2018 Community Health Needs Assessment Report

SPH Service Area

Prepared for:
St. Peter's Health

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Professional Research Consultants, Inc.

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Introduction

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Project Overview

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2012 and 2015, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of St. Peter's Health. 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 that historically have 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 St. Peter's Health by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey.

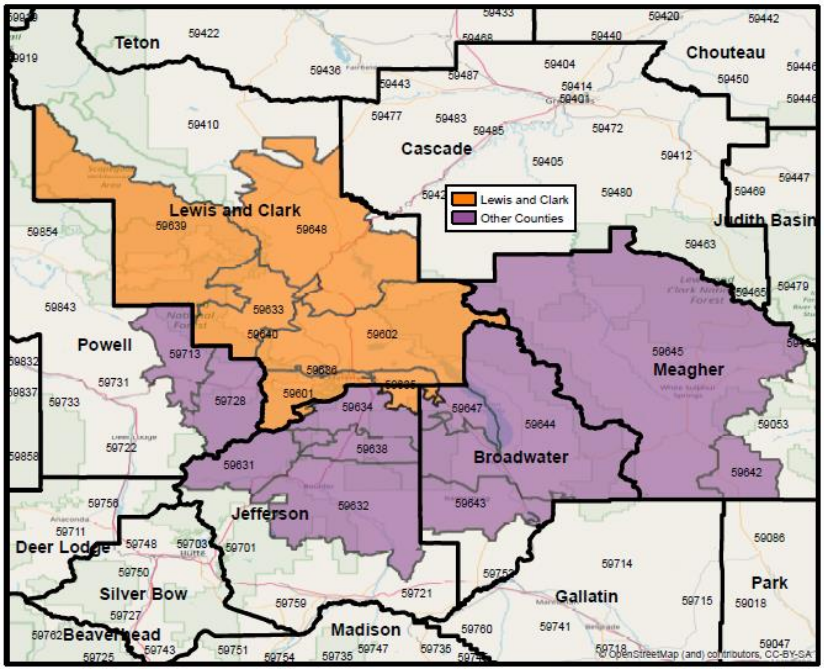
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by St. Peter's Health and PRC, with input from Lewis and Clark Public Health, and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as "SPH Service Area" in this report) is defined as each of the 25 residential ZIP Codes comprising the service area of St. Peter's Health. As can be seen in the following map, these ZIP Codes are predominantly associated with Lewis and Clark County, as well as the bordering counties of Broadwater, Jefferson, Meagher, and Powell (collectively referred to in this report as "Other Counties").



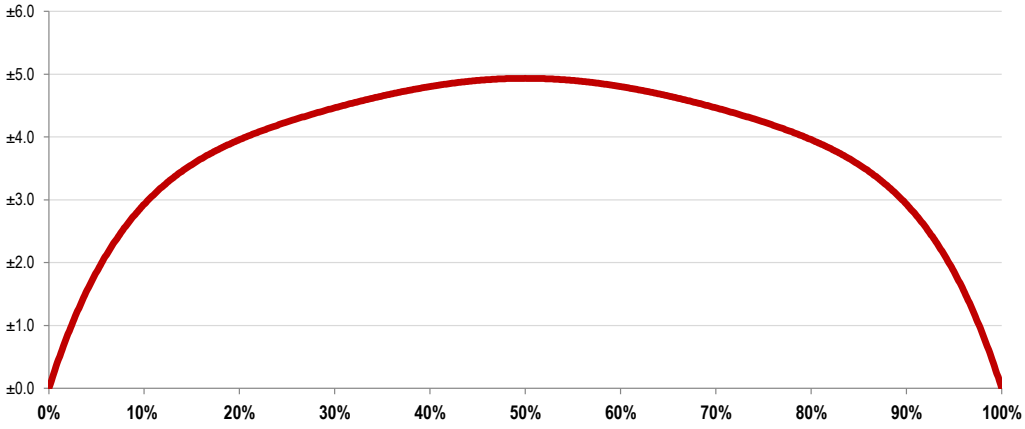
Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a stratified random sample of 400 individuals age 18 and older in the SPH Service Area, including 300 in Lewis and Clark County and 100 in the Other Counties. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the SPH Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 400 respondents is ±4.9% at the 95 percent confidence level.

Expected Error Ranges for a Sample of 400 Respondents at the 95 Percent Level of Confidence



Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 400 respondents answered a certain question with a "yes," it can be asserted that between 7.1% and 12.9% (10% ± 2.9%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 45.1% and 54.9% (50% ± 4.9%) of the total population would respond "yes" if asked this question.

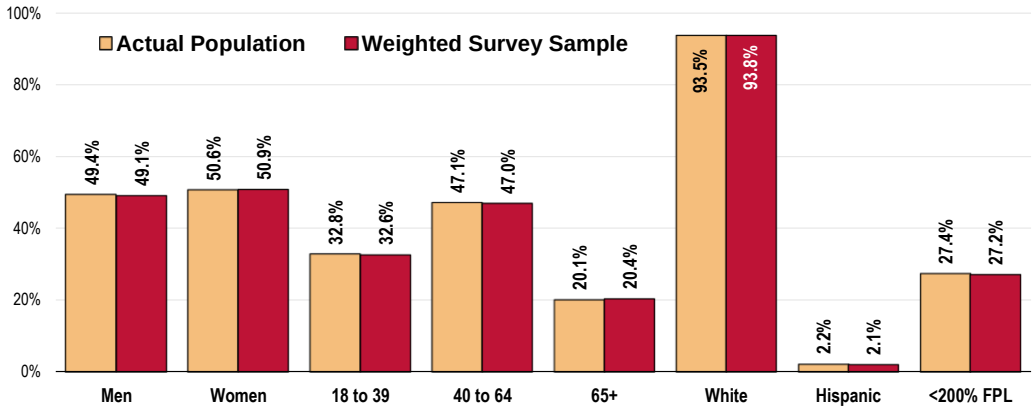
Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw

data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the SPH Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(SPH Service Area, 2018)



Sources:
- U.S. Census Bureau, 2011-2015 American Community Survey.
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2017 guidelines place the poverty threshold for a family of four at $24,400 annual household income or lower)*. In sample segmentation: "**low income**" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "**mid/high income**" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

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 also was implemented as part of this process. A list of recommended participants was provided by St. Peter's Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 116 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	**Number Invited**	**Number Participating**
Physicians	67	28
Public Health Representatives	43	16
Other Health Providers	69	20
Social Services Providers	51	21
Other Community Leaders	120	31

Final participation included representatives of the organizations outlined below.

- AARP Montana
- AWARE
- Bike Walk Montana
- Career Training Institute
- ChildWise Institute
- City of East Helena
- City of Helena
- Community Department and Planning, Lewis and Clark County
- County Mental Health Advisory Committee
- Department of Environmental Quality
- East Helena Public Schools
- Helena Citizen's Council
- Helena College
- Helena Family YMCA
- Helena Food Share
- Helena Housing Authority
- Lewis and Clark City County Board of Health
- Lewis and Clark County Department of Restorative Justice

- Lewis and Clark Literacy Council
- Lewis and Clark Public Health
- Local Advisory Council & Central Service Area Authority (LAC/CSAA)
- Montana Department of Environmental Quality
- Montana Department of Public Health and Human Services
- Montana Legal Services Association
- Montana No Kid Hungry
- Montana State University Extension, Lewis and Clark Co
- NAMI Helena
- Narrate Church
- NorthWestern Energy
- Our Place Community Drop-In Center
- Partners Ensuring Equal Rights and Supports
- Population Health Partners
- PureView Health Center
- Quinn Erwin Dental
- Rocky Mountain Development Council
- South Hills Dental
- St. Peter's Behavioral Health Unit
- St. Peter's Health
- St. Peter's Medical Group
- St. Peter's Medical North Clinic
- Treatment Court
- United Way of the Lewis and Clark Area
- WCC, LLC
- White Wolf United
- Youth Connections

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

Minority/medically underserved populations represented:

> *adolescents, African-Americans, Asians, children, children with disabilities, the elderly, those using English as a second language, foster families, Hispanics, the homebound, homeless individuals, the Hutterite population, immigrants/refugees, incarcerated, those lacking transportation, LGBTQ, residents with less education, low income, Medicare/Medicaid recipients, the mentally ill, Native Americans, residents in nursing homes, rural, those with substance abuse issues, those with heart/lung problems, individuals without a medical home, the unemployed/underemployed, veterans, victims of domestic violence/child abuse*

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

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area. Thus, these findings are not necessarily based on fact.

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 SPH Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

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

Note that secondary data reflect county-level data.

Benchmark Data

Trending

A similar survey was administered in the SPH Service Area in 2012 and 2015 by PRC on behalf of St. Peter's Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Montana Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also

provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2017 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People strives to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, State, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, “significance” of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community’s health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

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

IRS Form 990, Schedule H Compliance

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

IRS Form 990, Schedule H (2017)	See Report Page
Part V Section B Line 3a *A definition of the community served by the hospital facility*	9
Part V Section B Line 3b *Demographics of the community*	42
Part V Section B Line 3c *Existing health care facilities and resources within the community that are available to respond to the health needs of the community*	242
Part V Section B Line 3d *How data was obtained*	9
Part V Section B Line 3e *The significant health needs of the community*	18
Part V Section B Line 3f *Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Addressed Throughout
Part V Section B Line 3g *The process for identifying and prioritizing community health needs and services to meet the community health needs*	19
Part V Section B Line 3h *The process for consulting with persons representing the community's interests*	12
Part V Section B Line 3i *The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)*	249

Summary of Findings

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

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

Areas of Opportunity Identified Through This Assessment	

Access to Healthcare Services	• Barriers to Access
	  ○ Appointment Availability
	  ○ Transportation
	• Routine Medical Care (Children)
	• Ratings of Local Healthcare

Cancer	• Cancer is a leading cause of death. • Prostate Cancer Deaths • Cancer Prevalence (skin and non-skin)
Heart Disease & Stroke	• Heart disease is a leading cause of death. • Cardiovascular Risk Factors

Injury & Violence	• Unintentional Injury Deaths
	  ○ Including Motor Vehicle Crashes, Falls [Age 65+]
	• Falling in the Past Year [Age 45+]
	• Firearm-Related Deaths
	• Firearm Prevalence
	  ○ Including in Homes with Children

Mental Health	• Diagnosed Depression • Suicide Deaths • Mental Health ranked as a top concern in the Online Key Informant Survey
Nutrition, Physical Activity, & Weight	• Overweight & Obesity • Medical Advice on Weight
Potentially Disabling Conditions	• Activity Limitations • Arthritis [Age 50+]
Respiratory Diseases	• Asthma Prevalence [Adults] • Chronic Obstructive Pulmonary Disease (COPD) Prevalence
Substance Abuse	• Substance Abuse ranked as a top concern in the Online Key Informant Survey.

SPH Community Health Needs Assessment 2018

Prioritization of Needs

Slated to begin in January 2019, St. Peter's Health, in collaboration with Lewis and Clark Public Health, will convene about 75 members of our local public health system, including hospital administrators and community stakeholders, for the first of three meetings to participate in the Community Health Improvement Planning Task Force. Task force members will meet once per month for three consecutive months to develop a Community Health Improvement Plan (CHIP) – a long-term, strategic effort to address findings from the Community Health Needs Assessment (CHNA), as well as other public health concerns deemed necessary. These task force members will be led through a professionally facilitated process to develop the content for the CHIP and build on the previously published CHIP (2015), national planning efforts such as Healthy People 2020, and results from this most recent CHNA (2019). The task force will be required to develop a data-driven plan using the key priority areas of focus for collective action based on the best available community health data. They will then identify the top health-related priorities in the community, based on group discussion and analysis of the assessment data. During the task force sessions, members will be identifying:

- The community's most pressing health needs and priorities;
- Assets and resources available in our community to address those needs;
- Strategies for collective action to address health priorities, with a focus on policy;
- Metrics to measure progress in improving the health of our community and hospital service areas;
- Community partners who will take the lead for all identified strategies.

Historically, the 2013 and 2016 Community Health Improvement Plans had similar priorities, and based on the most recent CHNA it will be expected the following priority areas will receive focus:

- Mental Health
- Substance Abuse
- Chronic Disease
- Maternal and Child Health
- Environmental Health
- Access to Care

The results of the community-wide planning process will be contained in a final CHIP complete with a Plan Overview that will include a section titled: "Priority Areas of Focus to Improve Health."

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

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the SPH Service Area, including comparisons among the individual sub-areas, as well as trend data. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Summary Tables

TREND SUMMARY
(Current vs. Baseline Data)

Survey Data Indicators: Trends for survey-derived indicators represent significant changes since 2012.

Other (Secondary) Data Indicators: Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

In the following charts, SPH Service Area results are shown in the larger, blue column. For survey-derived indicators, this column represents the ZIP Code–defined service area; for data from secondary sources, this column represents aggregated county-level findings. *Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.*

The green columns [to the left of the SPH Service Area column] provide comparisons between the two sub-areas, identifying differences for each as "better than" (), "worse than" (), or "similar to" () the opposing area.

The columns to the right of the SPH Service Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Again, symbols indicate whether the SPH 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	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
Linguistically Isolated Population (Percent)			0.0	0.4	4.5		
Population in Poverty (Percent)	12.1	9.5	11.4	14.9	15.1		
Population Below 200% FPL (Percent)	26.8	29.1	27.4	35.3	33.6		
Children Below 200% FPL (Percent)	32.9	40.5	34.8	42.8	43.3		
No High School Diploma (Age 25+, Percent)	5.1	7.3	5.8	7.1	13.0		
Unemployment Rate (Age 16+, Percent)	4.2	5.1	4.4	4.7	4.2		3.2
% Worry/Stress Over Rent/Mortgage in Past Year	16.3	16.7	16.4		30.8		

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

	better	similar	worse

Overall Health	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
% "Fair/Poor" Overall Health	17.9	6.1	15.7	15.6	18.1		12.4
% Activity Limitations	28.3	28.4	28.4	23.9	25.0		21.4
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Access to Health Services	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
% [Age 18-64] Lack Health Insurance	6.9	8.6	7.2	10.0	13.7	0.0	10.3
% Difficulty Accessing Healthcare in Past Year (Composite)	46.9	35.4	44.7		43.2		42.1
% Difficulty Finding Physician in Past Year	16.1	17.4	16.4		13.4		12.0
% Difficulty Getting Appointment in Past Year	24.5	20.9	23.9		17.5		23.7
% Cost Prevented Physician Visit in Past Year	17.7	4.5	15.2	11.3	15.4		13.5

Access to Health Services (continued)	Each Sub-Area vs. Others		SPH Service Area	SPH Service Area vs. Benchmarks			TREND
	Lewis and Clark County	Other Counties		vs. MT	vs. US	vs. HP2020	
% Transportation Hindered Dr Visit in Past Year	6.5	5.8	6.4		8.3		3.2
% Inconvenient Hrs Prevented Dr Visit in Past Year	13.6	7.4	12.4		12.5		12.3
% Language/Culture Prevented Care in Past Year	0.0	0.0	0.0		1.2		
% Cost Prevented Getting Prescription in Past Year	10.5	6.1	9.7		14.9		10.9
% Skipped Prescription Doses to Save Costs	12.0	9.0	11.4		15.3		11.0
% Difficulty Getting Child's Healthcare in Past Year			1.9		5.6		4.9
Primary Care Doctors per 100,000	88.1	77.0	84.9	81.9	87.8		80.3
% Have a Specific Source of Ongoing Care	82.9	83.9	83.1		74.1	95.0	78.6
% Have Had Routine Checkup in Past Year	64.9	63.3	64.6	65.6	68.3		62.6
% Child Has Had Checkup in Past Year			77.0		87.1		71.6

Access to Health Services (continued)	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
% Two or More ER Visits in Past Year	9.7	4.8	8.8		9.3		6.7
% Rate Local Healthcare "Fair/Poor"	21.7	18.8	21.1		16.2		23.9
Live in a Health Professional Shortage Area (Percent)	0.0	27.1	7.9	44.6	33.1		
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Cancer	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
Cancer (Age-Adjusted Death Rate)	155.8	160.8	158.6	153.0	158.5	161.4	175.9
Lung Cancer (Age-Adjusted Death Rate)			41.9	38.2	40.3	45.5	
Prostate Cancer (Age-Adjusted Death Rate)			26.5	21.5	19.0	21.8	
Female Breast Cancer (Age-Adjusted Death Rate)			19.7	20.0	20.3	20.7	
Colorectal Cancer (Age-Adjusted Death Rate)			15.1	14.1	14.1	14.5	

Cancer (continued)	Each Sub-Area vs. Others		SPH Service Area	SPH Service Area vs. Benchmarks			TREND
	Lewis and Clark County	Other Counties		vs. MT	vs. US	vs. HP2020	
Female Breast Cancer Incidence Rate	107.2	107.7	107.3	123.1	123.5		
Prostate Cancer Incidence Rate	105.7	99.8	103.7	116.6	114.8		
Lung Cancer Incidence Rate	58.4	67.5	61.1	56.8	61.2		
Colorectal Cancer Incidence Rate	40.3	48.7	42.6	39.1	39.8		
% Cancer (Other Than Skin)	9.9	10.5	10.0	8.6	7.1		4.8
% Skin Cancer	13.0	16.6	13.7	7.2	8.5		10.4
% “Always” Use Sunscreen Outside on a Sunny Day	17.3	9.9	15.9				19.5
% [Women 40+] Mammogram in Past 2 Years	71.1	66.4	70.1	66.7	71.5		78.3
% [Women 50-74] Mammogram in Past 2 Years			74.2	73.9	77.0	81.1	78.6
% [Age 50-75] Colorectal Cancer Screening	76.1	70.6	74.9	62.1	76.4	70.5	73.2

