Center

Diabetes

Billings Clinic

Glendive Medical Center
Healthy Lifestyles
Holy Rosary Diabetes Care Team
Holy Rosary Healthcare
Local Diabetic Education Instructors
Local Dietitians
Local Family Practice Physicians
Local Gyms
Local Health Food Stores
Local Home Health Services
Local Medical Supply Services
Local Ministries
Local Physicians
Local Public Health Departments
McCone County Health Center
OneHealth
Senior Center
VA Healthcare

Family Planning

Glendive Medical Center
McCone County Health Center
OneHealth
Pregnancy Outreach Clinic
Local Public Health Departments
WIC Program

Hearing & Vision

Audiologists
Local Clinics

Heart Disease & Stroke

AHEC
Billings Clinic
Cardiologists From Billings
Comforting Hands Massage
Holy Rosary Healthcare EKGs and Diagnostic Testing
Holy Rosary Healthcare Emergency Room
Holy Rosary Healthcare Healthy Lifestyles Program
Holy Rosary Healthcare Heart and Lung Rehab Program
Holy Rosary Healthcare Visiting Cardiologist

Holy Rosary Hospital
 Local Weight Rooms
 McCone County Health Center
 OneHealth
 VA

HIV/AIDS

AHEC
 Billings Clinic
 Holy Rosary Healthcare
 OneHealth
 VA

Immunization & Infectious Diseases

AHEC
 Billings Clinic
 Holy Rosary Healthcare
 VA

Infant & Child Health

Billings Clinic
 DEAP
 Glendive Medical Center
 Holy Rosary Clinic
 Holy Rosary Healthcare
 Local Physicians
 OneHealth

Injury & Violence

Billings Clinic
 Custer Network Against Domestic Violence
 Holy Rosary Healthcare
 Local Law Enforcement Agencies
 Local Physicians
 Mental Health Center
 State of Montana Child and Family Services

Mental Health

AHEC
 AWARE
 Billings Clinic

Choices Counseling
 Community Mental Health Center
 DEAP
 DPHHS Mental Health Bureau
 Eastern Montana Medical Health Center
 Glendive Medical Center
 Holy Rosary Healthcare
 Independent Treatment Options
 Krutzfeld Counseling
 Local Counselors, Therapists, Psychologists, Social Workers
 Local Law Enforcement
 Local Medical Facilities
 Local Physicians
 Local School Guidance Counselors
 Local Spiritual Care
 Local Telepsych Services
 Mental Health Center
 OneHealth
 Toll-Free Montana Support Line
 VA Medical Center

Nutrition, Physical Activity & Weight

Billings Clinic
 Bountiful Basket Program
 Centra
 Custer County Food Bank
 Door 804
 Great Outdoors of Eastern Montana
 Healthy Lifestyles
 Holy Rosary Healthcare
 Holy Rosary Healthcare Cardiac Rehab Program
 Holy Rosary Healthcare JOLT Program for Youth
 Local Exercise Classes
 Local Extension Service
 Local Farmer's Markets
 Local Free Youth Sports Programs
 Local Gyms/Fitness Centers
 Local Health Food Stores
 Local Public Schools
 MCC Central
 Miles City Soup Kitchen

MSU Home Extension Office
OneHealth
Weight Watchers
WIC Program/DEAP

Oral Health

Billings Clinic
Community Health Center
Hogan Family Dental
Holy Rosary Healthcare Dental Program
Holy Rosary, Ronald McDonald Clinic
Local Dentists
Local Health Professionals
Local School Nurses
McCone County Health Center
McFarland Dental
Montana Donated Dental Services
OneHealth Voucher Program
Smile Bus
The Smile Center
Visiting Oral Surgeons

Respiratory Diseases

AHEC
Billings Clinic
Holy Rosary Healthcare
LinCare and Oxygen Providers
Local Pulmonary Rehabilitation
OneHealth
State of Montana Quit Line
VA Medical Center

Substance Abuse

Alcoholics Anonymous
Billings Clinic
Child and Family Services
Community Mental Health Center
District II Drug and Alcohol Program
Drug Court
Eastern Montana Mental Health Center
Holy Rosary Healthcare

Inpatient Treatment Center
Lighthouse Recovery Program
Local Clergy
Local Counselors, Therapists, Social Workers, Psychologists
Local Drug or Alcohol Rehab Services
Local Independent Treatment
Local Substance Abuse Support Groups
Local Twelve Step Programs
Mental Health Center
Montana Quit Line
Private Chemical Dependency Outpatient Services
Scram 24-7
St. Vincent DePaul Group
Substance Abuse Unit, Mental Health Center

Tobacco Use

Billings Clinic
Glendive Medical Center
Holy Rosary Healthcare
Local Schools/School Counselors
Local Tobacco Prevention Programs
Montana Quit Line
OneHealth
Powder River Medical Clinic
Southeastern Montana Tobacco Use Prevention Program
WIC/DEAP