Dementias, Including Alzheimer's Disease	Each Sub-Area vs. Others		SPH Service Area	SPH Service Area vs. Benchmarks			TREND
	Lewis and Clark County	Other Counties		vs. MT	vs. US	vs. HP2020	
Alzheimer's Disease (Age-Adjusted Death Rate)			18.6	20.8	28.4		17.6
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Diabetes	Each Sub-Area vs. Others		SPH Service Area	SPH Service Area vs. Benchmarks			TREND
	Lewis and Clark County	Other Counties		vs. MT	vs. US	vs. HP2020	
Diabetes (Age-Adjusted Death Rate)	12.4	19.8	14.6	22.4	21.1	20.5	20.5
% Diabetes/High Blood Sugar	9.6	7.5	9.2	8.1	13.3		9.1
% Borderline/Pre-Diabetes	4.9	4.6	4.8		9.5		6.5
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	48.8	43.9	47.9		50.0		52.7
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Health Education & Outreach	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
% [Employed] Workplace Offers Workplace Wellness Program			66.6				56.4
% [Employed] Participated in Workplace Wellness Prgm/Past Yr			55.6				54.6
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Heart Disease & Stroke	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	129.8	159.3	138.6	152.7	167.0	156.9	176.1
Stroke (Age-Adjusted Death Rate)	28.8	36.6	31.0	34.2	37.1	34.8	35.4
% Heart Disease (Heart Attack, Angina, Coronary Disease)	4.1	5.4	4.3		8.0		6.2
% Stroke			1.9	3.2	4.7		1.5
% Told Have High Blood Pressure (Ever)	30.5	42.3	32.7	29.1	37.0	26.9	33.5
% [HBP] Taking Action to Control High Blood Pressure	93.7	89.4	92.8		93.8		94.1

Heart Disease & Stroke (continued)	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	vs. US	vs. HP2020	TREND
% Cholesterol Checked in Past 5 Years	84.7	85.7	84.9	74.6	85.1	82.1	87.9
% Told Have High Cholesterol (Ever)	29.7	34.4	30.6	33.1	36.2	13.5	28.5
% [HBC] Taking Action to Control High Blood Cholesterol	87.9	85.8	87.4		87.3		85.9
% 1+ Cardiovascular Risk Factor	84.7	89.9	85.7		87.2		78.1
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

HIV	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	vs. US	vs. HP2020	TREND
HIV Prevalence Rate	34.5	101.2	44.6	46.4	353.2		
% [Age 18-44] HIV Test in the Past Year			23.3		24.7		7.3
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Immunization & Infectious Diseases	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	vs. US	vs. HP2020	TREND
% [Age 65+] Flu Vaccine in Past Year			72.0	57.3	76.8	70.0	59.8
% [High-Risk 18-64] Flu Vaccine in Past Year			59.5		55.7	70.0	55.8
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Infant Health & Family Planning	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	vs. US	vs. HP2020	TREND
Low Birthweight Births (Percent)	8.4	8.3	8.4	7.3	8.2	7.8	8.5
Infant Death Rate			4.8	5.7	5.9	6.0	5.9
Births to Teenagers Under Age 20 (Percent)	34.7	24.6	31.8	34.8	36.6		
% [Parents] Child Was Ever Breastfed or Fed Breastmilk			88.2				81.7
% [Parents] Would Want a Newborn to Receive All Vaccinations			89.3				92.2
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Injury & Violence	Each Sub-Area vs. Others		SPH Service Area	SPH Service Area vs. Benchmarks			TREND
	Lewis and Clark County	Other Counties		vs. MT	vs. US	vs. HP2020	
Unintentional Injury (Age-Adjusted Death Rate)	57.5	66.4	59.5	54.3	43.7	36.4	60.7
Motor Vehicle Crashes (Age-Adjusted Death Rate)	11.7	27.2	15.6	18.5	11.0	12.4	
[65+] Falls (Age-Adjusted Death Rate)			157.3	83.5	60.6	47.0	
% [Age 45+] Fell in the Past Year	45.3	49.5	46.2		31.6		
Firearm-Related Deaths (Age-Adjusted Death Rate)			17.3	18.1	11.1	9.3	
Homicide (Age-Adjusted Death Rate)			2.5	3.4	5.6	5.5	
Violent Crime Rate	320.9	250.9	300.9	297.6	379.7		
% Victim of Violent Crime in Past 5 Years	1.0	1.7	1.2		3.7		2.6
% Victim of Domestic Violence (Ever)	13.5	18.0	14.3		14.2		14.2
% Firearm in Home	66.4	82.0	69.4		32.7		69.8
% [Homes With Firearms] Weapon(s) Unlocked & Loaded	18.3	32.3	21.5		26.9		17.8

Injury & Violence (continued)	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
% [Homes With Children] Firearm in Home			74.5		39.1		77.2
% "Always" Wear Seat Belt	82.2	68.4	79.6			92.0	75.7
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat			97.3		85.6		93.2
% “Always” Use a Helmet When Riding a Motorcycle			62.5				56.3
% “Always” Use a Helmet When Riding a Bicycle	36.1	33.0	35.5				42.7
% Child [Age 5-17] "Always" Wears Bicycle Helmet			55.4		48.8		51.0
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Kidney Disease	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
Kidney Disease (Age-Adjusted Death Rate)			6.5	10.1	13.2		8.7
% Kidney Disease	2.3	0.0	1.9	2.5	3.8		4.3

Mental Health	Each Sub-Area vs. Others		SPH Service Area	SPH Service Area vs. Benchmarks			TREND
	Lewis and Clark County	Other Counties		vs. MT	vs. US	vs. HP2020	
% "Fair/Poor" Mental Health	13.0	5.6	11.6		13.0		9.3
% Diagnosed Depression	24.8	23.1	24.5	19.5	21.6		16.8
% Symptoms of Chronic Depression (2+ Years)	27.8	22.0	26.7		31.4		23.8
% Typical Day Is "Extremely/Very" Stressful	10.2	10.6	10.3		13.4		13.8
Suicide (Age-Adjusted Death Rate)	21.9	27.7	23.3	25.0	13.0	10.2	16.5
% Taking Rx/Receiving Mental Health Trtmt	19.6	10.5	17.9		13.9		
% Have Ever Sought Help for Mental Health	42.5	23.7	38.9		30.8		25.4
% [Those With Diagnosed Depression] Seeking Help			88.1		87.1		85.7
% Unable to Get Mental Health Svcs in Past Yr	6.6	3.6	6.1		6.8		
% Feeling Isolated From Others	21.5	11.1	19.5				
% Feeling Left Out	24.9	13.0	22.7				

Mental Health (continued)	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	vs. US	vs. HP2020	TREND
% Feeling A Lack of Companionship	23.2	18.8	22.4				
% Lonely	15.8	9.1	14.5				
% Average <7 Hours of Sleep per Night	33.5	36.3	34.0		36.7		31.5
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Nutrition, Physical Activity & Weight	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	vs. US	vs. HP2020	TREND
% Food Insecure	14.0	14.3	14.0		27.9		
% "Very/Somewhat" Difficult to Buy Fresh Produce	11.5	19.0	12.9		22.1		18.1
Population With Low Food Access (Percent)	19.0	23.1	20.2	24.3	22.4		
% No Leisure-Time Physical Activity	20.9	26.2	21.9	19.9	26.2	32.6	17.0
% Meeting Physical Activity Guidelines	31.9	33.1	32.1	24.5	22.8	20.1	

Nutrition, Physical Activity & Weight (continued)	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	vs. US	vs. HP2020	TREND
Recreation/Fitness Facilities per 100,000	20.5	11.6	17.9	15.1	10.5		
% Overweight (BMI 25+)	68.0	63.7	67.2	62.7	67.8		58.2
% Healthy Weight (BMI 18.5-24.9)	30.8	34.8	31.6	35.3	30.3	33.9	41.4
% Obese (BMI 30+)	29.9	28.8	29.7	25.5	32.8	30.5	21.3
% Medical Advice on Weight in Past Year	18.1	16.0	17.7		24.2		19.0
% [Overweights] Counseled About Weight in Past Year	21.4	20.8	21.3		29.0		24.6
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Oral Health	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	vs. US	vs. HP2020	TREND
% Have Dental Insurance	68.8	68.9	68.8		59.9		64.1
% [Age 18+] Dental Visit in Past Year	74.5	78.0	75.2	65.5	59.7	49.0	71.3
% Child [Age 2-17] Dental Visit in Past Year			93.4		87.0	49.0	88.1

Potentially Disabling Conditions	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
% Multiple Chronic Conditions	54.3	63.7	56.1		56.8		
% [50+] Arthritis/Rheumatism	39.2	32.7	37.7		38.3		29.3
% [50+] Osteoporosis	11.5	4.9	10.1		9.4	5.3	6.7
% Sciatica/Chronic Back Pain	26.5	28.5	26.9		22.9		23.3
% Eye Exam in Past 2 Years	62.6	63.3	62.7		55.3		60.4
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Respiratory Diseases	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
CLRD (Age-Adjusted Death Rate)	45.1	37.8	43.0	50.8	40.9		56.2
Pneumonia/Influenza (Age-Adjusted Death Rate)	12.1	18.6	14.2	12.8	14.6		13.7
% [Adult] Currently Has Asthma	13.1	16.1	13.7	8.6	11.8		8.4

Respiratory Diseases (continued)	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
% Adults Asthma (Ever Diagnosed)	18.8	20.6	19.1	12.8	19.4		13.8
% [Child 0-17] Currently Has Asthma			7.6		9.3		4.2
% Child [Age 0-17] Asthma (Ever Diagnosed)			8.9		11.1		7.7
% COPD (Lung Disease)	13.9	11.5	13.4	7.5	8.6		7.8
% Use a Wood-Burning Stove to Heat the Home	22.6	37.1	25.3				22.1
% [Respondents with Stoves] Stove is EPA-Certified			71.0				
% Do Not Think Wood Smoke Poses a Serious Health Issue	36.2	56.0	39.9				41.1

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

	vs. MT	vs. US	vs. HP2020
	better	similar	worse

Sexually Transmitted Diseases	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
Chlamydia Incidence Rate	349.0	221.9	312.7	412.9	456.1		
Gonorrhea Incidence Rate	6.1	23.0	10.9	42.8	110.7		
% [Unmarried 18-64] 3+ Sexual Partners in Past Year			6.8		13.8		10.1
% [Unmarried 18-64] Using Condoms			26.4		39.4		29.7
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Substance Abuse	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)			8.3	7.9	14.3	11.3	7.3
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)			10.3	13.8	10.6	8.2	11.1
% Current Drinker	62.8	58.5	62.0		55.0		63.6
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	18.9	17.0	18.6	18.9	20.0	24.4	16.3

Substance Abuse (continued)	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
% Excessive Drinker	23.3	21.0	22.8		22.5	25.4	19.7
% Drinking & Driving in Past Month	1.8	5.3	2.5	4.7	5.2		3.7
% Took Prescription Drugs On Own in Past Year	2.9	3.6	3.1				
% Illicit Drug Use in Past Month	3.0	0.9	2.6		2.5	7.1	1.0
% Difficulty Finding Help for Drug/Alcohol Problem/Past 12 Mos	1.0	0.0	0.8				
% Life Negatively Affected by Substance Abuse	41.2	41.7	41.3		37.3		

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

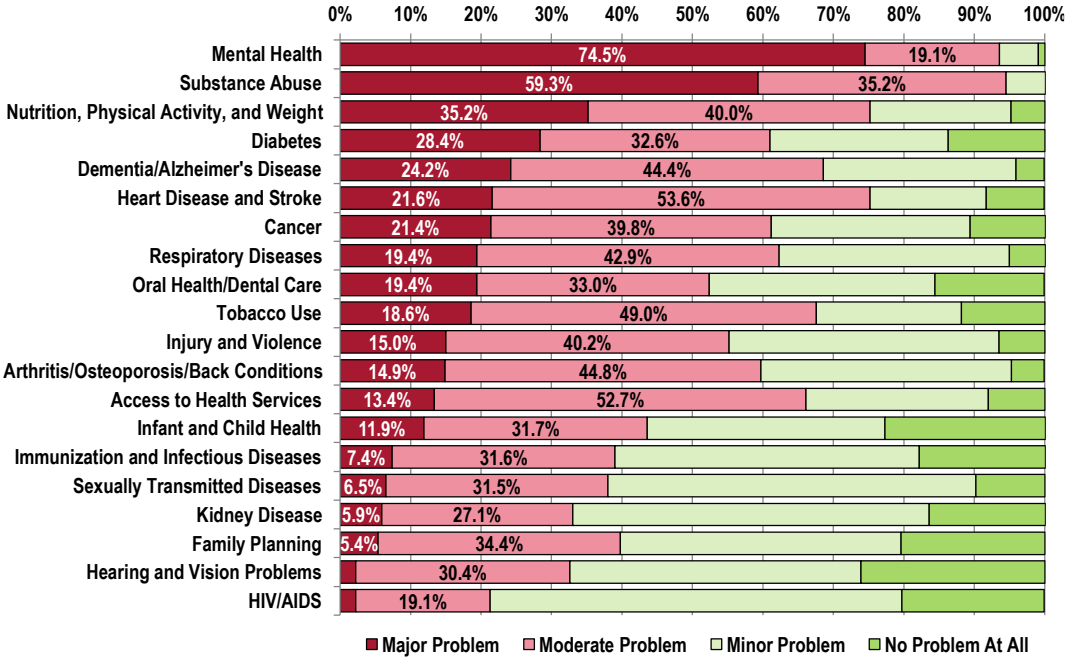
	better	similar	worse

Tobacco Use	Each Sub-Area vs. Others: Lewis and Clark County	Each Sub-Area vs. Others: Other Counties	SPH Service Area	SPH Service Area vs. Benchmarks: vs. MT	SPH Service Area vs. Benchmarks: vs. US	SPH Service Area vs. Benchmarks: vs. HP2020	TREND
% Current Smoker			17.8				
% Someone Smokes at Home	9.8	11.3	10.1				
% [Nonsmokers] Someone Smokes in the Home	3.2	4.0	3.4				
% [Household With Children] Someone Smokes in the Home			7.4				
% [Smokers] Have Quit Smoking 1+ Days in Past Year			49.6				
% [Smokers] Received Advice to Quit Smoking			54.6				
% Currently Use Vaping Products	6.5	0.7	5.4	4.1	3.8		
	Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.			better	similar	worse	

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 20 health issues is a problem in their own community, using a scale of "major problem," "moderate problem," "minor problem," or "no problem at all." The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)

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



Community Description

Professional Research Consultants, Inc.

Population Characteristics

Total Population

The five counties that contain the SPH Service Area (the focus of this Community Health Needs Assessment) encompass over 11,000 square miles and houses a total population of 92,170 residents, according to latest census estimates.

Total Population

(Estimated Population, 2012-2016)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Lewis and Clark County	65,989	3,458.54	19.08
Other Counties	26,181	7,567.11	3.46
SPH Service Area	92,170	11,025.66	8.36
Montana	1,023,391	145,546.98	7.03
United States	318,558,162	3,532,068.58	90.19

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2018 from Community Commons at http://www.chna.org.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Population Change 2000-2010

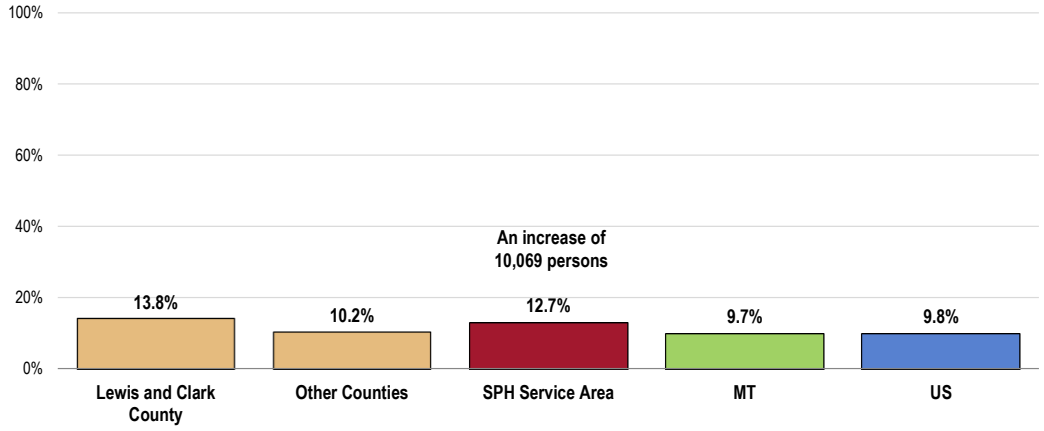
A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, the population of the SPH Service Area increased by 10,069 persons, or 12.7%.

- Proportionally similar to the increase seen across both the state and the nation.

Change in Total Population

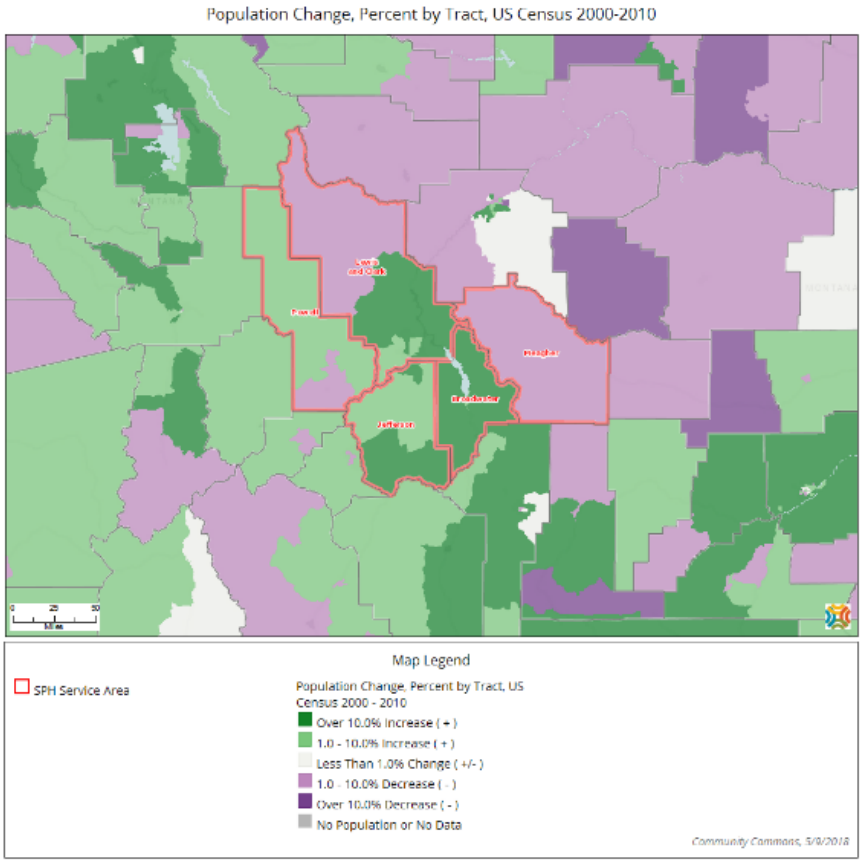
(Percentage Change Between 2000 and 2010)



Sources:
- Retrieved April 2018 from Community Commons at http://www.chna.org.
- US Census Bureau Decennial Census (2000-2010).

Notes:
- A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Note that the largest percent of population growth appears to have been in Broadwater County, as well as the southern areas of both Jefferson and Lewis and Clark counties.



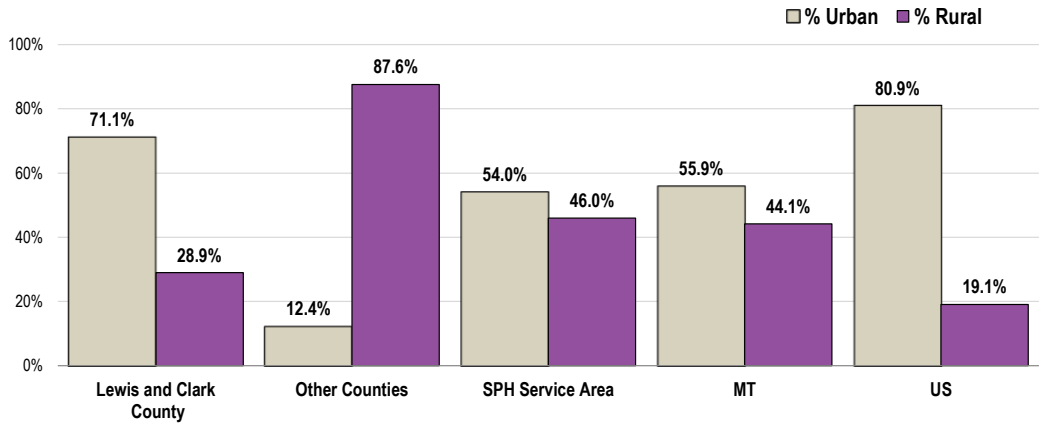
Urban/Rural Population

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 SPH Service Area is slightly more urban than rural, with 54.0% of the population living in areas designated as urban.

- Note the drastic difference by county areas.

Urban and Rural Population
(2010)

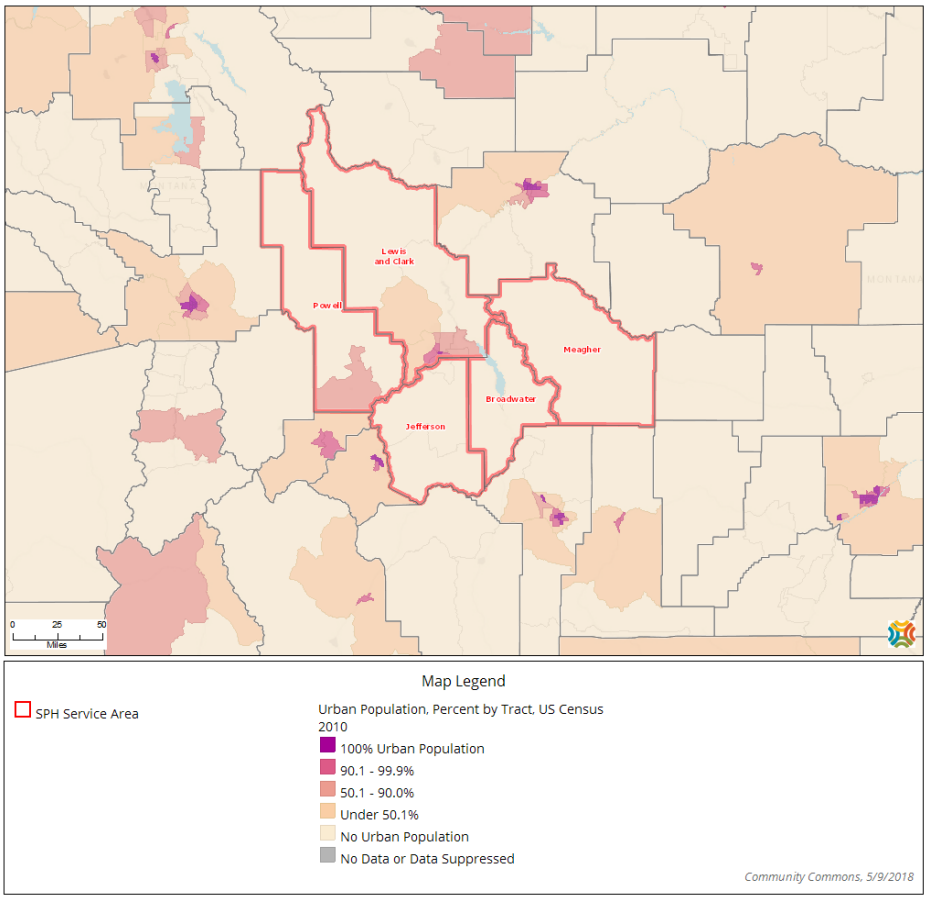


Sources:
- US Census Bureau Decennial Census (2010).
- Retrieved April 2018 from Community Commons at http://www.chna.org.

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

- Note the following map, outlining the urban population in SPH Service Area census tracts as of 2010.

Urban Population, Percent by Tract, US Census 2010



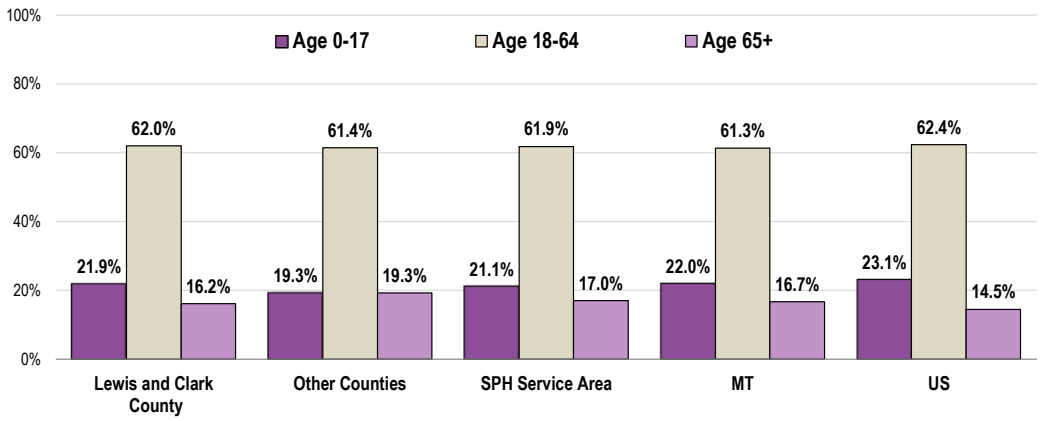
Age

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

In the SPH Service Area, 21.1% of the population are infants, children, or adolescents (age 0-17); another 61.9% are age 18 to 64, while 17.0% are age 65 and older.

- The percentage of older adults (65+) is almost identical to that found statewide and higher than the US figure.

Total Population by Age Groups, Percent
(2012-2016)



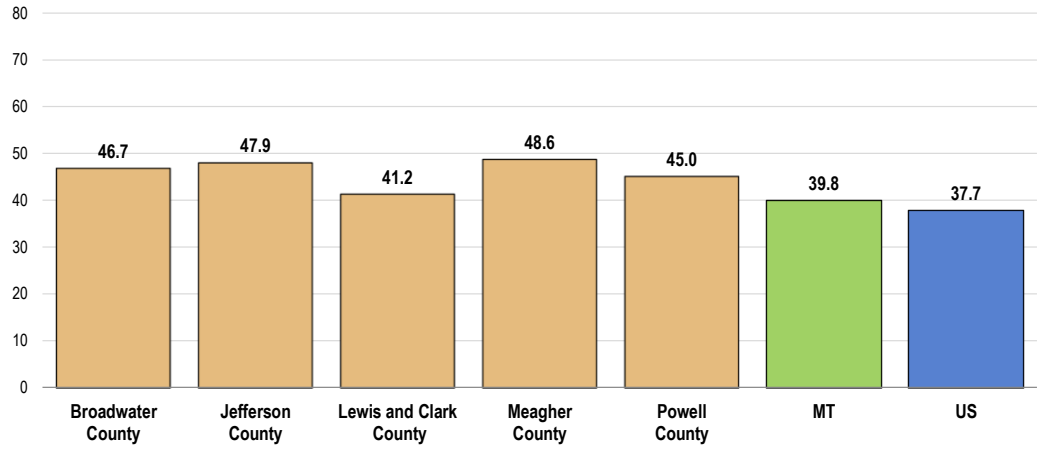
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2018 from Community Commons at http://www.chna.org.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Median Age

The SPH Service Area is "older" than the state and the nation in that the median age is higher.

- Highest in Meagher County and lowest in Lewis and Clark County.

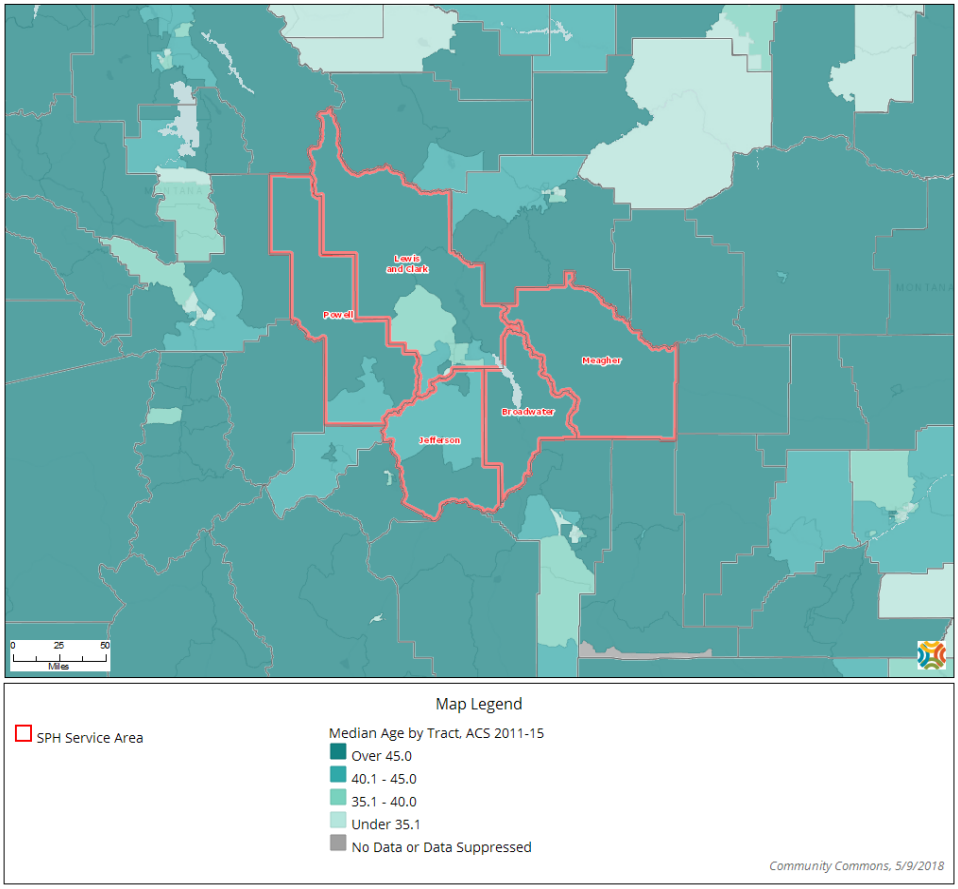
Median Age
(2012-2016)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

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

Median Age by Tract, ACS 2011-2015



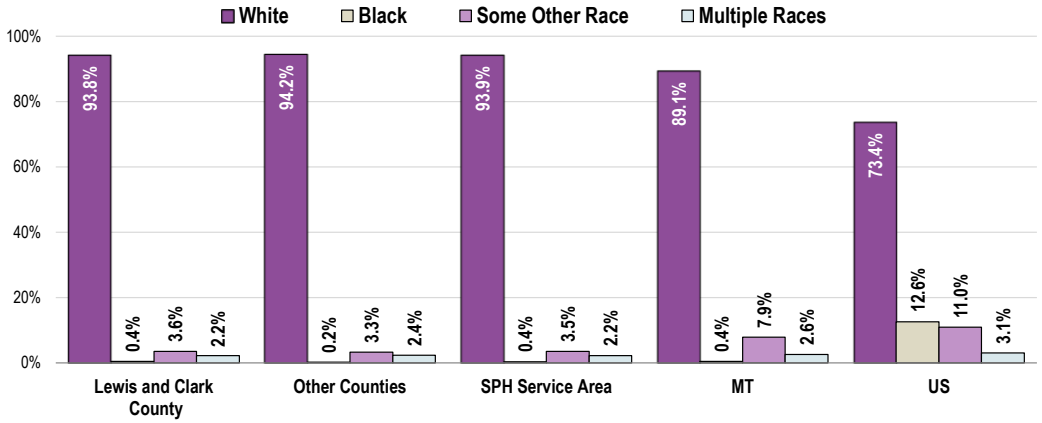
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 93.9% of residents of SPH Service Area are White.

- This is generally similar to the state racial distribution.
- Nationally, the US population is less White, more Black, more "other" race, and more multi-race.

Total Population by Race Alone, Percent
(2012-2016)



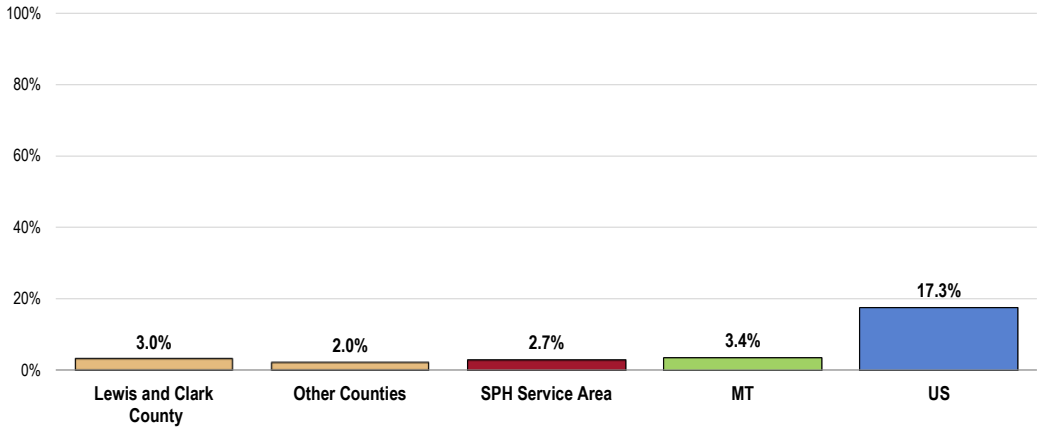
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2018 from Community Commons at http://www.chna.org.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Ethnicity

A total of 2.7% of SPH Service Area residents are Hispanic or Latino.

- Similar to state findings.
- Much lower than the nationwide percentage.

Hispanic Population
(2012-2016)

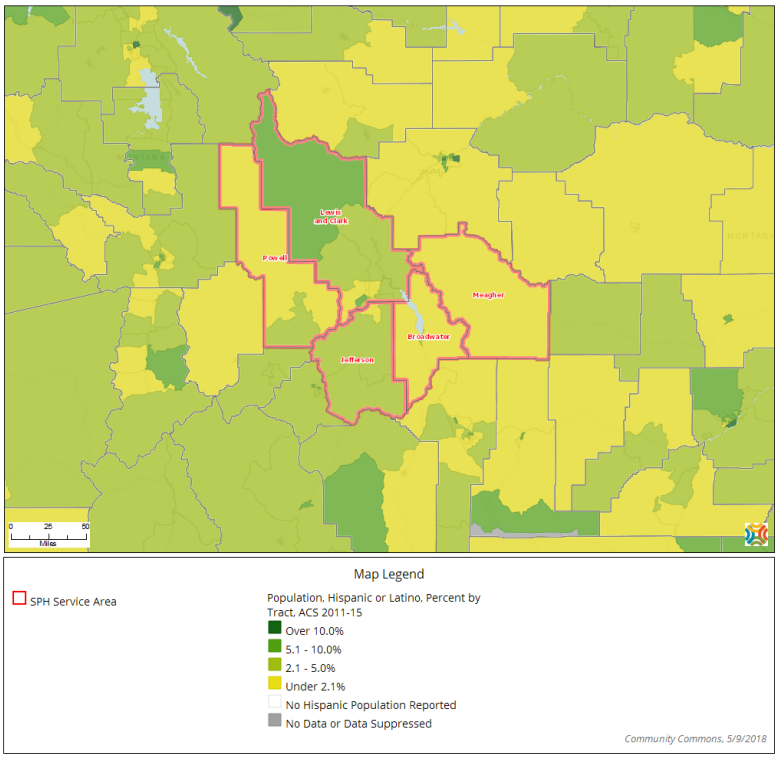


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

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.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- The Hispanic population appears to be most concentrated in the northern part of Lewis and Clark County.

Population Hispanic or Latino, Percent by Tract, ACS 2011-2015

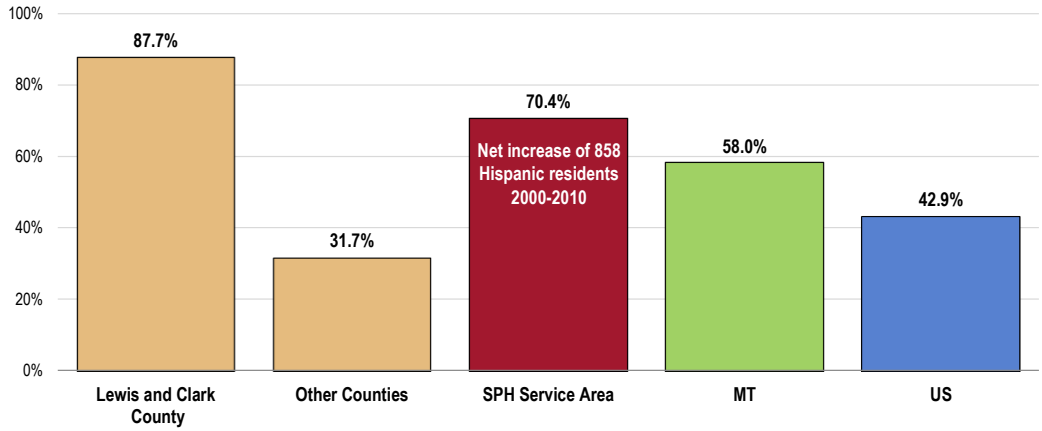


Between 2000 and 2010, the Hispanic population in the SPH Service Area increased by 858, or 70.4%.

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

Hispanic Population Change

(Percentage Change in Hispanic Population Between 2000 and 2010)



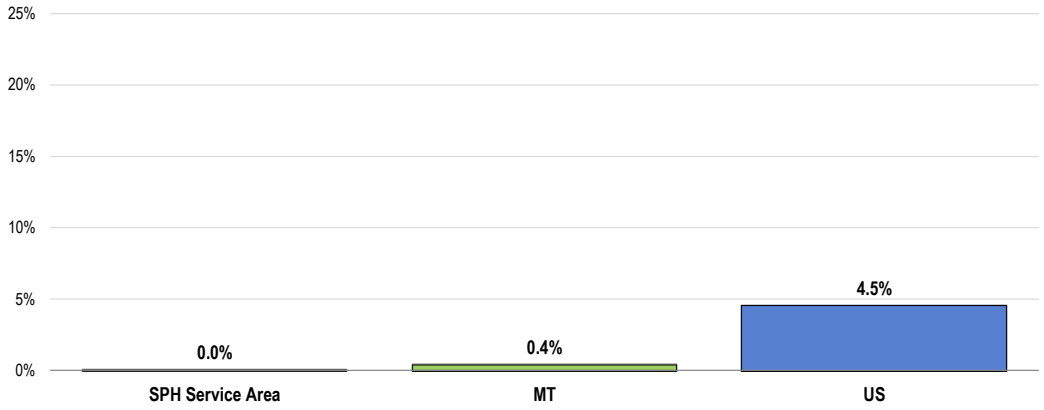
Sources:
- US Census Bureau Decennial Census (2000-2010).
- Retrieved April 2018 from Community Commons at http://www.chna.org.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Linguistic Isolation

Census data show no population in the SPH Service Area population age 5 and older who 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 found statewide and (especially) nationwide.

Linguistically Isolated Population
(2012-2016)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

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

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

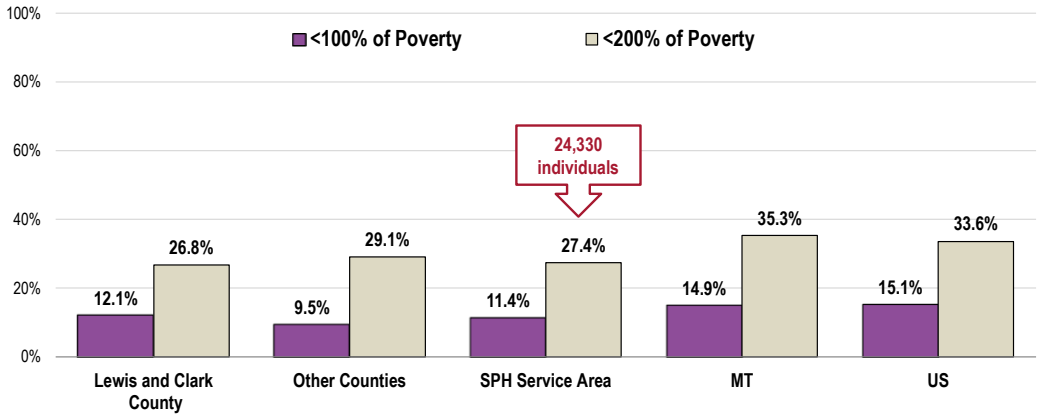
The latest census estimate shows 11.4% of the SPH Service Area population living below the federal poverty level.

In all, 27.4% of SPH Service Area residents (an estimated 24,330 individuals) live below 200% of the federal poverty level.

- Lower than the proportions reported statewide and nationally.

Population in Poverty

(Populations Living Below 100% and Below 200% of the Poverty Level; 2012-2016)

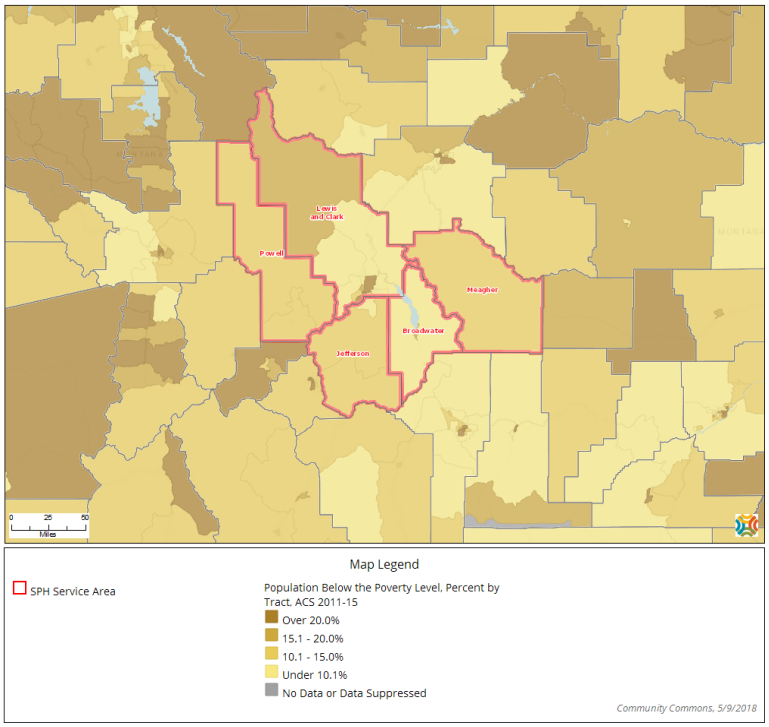


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

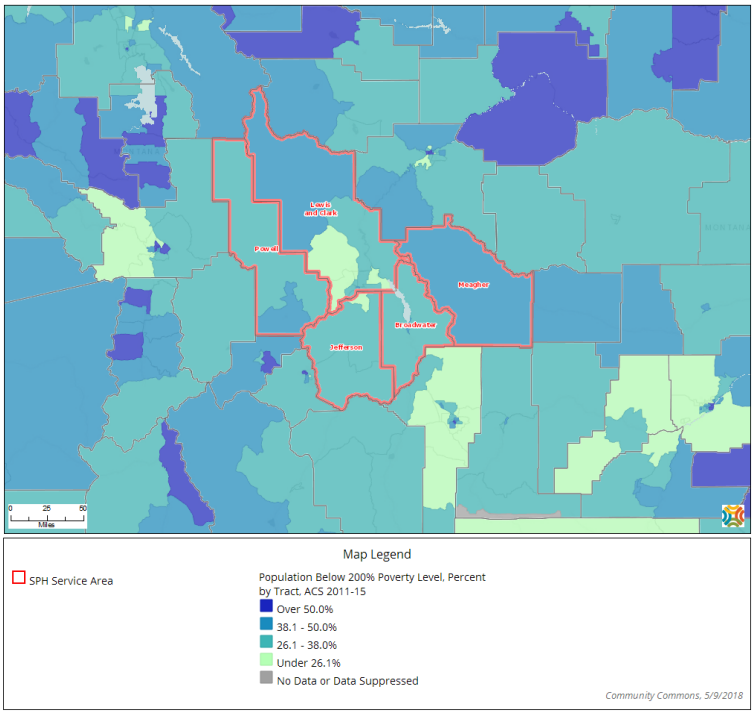
Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- A higher concentration of persons living below the 100% and 200% poverty thresholds is found in the northern area of Lewis and Clark County.

Population Below the Poverty Level, Percent by Tract, ACS 2011-2015



Population Below 200% of Poverty, Percent by Tract, ACS 2011-2015



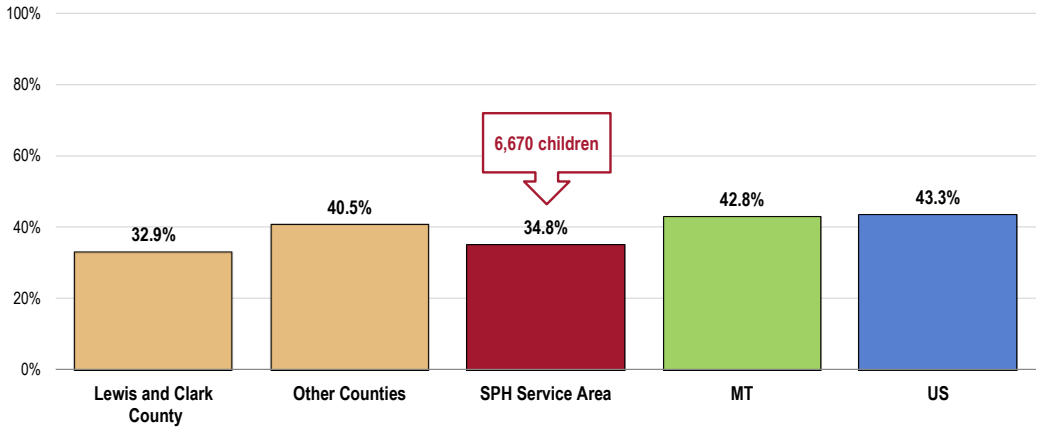
Children in Low-Income Households

Additionally, 34.8% of SPH Service Area children age 0-17 (representing an estimated 6,670 children) live below the 200% poverty threshold.

- Below the proportion found statewide and nationally.
- Children in the Other Counties area are more likely to live below the 200% of the poverty level.

Percent of Children in Low-Income Households

(Children 0-17 Living Below 200% of the Poverty Level, 2012-2016)

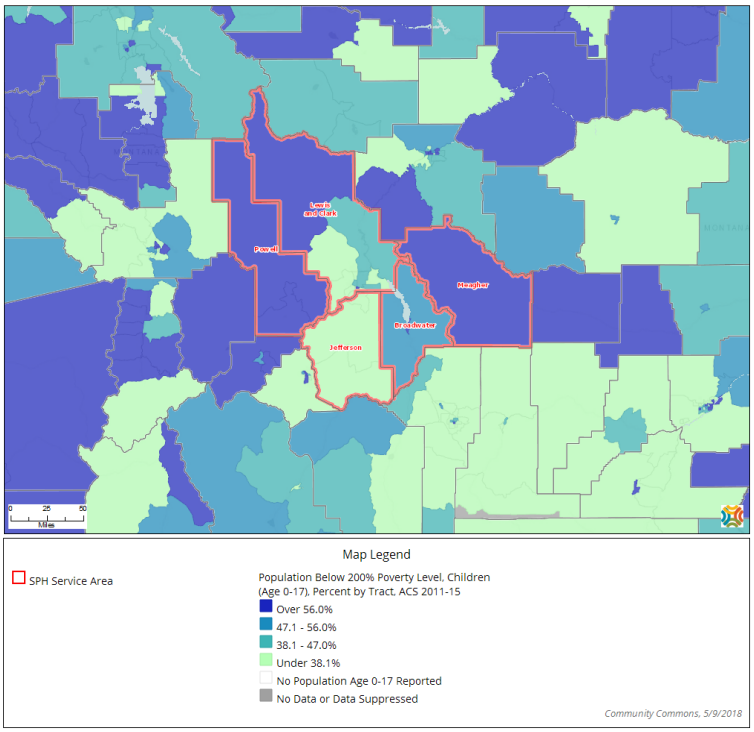


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of children aged 0-17 living in households with income below 200% 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.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Geographically, a notably higher concentration of children in lower-income households is found in the northern part of Lewis and Clark County, as well as all of Meager and Powell counties.

Children (0-17) Living Below 200% of Poverty, Percent by Tract, ACS 2011-2015



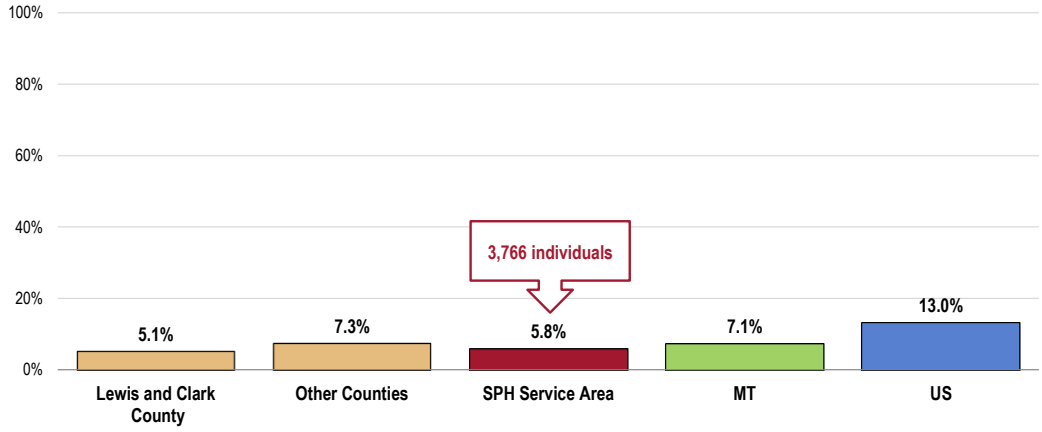
Education

Among the SPH Service Area population age 25 and older, an estimated 5.8% (over 3,700 people) do not have a high school education.

- More favorable than found across the state or nation.

Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2012-2016)

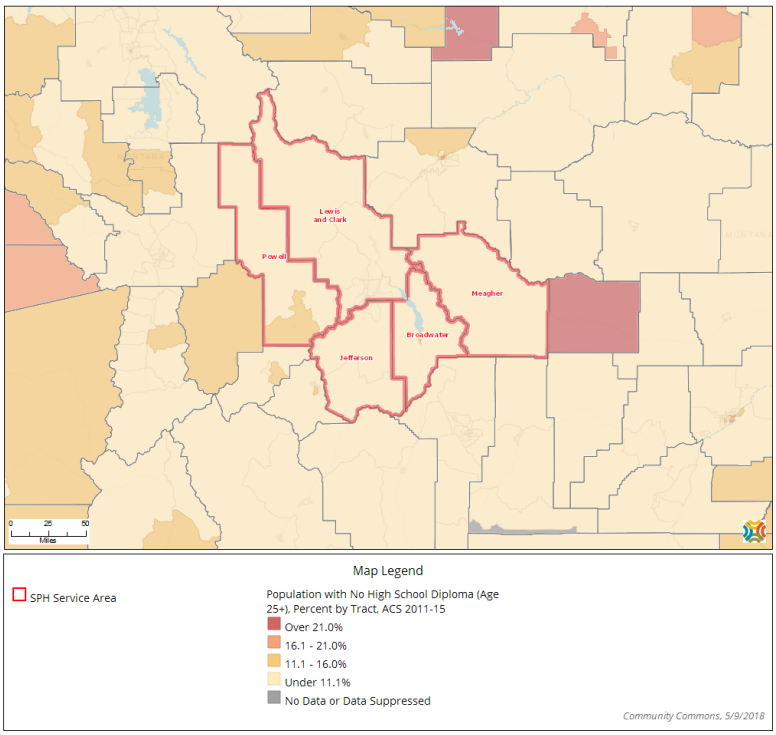


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Geographically, this indicator is more concentrated in the southern part of Powell County.

Population with No High School Diploma, Percent by Tract, ACS 2011-2015



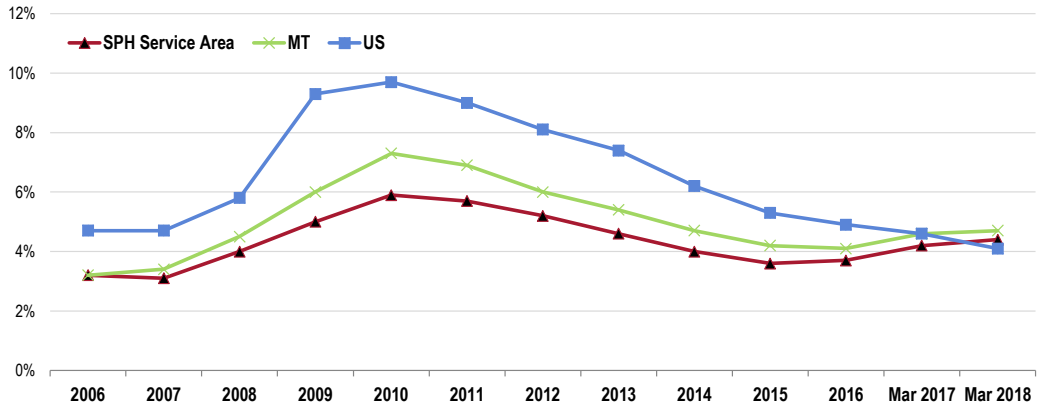
Employment

According to data derived from the US Department of Labor, the unemployment rate in the SPH Service Area as of March 2018 was 4.4%.

- Similar to the statewide and national unemployment rates.
- TREND: Unemployment for the SPH Service Area has trended downward since 2010, echoing the state and national trends.

Unemployment Rate

(Percent of Non-Institutionalized Population Age 16+ Unemployed, Not Seasonally-Adjusted)



Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

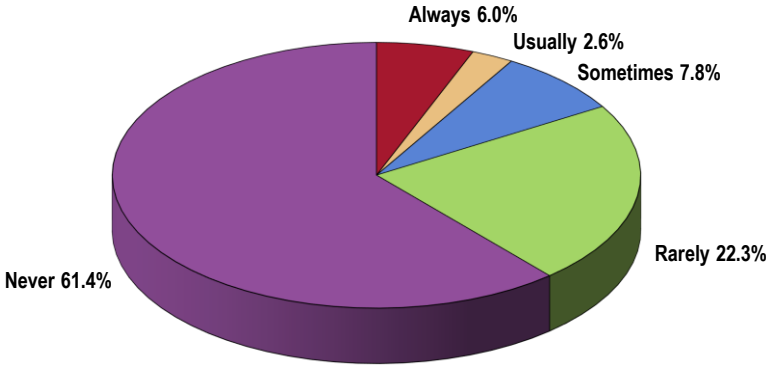
Notes:
- This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

Housing Insecurity

While most surveyed adults rarely, if ever, worry about the cost of housing, a considerable share (16.4%) reported that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

Frequency of Worry or Stress Over Paying Rent/Mortgage in the Past Year

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 71]

Notes:
- Asked of all respondents.

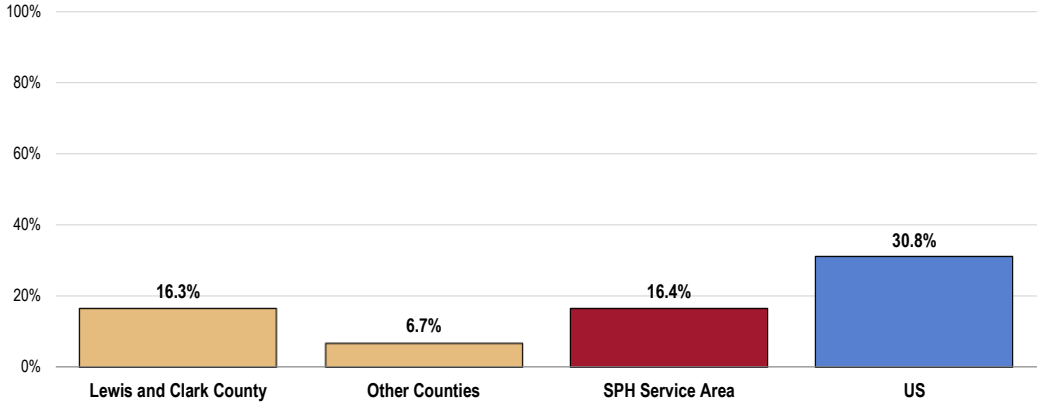
NOTE:

For survey-derived data, differences noted in the text represent significant differences determined through statistical testing.

Where sample sizes permit, community-level data are provided.

- Compared to the US prevalence, the SPH Service Area proportion of adults who worried about paying for rent or mortgage in the past year is more favorable.
- No significant difference by county area.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 71]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

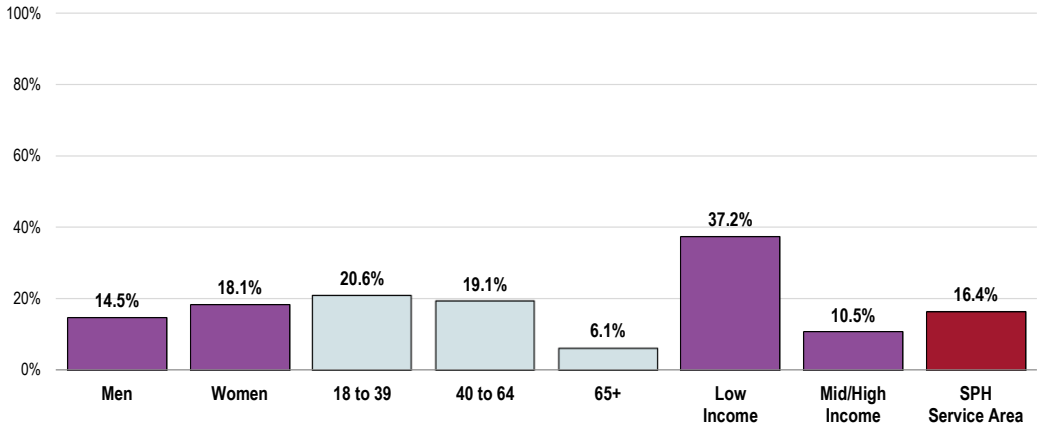
Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Adults more likely to report housing insecurity include those under age 40 (negative correlation with age) and residents living at lower incomes.
- The difference by gender, as illustrated in the following chart, is not statistically significant.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by sex, age groupings, income (based on poverty status), and race/ethnicity.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 71]

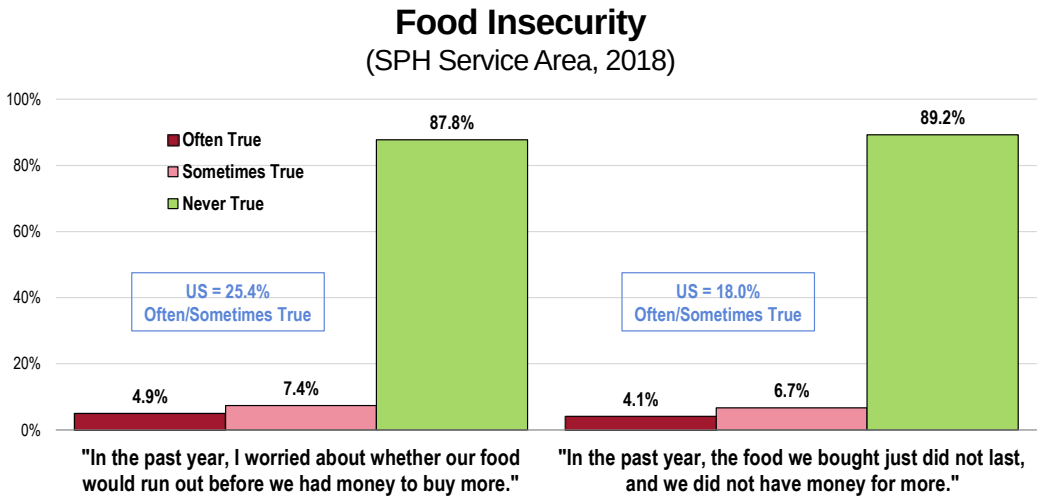
Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Food Insecurity

In the past year, 12.3% of SPH Service Area adults "often" or "sometimes" worried about whether their food would run out before they had money to buy more.

Another 10.8% report a time in the past year ("often" or "sometimes") when the food they bought just did not last, and they did not have money to get more.

- Both percentages are statistically lower than the national prevalence.



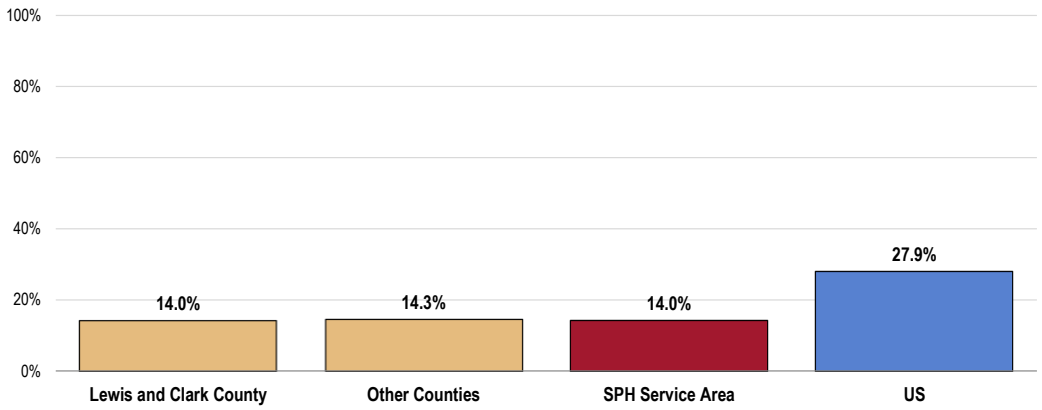
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 87-88]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects the total sample of respondents.

Overall, 14.0% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

- Statistically similar by county area.
- Food insecurity in the SPH Service Area is half the US prevalence.

Food Insecurity

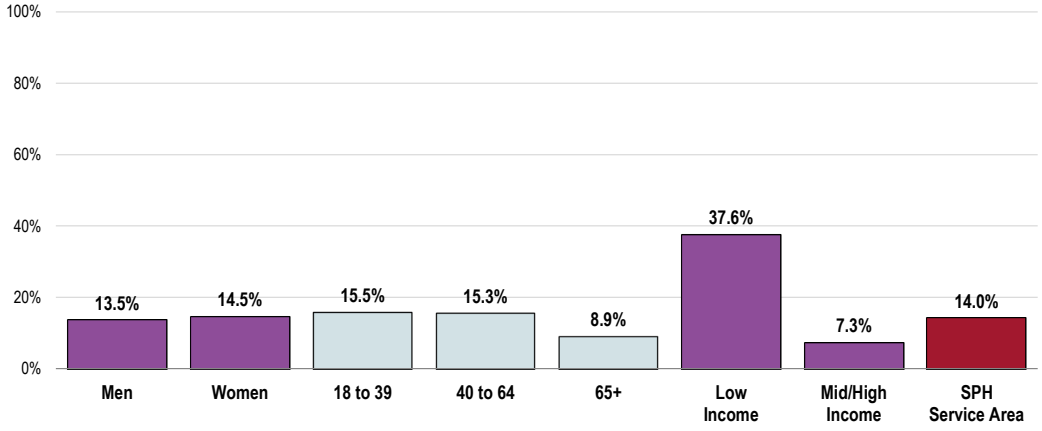


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Adults living at lower incomes are significantly more likely to be affected by food insecurity.

Food Insecurity
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

General Health Status

Professional Research Consultants, Inc.

Overall Health Status

Evaluation of Health Status

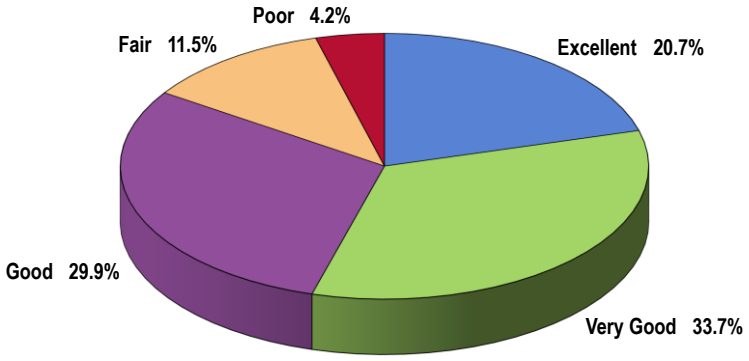
The initial inquiry of the PRC Community Health Survey asked respondents the following:

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

Over half (54.4%) of SPH Service Area adults rate their overall health as "excellent" or "very good."

- Another 29.9% gave "good" ratings of their overall health.

Self-Reported Health Status
(SPH Service Area, 2018)



Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: • Asked of all respondents.

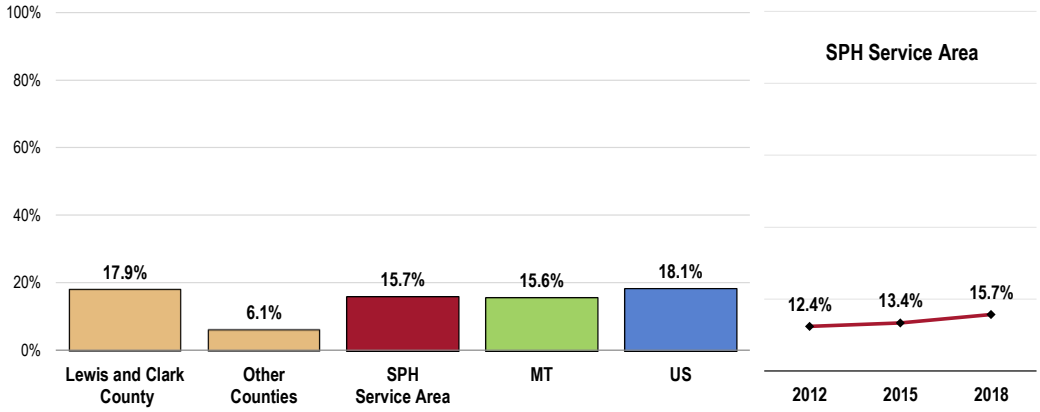
However, 15.7% of SPH Service Area adults believe that their overall health is "fair" or "poor."

- Similar to statewide and national findings.
- Most favorable in the Other Counties area.
- TREND: No statistically significant change has occurred when comparing "fair/poor" overall health reports to previous survey results.

NOTE:

Trends are measured against baseline data – i.e., the earliest year that data are available or that is presented in this report.

Experience "Fair" or "Poor" Overall Health



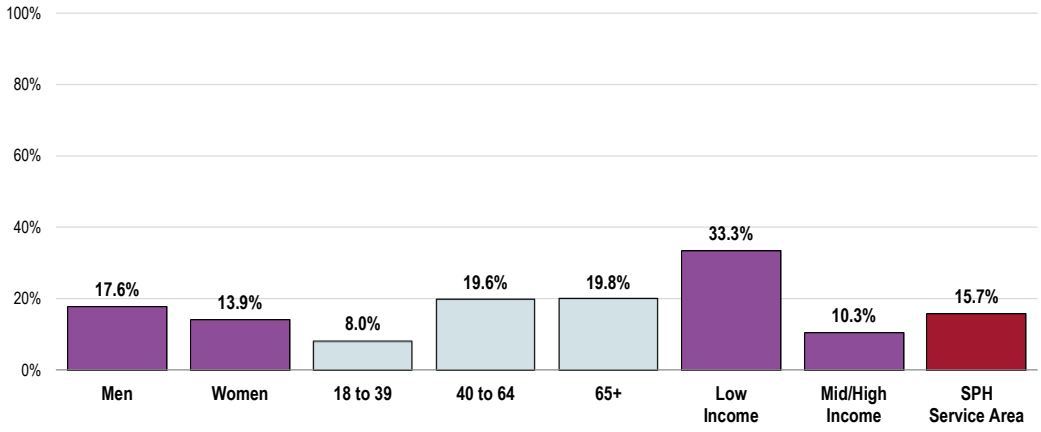
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- One-third of low income adults report experiencing "fair" or "poor" overall health.
- Ratings of "fair/poor" health also increases with age.

Experience "Fair" or "Poor" Overall Health

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

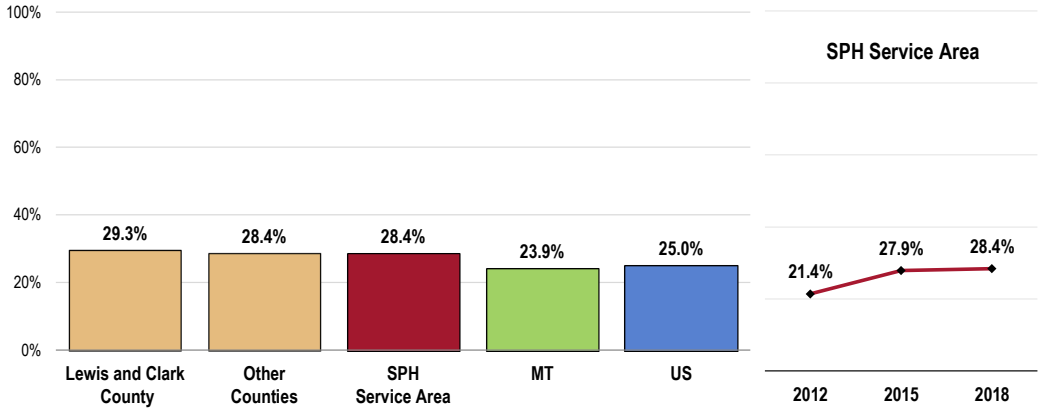
- Healthy People 2020 (www.healthypeople.gov)

A total of 28.4% of SPH Service Area adults are limited in some way in some activities, due to a physical, mental, or emotional problem.

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

- Similar to the state and national prevalence.
- Similar by county area.
- TREND: Marks a statistically significant increase in activity limitations since 2012.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

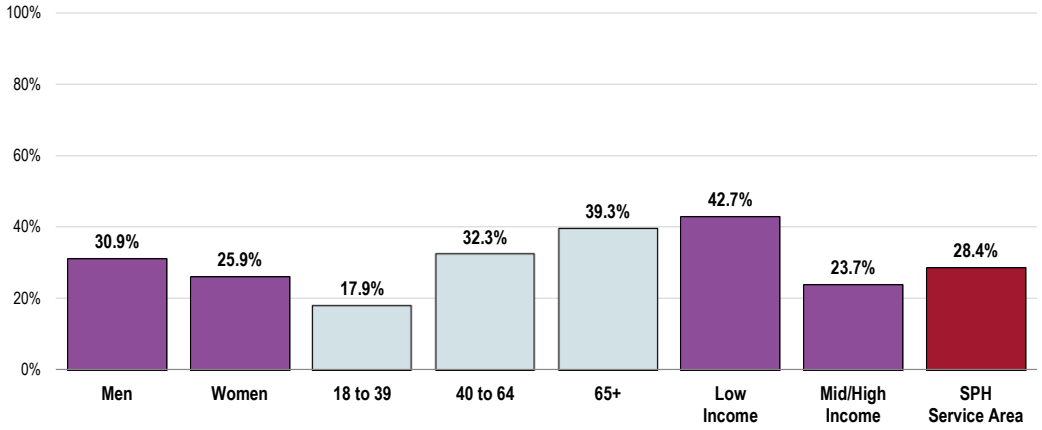
Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

In looking at responses by key demographic characteristics, these adults are statistically more likely to report some type of activity limitation:

- Those age 65 and older (note the positive correlation with age).
- Residents at lower incomes.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem

(SPH Service Area, 2018)



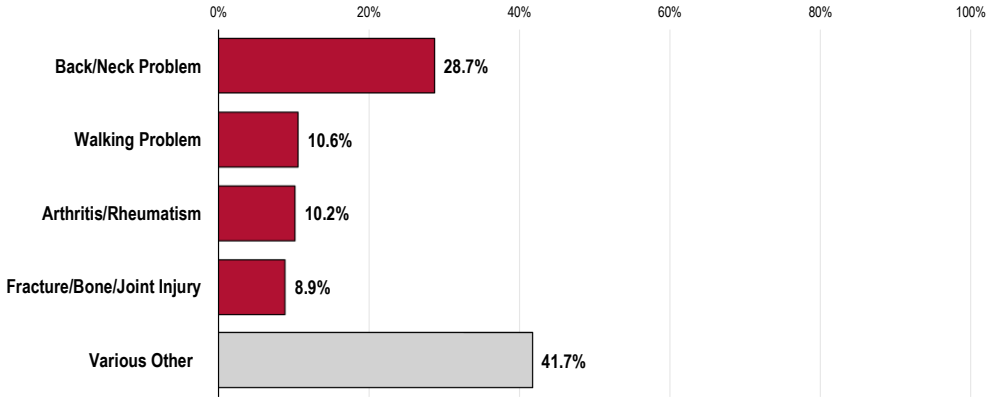
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 109]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Among persons reporting activity limitations, these are most often attributed to musculo-skeletal issues, such as back/neck problems, difficulty walking, arthritis/rheumatism, or fractures or bone/joint injuries.

Type of Problem That Limits Activities

(Among Those Reporting Activity Limitations; SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 110]

Notes:
- Asked of those respondents reporting activity limitations.

Mental Health

About Mental Health & Mental Disorders

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

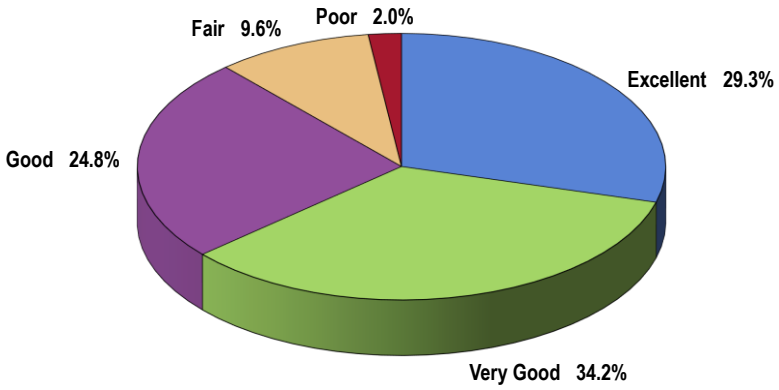
Evaluation of Mental Health Status

"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?"

A total of 63.5% of SPH Service Area adults rate their overall mental health as "excellent" or "very good."

- Another 24.8% gave "good" ratings of their own mental health status.

Self-Reported Mental Health Status
(SPH Service Area, 2018)

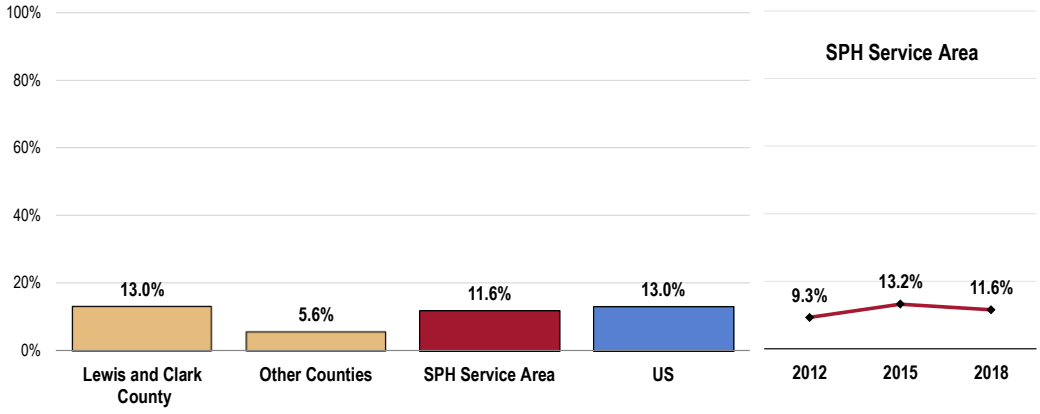


Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]
Notes: • Asked of all respondents.

A total of 11.6% of SPH Service Area adults, however, believe that their overall mental health is "fair" or "poor."

- Similar to the "fair/poor" response reported nationally.
- Highest in Lewis and Clark County.
- TREND: Statistically unchanged since 2012.

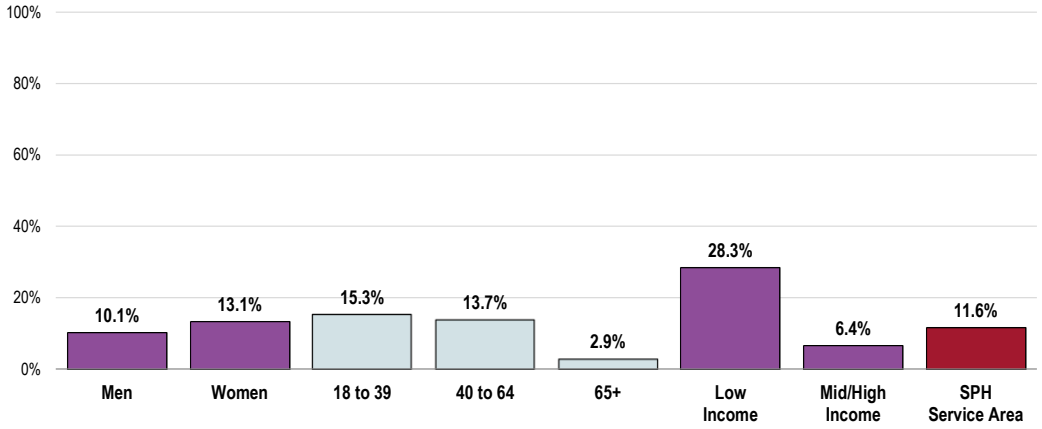
Experience "Fair" or "Poor" Mental Health



Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]
• 2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Note the strong negative correlation between poor mental health with both income and age.

Experience "Fair" or "Poor" Mental Health
(SPH Service Area, 2018)



Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 99]
Notes: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

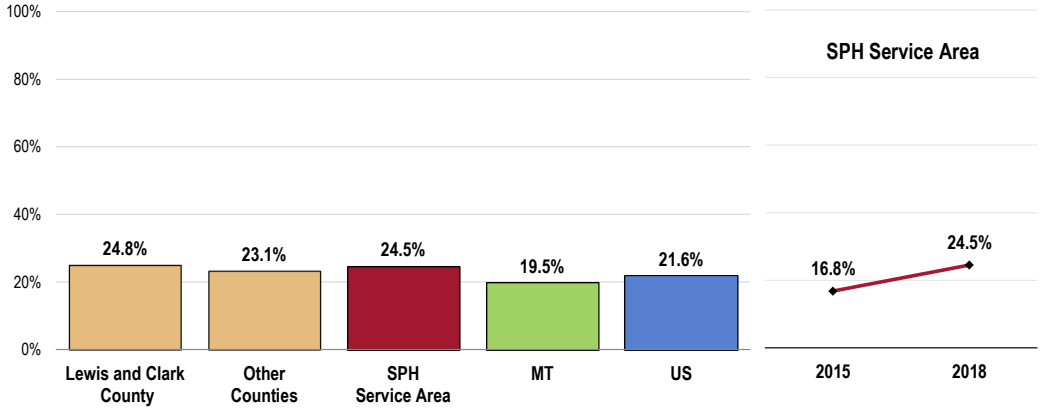
Depression

Diagnosed Depression

One-quarter (24.5%) of SPH Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

- Higher than state findings.
- Comparable to national findings.
- Statistically similar by community.
- TREND: Diagnosed depression among residents in the SPH Service Area has increased over time.

Have Been Diagnosed With a Depressive Disorder



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 102]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

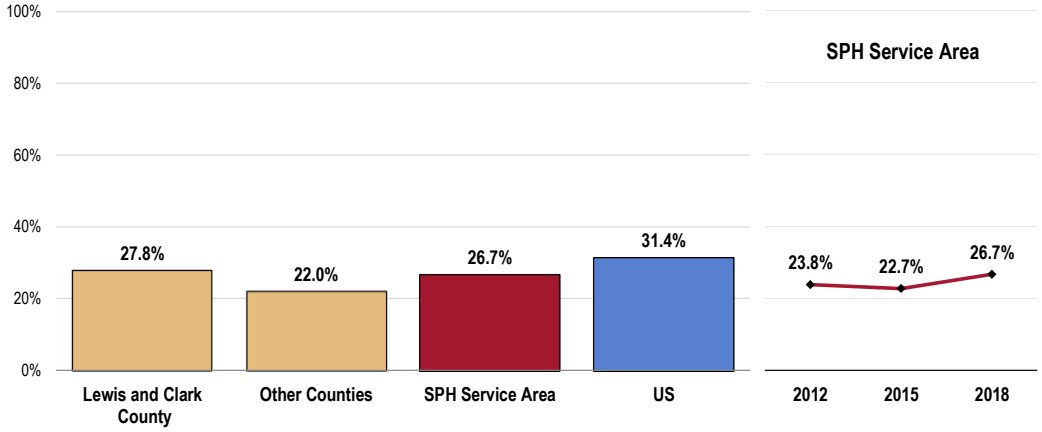
Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Symptoms of Chronic Depression

A total of 26.7% of SPH Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

- Statistically similar to national findings.
- Similar by county area.
- TREND: The increase over time is not significant.

Have Experienced Symptoms of Chronic Depression

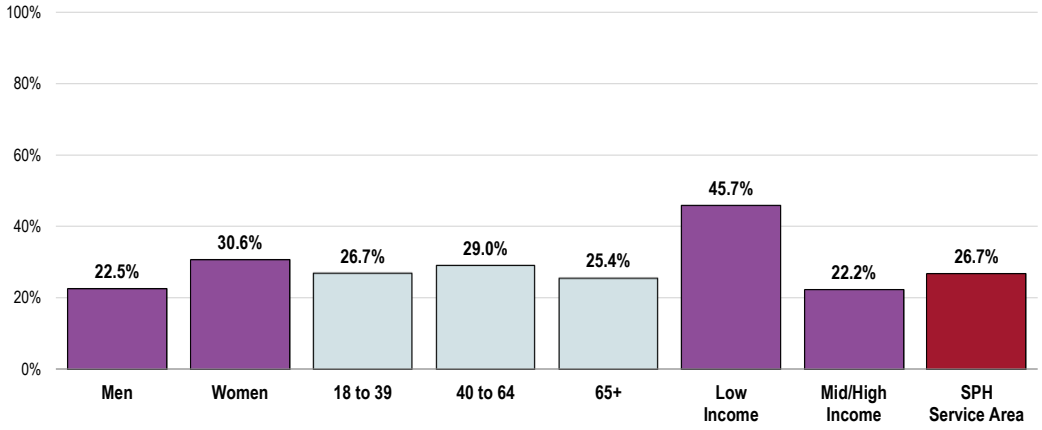


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Note that the prevalence of chronic depression among adults with lower incomes.

Have Experienced Symptoms of Chronic Depression
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 100]

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stress

More than 8 in 10 of SPH Service Area adults consider their typical day to be "not very stressful" (22.3%) or "not at all stressful" (61.4%).

RELATED ISSUE:

See also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

- Another 7.8% of survey respondents characterize their typical day as "moderately stressful."

Perceived Level of Stress On a Typical Day

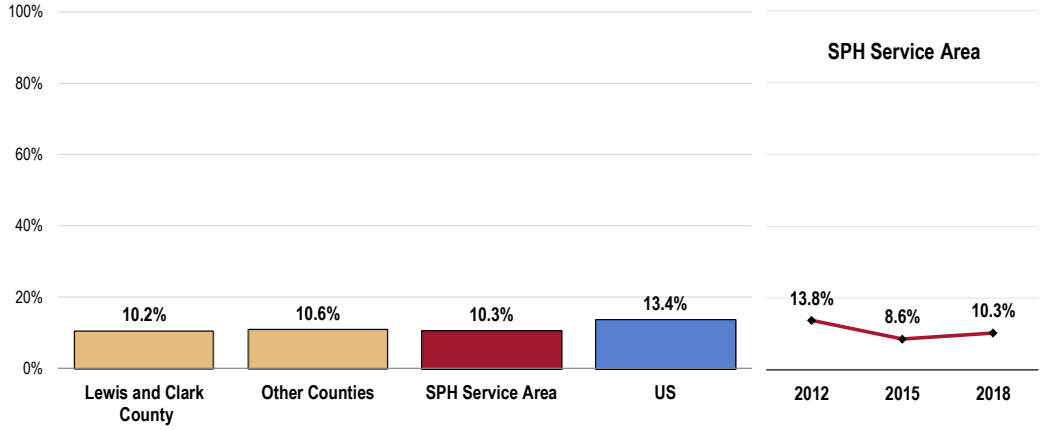
(SPH Service Area, 2018)

Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
Notes: • Asked of all respondents.

In contrast, 10.3% of SPH Service Area adults experience "very" or "extremely" stressful days on a regular basis.

- Similar to national findings.
- Similar by community.
- TREND: Statistically similar to the 2012 findings.

Perceive Most Days As "Extremely" or "Very" Stressful



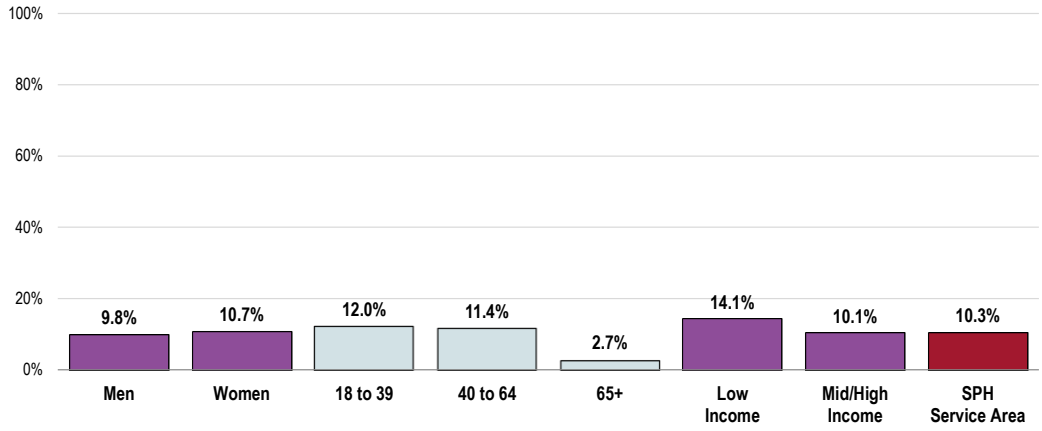
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Note that high stress levels are more prevalent among adults under age 65 (negative correlation with age).

Perceive Most Days as "Extremely" or "Very" Stressful

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 101]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Suicide

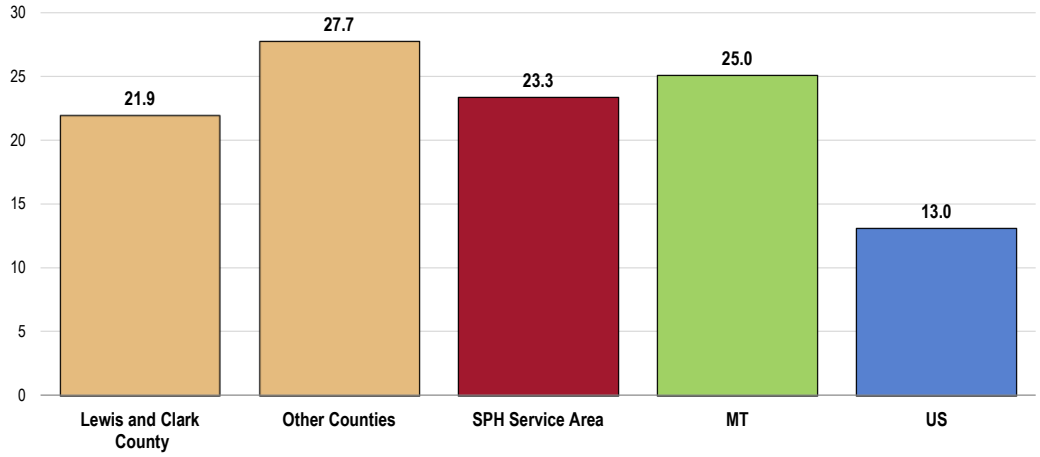
Between 2014 and 2016, there was an annual average age-adjusted suicide rate of 23.3 deaths per 100,000 population in the SPH Service Area.

- Similar to the statewide rate.
- Much higher than the national rate.
- Fails to satisfy the Healthy People 2020 target of 10.2 or lower.
- Higher in the Other Counties area.

Suicide: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 10.2 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

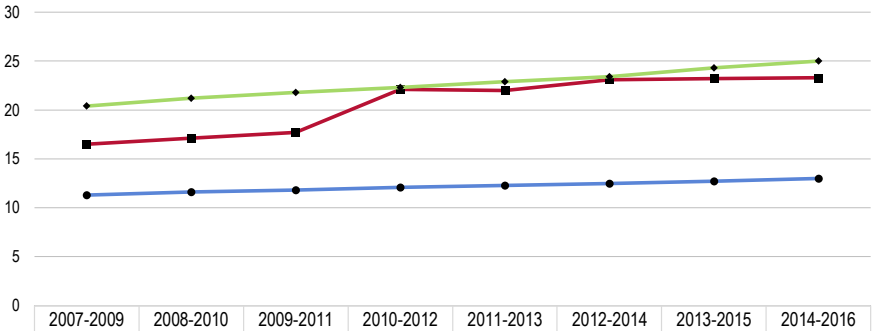
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- TREND: The area suicide rate has overall trended upward over time.

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 10.2 or Lower



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	16.5	17.1	17.7	22.1	22.0	23.1	23.2	23.3
MT	20.4	21.2	21.8	22.3	22.9	23.4	24.3	25.0
US	11.3	11.6	11.8	12.1	12.3	12.5	12.7	13.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]

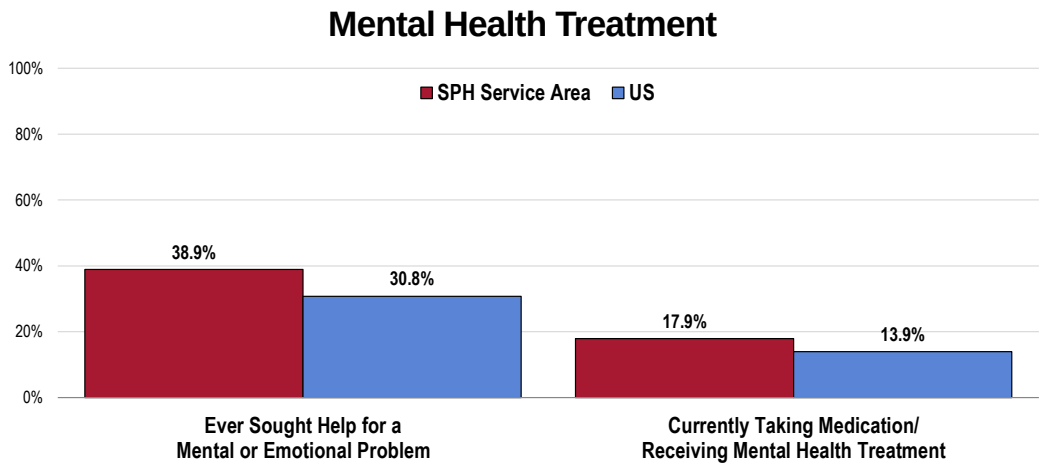
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Mental Health Treatment

A total of 38.9% of SPH Service Area adults acknowledge having ever sought professional help for a mental or emotional problem.

- The proportion of those seeking help is more favorable than national findings.

A total of 17.9% are currently taking medication or receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 103-104]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects the total sample of respondents.

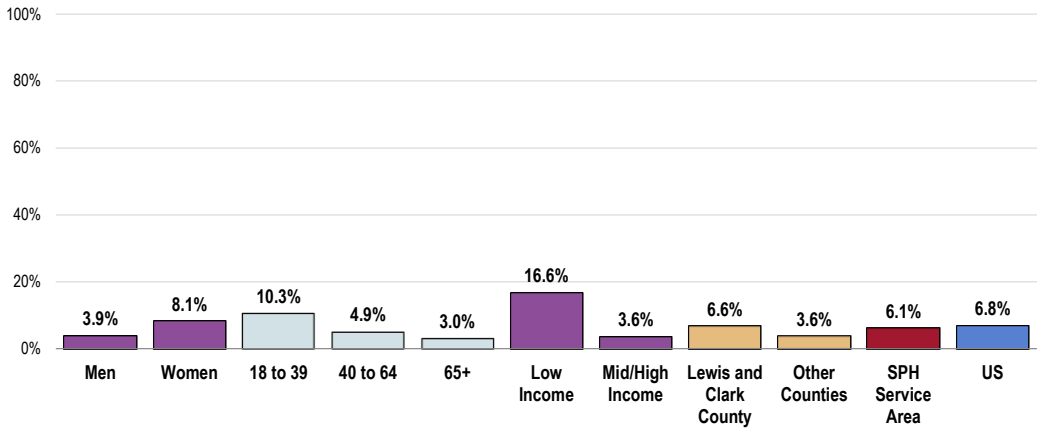
Difficulty Accessing Mental Health Services

A total of 6.1% of SPH Service Area adults report a time in the past year when they needed mental health services but were not able to get them.

- Similar to the national finding.
- Statistically similar by community.
- Access difficulty is notably more prevalent among those with lower incomes.

Unable to Get Mental Health Services When Needed in the Past Year

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 105]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

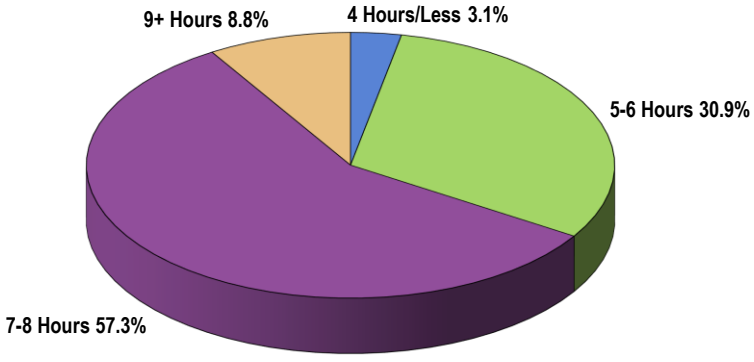
Among persons citing difficulties accessing mental health services in the past year, these are predominantly attributed to **cost or insurance issues** and **poor accessibility**; barriers mentioned much less frequently include lack of transportation and poor quality providers.

Sleep

A majority (66.1%) of SPH Service Area adults average at least 7 hours of sleep per night.

Average Hours of Sleep Per Night

(SPH Service Area, 2018)



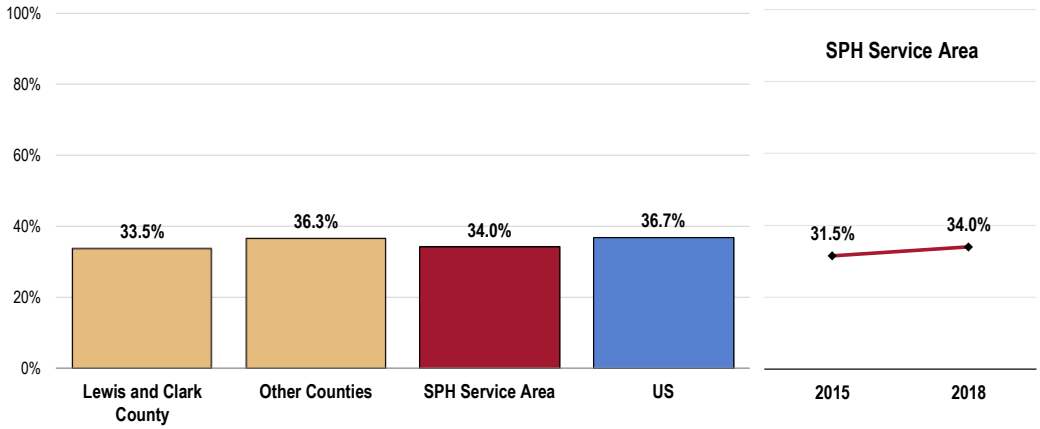
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 322]

Notes:
- Asked of all respondents.

On the other hand, over one-third (34.0%) of area adults report getting fewer than 7 hours of sleep on an average night.

- Similar to the national average.
- Similar by county area.
- TREND: The increase since 2015 is not significant.

Generally Sleep Less Than Seven Hours Per Night

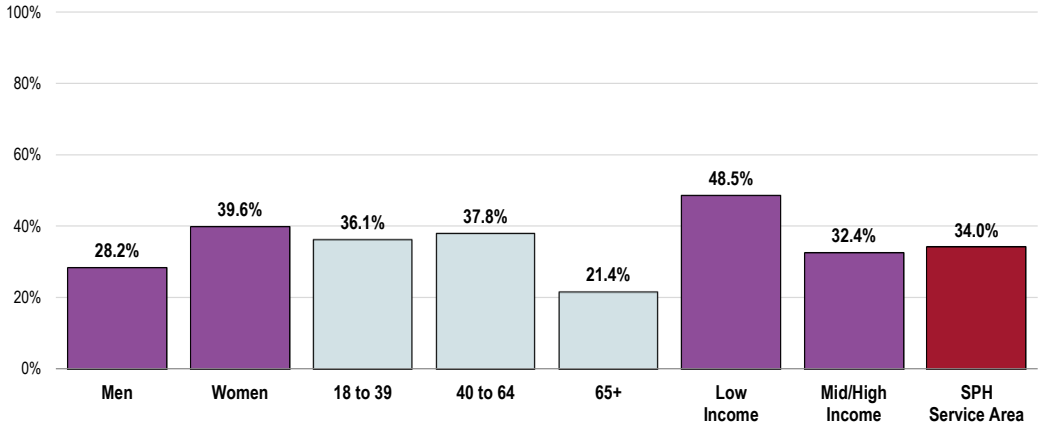


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 322]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- By demographics, notably higher among adults with lower incomes, as well as women and those under age 65.

Generally Sleep Less Than Seven Hours Per Night
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 322]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Loneliness

For this indicator, "lonely" is defined as respondents who score 6-9 points in the series of three questions from the UCLA Loneliness Scale. Points were awarded based on "hardly ever" (1), "some of the time" (2), or "often" (3) responses.

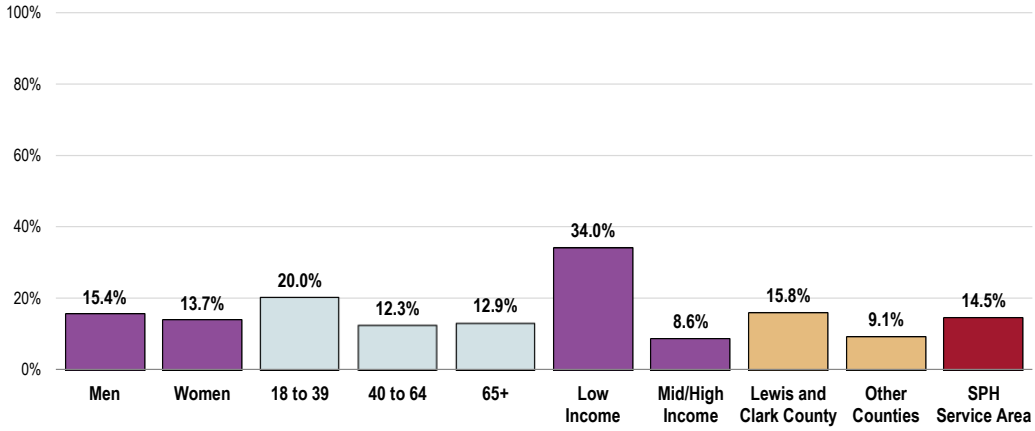
Respondents were asked three questions as part of the UCLA Loneliness Scale. Those giving "often" or "some of the time" responses are as follows:

- Feeling isolated from others: 19.5%
- Lacking companionship: 22.3%
- Feeling left out: 22.7%

When combined, 14.5% of area adults fit criteria for being lonely.

- Similar by area.
- Note that one-third of low income residents fit criteria for loneliness.

Loneliness
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 335]

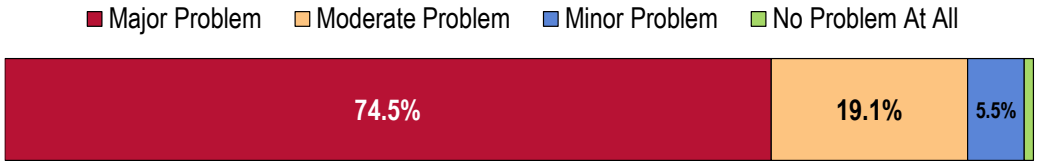
Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- In this case, "lonely" is defined for respondents who score 6-9 points in a series of three questions from the UCLA Loneliness Scale. Points are awarded based on "Hardly Ever" (1), "Some of the Time" (2), or "Often" (3) responses as to how often they lack companionship, feel left out, and/or feel isolated from others.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Key Informant Input: Mental Health

Three-quarters (74.5%) 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, 2018)



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

Top Concerns

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

Access to Care/Services

The biggest challenges for people with mental health issues include accessing consistent treatment that is affordable and effective, both inpatient and outpatient. Helena has some of the highest suicide rates in the state. – Social Services Provider

There is a lack of readily available mental health services- And if they are available, they are costly. The people that need services often don't have money to pay. Even normal people are feeling stress from the long winter, upcoming fire season. – Other Health Provider

Stability of community-based services is nonexistent. Crisis services are barely in place, and true diversion and early intervention services are poor in quality and quantity. State doesn't care, the county steps up when they can. – Community Leader

There are very limited resources for our mental health community. Average wait time for an initial consultation with a pediatric psychologist is over six months. Adults are abusing the emergency department for their mental health needs. – Other Health Provider

Not enough services, especially things that really work to help people with mental illness. People are more likely to end up in jail and prison than in treatment- Even though Medicaid is supposed to cover mental health. – Community Leader

Lack of services and delays and difficulty in accessing available services. Very little follow-up due to lack of adequate staffing. Failure to accept input from family members. Minimum opportunities for admission to overnight or three-day holds. – Community Leader

We have significant issues with outpatient mental health management in our community, though this has improved in the past years with hiring several new psychiatrists. However, the pediatric population has no outpatient psychiatry. – Physician

Access to critical, immediate, mid-treatment and long-care facilities. Our jail is busting at the seams housing mental health folks requiring leaving dangerous criminals on the streets. Addicts contribute significantly to mental health. – Public Health Representative

Lack of access to services in the East Helena area, no infrastructure for community commitments, no place to house homeless folks struggling with mental health issues if they're 86'd from God's Love. No significant follow up after someone leaves. – Community Leader

Mental health services. Easily accessible from all areas of town and affordable. Having more resources to identify mental illness in individuals and educate public on the impact of mental illness to our community. – Public Health Representative

No ID's to access assistance, unable to get to locations for services, stigma, adequate stable housing, access to medications, having to decompensate before true assistance can be offered. – Social Services Provider

Access to care. For those who have insurance, access is still expensive and limited. Those without insurance, there is little available. Wait times for care can be long or appointments infrequent. There is also very little preventive or holistic care. – Social Services Provider

Lack of resources. Organizations that do exist are underfunded and can only service a small percentage of people needing these services. – Community Leader

We do not have enough inpatient beds, nor enough access to health care professionals to treat those people with severe mental health problems. – Physician

There is a lack of inpatient care facilities, and I think that crisis care is not addressed sufficiently. – Community Leader

Timely access to care. – Physician

Access to mental health care. – Public Health Representative

Access to care. – Other Health Provider

Access to mental health care and expense involved for treatment. – Physician

Access to care, expense of medication, stigma, inadequate funding by state and federal programs. – Other Health Provider

Access, availability, particularly during time of crisis. – Physician

Access to psychiatrist, funding for existing programs such as AWARE. – Physician

There are not enough programs to meet the needs of our mentally ill population. – Social Services Provider

Lack of good public accessible care. – Physician

Access to mental health services, enough providers. Need more gun locks, more screening at medical providers and schools needed for suicide, depression and anxiety. – Public Health Representative

Treatment facilities and options. – Community Leader

No funding and no access. – Physician

Access to care. – Community Leader

Lack of providers, available appointments and lack of screening tools to evaluate this problem. – Social Services Provider

Access to mental health is hard. It is costly for the family needing it, it is hard to staff and is has very limited availability. – Social Services Provider

Access, affordability and skilled clinicians. – Social Services Provider

Access to care and recognizing when medical interventions are necessary. – Public Health Representative

Access, resources and funding. – Other Health Provider

Lack of housing and general support options for those with moderate to severe disability. – Social Services Provider

No access to care. – Physician

Space and caregivers for these patients young and old. Shodair is full a lot of time and adults get lost in the shuffle. – Other Health Provider

Access to providers, housing, and employment. – Physician

Access to care. – Community Leader

Getting services. – Community Leader

There isn't enough access to mental health services in this community. There aren't enough ways to pay for it, and there aren't enough providers. – Public Health Representative

Access to care and opportunities to contribute to the community through meaningful work, Helena Industries is closing. – Community Leader

One of the biggest challenges we have as a community is dealing with the short-term and long-term effects of mental health on the community. It is important for early diagnosis of the issues, but also for education concerning the stigma. – Community Leader

Lack of access. Length of time from referral to first visit. – Other Health Provider

Mental health is a major problem in most communities. It difficult to access care for many patients and contributes to other comorbidities. Serious mental illness is expensive to care for and challenging for providers and support staff. – Physician

Lack of resources. – Physician

Access to good quality care for mental health issues. This includes access to counseling, as well as other treatment options. – Social Services Provider

Lack of Providers

Not enough mental health providers, especially for low-income individuals. Additionally, there is stigma associated with seeking services. – Community Leader

There are significant limitations to using the crisis response team. I find the threshold for involuntary holds to be excessively high in this state, and it puts people at risk. Significant lack of prescribers but particularly counselors. – Physician

Not enough professionals to address the variety of needs, and hardly anyone [for] young children. – Social Services Provider

Inadequate number of outpatient psychiatrists in the community, particularly those who take Medicare/Medicaid. – Physician

There seems to be reasonable access to counselors, but limited access to psychiatrists/prescribers. Emergent detention process is remarkably cumbersome here compared to my prior work environments, Colorado and New Mexico. – Physician

Severe lack of mental health providers in the community. Many of the mentally ill are also some of the most indigent patients, which makes their access to care even more difficult. – Physician

Not enough co-occurring counselors or addiction counselors. Not enough psychiatrists. – Physician

Access to mental health providers and support. – Physician

Denial/Stigma

There is a lot of isolation in our community, and I've seen this across all age groups. There is also a stigma around mental health and asking for help with personal mental health issues. I think there is also a lack of mental health professionals. – Public Health Representative

Getting over the hurdle of asking for help. There is a stigma around the appearance of weakness in Montana and Helena is no exception. – Other Health Provider

Stigma. Montana has a "pull yourselves up by the bootstraps" mentality, which is not conducive to reaching out for help. Youth who have had a suicide attempt oftentimes can't be found a bed for treatment. Lack of space. – Social Services Provider

Stigma and lack of qualified practitioners. – Public Health Representative

Acceptance and understanding of mental health problems and how they manifest by the general population. Recognition by governmental leaders of true medical conditions and greatly increased funding for treatment. Access to services. – Community Leader

Diagnosis/Treatment

Lack of identification and patient free will to refuse treatment. – Community Leader

Disjointed services, service providers who do not speak with each other. Refusal of service providers to use the Connect Client Referral system, not enough services. – Social Services Provider

In my opinion, school district is not a partner in offering help. Afraid of offending; need a pre-treatment program to keep people with mental health issues out of the courts, safe from others. – Other Health Provider

The number one health problem is no cohesive planning being done. Lots of evidence-based knowledge, but it's scattered. – Other Health Provider

Our system is a wreck. No one is statutorily responsible for providing services and/or for a crisis system. The access is horrible. – Public Health Representative

Affordable Care/Services

Access to affordable mental health services. Access to acute care for mental health services and case management services that have been recently cut due to funding losses. – Social Services Provider

For adults, financial ability to access. Continuity of care between providers is difficult. For youth, access to supports that last the duration of treatment. Services end abruptly and/or treatment does not follow from high level of care to lower level. – Social Services Provider

Financial barriers to mental health care. Lack of insurance and financial assistance can lead to inconsistent or inadequate treatment. Some mental health care providers do not accept Medicaid. Lack of mental health professionals. – Public Health Representative

There is a lack of affordable mental health resources available, even to those with health insurance. – Other Health Provider

Co-Occurrences

Mental health impairs decision making, ability to acquire/maintain employment. – Physician

Suicide and depression/anxiety is a huge problem in Montana, but also for this community. There were many suicides among teens this past year, and mental health relates to alcohol/substance abuse and physical inactivity. Needs to be more community action. – Public Health Representative

Our local shelter is used as a drop-off from the state mental hospital. Many begin drinking and drug use to control their issues. The state doesn't communicate with these people being released. – Social Services Provider

Prevalence/Incidence

RMDC is currently underway with our own comprehensive community needs assessment. It appears that mental health is almost number one from our responses.– Social Services Provider

In 2016, a community health improvement task force made up of people from a variety of backgrounds and perspectives ranked mental health as the number one health concern in Lewis and Clark County. – Public Health Representative

Health Awareness/Education

There is a lack of education related to mental illnesses. The crisis care system is underfunded and stressed. There is a lack of qualified mental health professionals. – Other Health Provider

Education, screening, and access to care. Affordable treatments. – Other Health Provider

Lack of Funding

Lack of resources due to budget cuts at the state level. – Community Leader

Our mental health system, even when better funded, has struggled to provide services to those with the greatest challenges. Recent reductions in case management services will only increase these issues. Providers need to be supported in helping. – Social Services Provider

Adverse Childhood Experiences/Trauma

Adverse childhood experiences/trauma. This is connected to other health issues. – Social Services Provider

Death, Disease, & Chronic Conditions

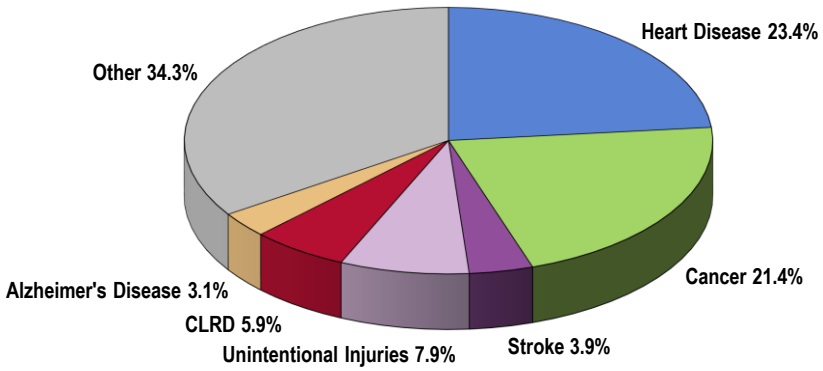
Professional Research Consultants, Inc.

Leading Causes of Death

Distribution of Deaths by Cause

Together, cardiovascular disease (heart disease and stroke) and cancers accounted for nearly one-half of all deaths in the SPH Service Area 2014-2016.

Leading Causes of Death
(SPH Service Area, 2014-2016)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.

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.

Age-Adjusted Death Rates for Selected Causes

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.

The following chart outlines 2014-2016 annual average age-adjusted death rates per 100,000 population for selected causes of death in the SPH Service Area.

Each of these is discussed in greater detail in subsequent sections of this report.

Age-Adjusted Death Rates for Selected Causes

(2014-2016 Deaths per 100,000 Population)

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

	SPH Service Area	Montana	US	HP2020
Malignant Neoplasms (Cancers)	158.6	153.0	158.5	161.4
Diseases of the Heart	138.6	152.7	167.0	156.9*
Unintentional Injuries	59.5	54.3	43.7	36.4
Chronic Lower Respiratory Disease (CLRD)	43.0	50.8	40.9	n/a
Cerebrovascular Disease (Stroke)	31.0	34.2	37.1	34.8
Intentional Self-Harm (Suicide)	23.3	25.0	13.0	10.2
Alzheimer's Disease	18.6	20.8	28.4	n/a
Firearm-Related	17.3	18.1	11.1	9.3
Motor Vehicle Deaths	15.6	18.5	11.0	12.4
Diabetes	14.6	22.4	21.1	20.5*
Pneumonia/Influenza	14.2	12.8	14.6	n/a
Cirrhosis/Liver Disease	10.3	13.8	10.6	8.2
Unintentional Drug-Related Deaths	8.3	7.9	14.3	11.3
Kidney Disease	6.5	10.1	13.2	n/a
Homicide/Legal Intervention (2007-2016)	2.5	3.4	5.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov.

Note:
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
- *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.

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

Heart Disease Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

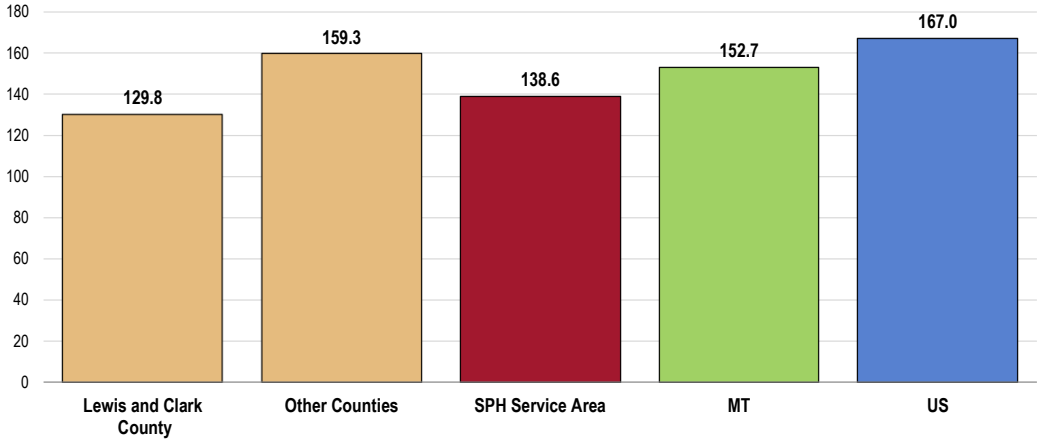
Between 2014 and 2016 there was an annual average age-adjusted heart disease mortality rate of 138.6 deaths per 100,000 population in the SPH Service Area.

- Similar to the statewide rate.
- Lower than the national rate.
- Similar to the Healthy People 2020 target of 156.9 or lower (as adjusted to account for all diseases of the heart).
- Higher in the Other Counties area.

Heart Disease: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 156.9 or Lower (Adjusted)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

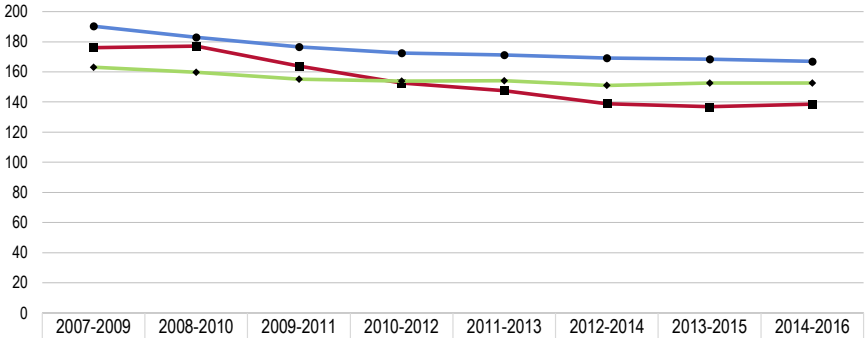
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- TREND: The heart disease mortality rate has decreased in the SPH Service Area at a greater rate than seen across Montana and the US overall.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 156.9 or Lower (Adjusted)



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	176.1	177.1	163.9	152.5	147.6	138.8	136.9	138.6
MT	163.1	159.7	155.1	154.0	154.1	151.0	152.6	152.7
US	190.3	182.9	176.7	172.6	171.3	169.1	168.4	167.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke Deaths

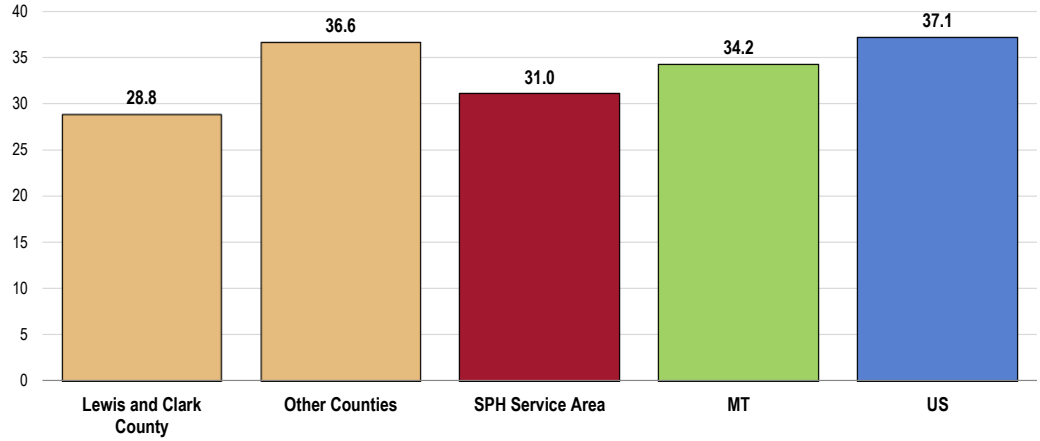
Between 2014 and 2016, there was an annual average age-adjusted stroke mortality rate of 31.0 deaths per 100,000 population in the SPH Service Area.

- Similar to the statewide rate.
- More favorable than the national rate.
- Similar to the Healthy People 2020 target of 34.8 or lower.
- Higher in the Other Counties area.

Stroke: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

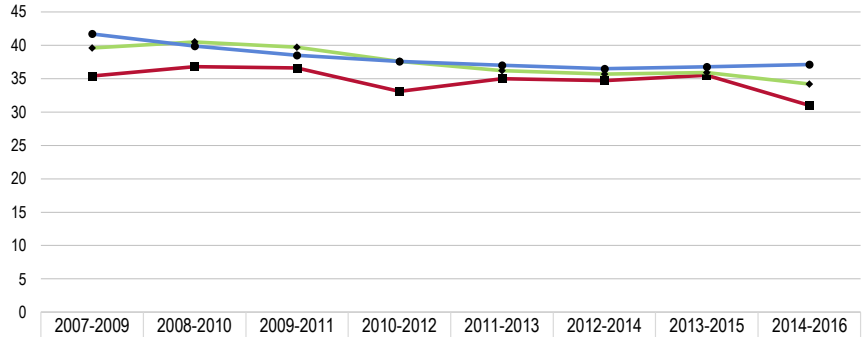
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- TREND: No clear trend in stroke deaths over time.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 34.8 or Lower



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	35.4	36.8	36.6	33.1	35.0	34.7	35.5	31.0
MT	39.6	40.5	39.7	37.6	36.2	35.7	35.9	34.2
US	41.7	39.9	38.5	37.6	37.0	36.5	36.8	37.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

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

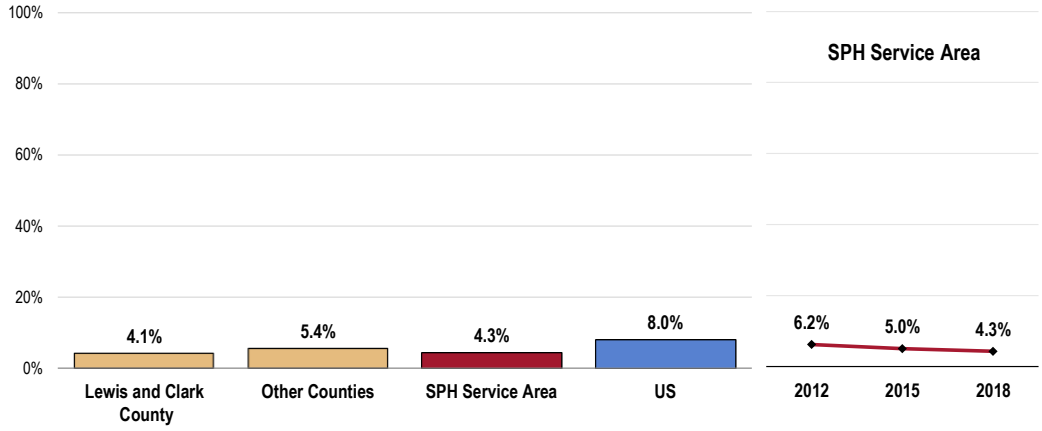
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 4.3% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

- Lower than the national prevalence.
- Similar by community.
- TREND: Statistically unchanged since 2012.

Prevalence of Heart Disease

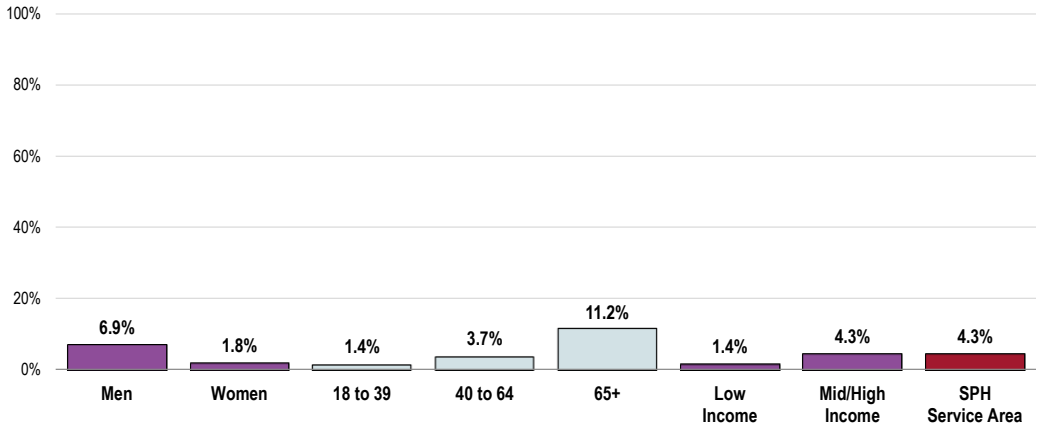


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Men and seniors (age 65+) are more likely to have been diagnosed with chronic heart disease.

Prevalence of Heart Disease
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]

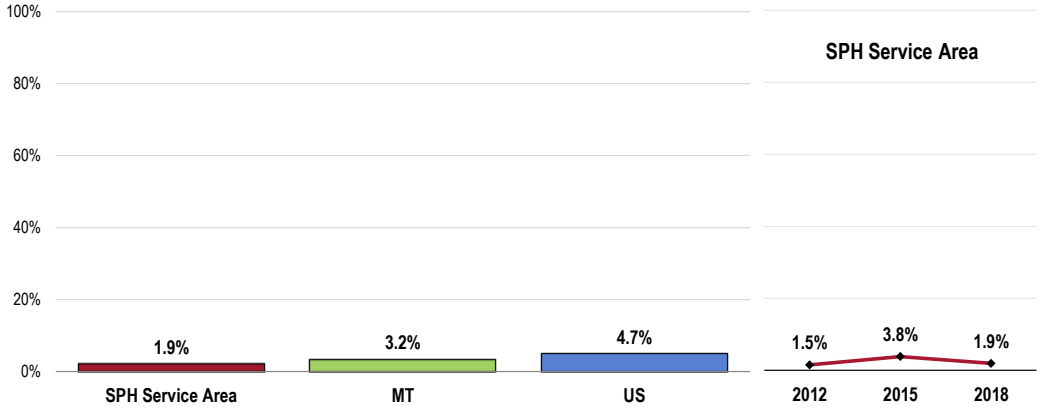
Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Prevalence of Stroke

A total of 1.9% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

- Similar to statewide findings.
- Lower than national findings.
- TREND: No significant difference in stroke prevalence over time.

Prevalence of Stroke



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 33]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

About Cardiovascular Risk

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

- Healthy People 2020 (www.healthypeople.gov)

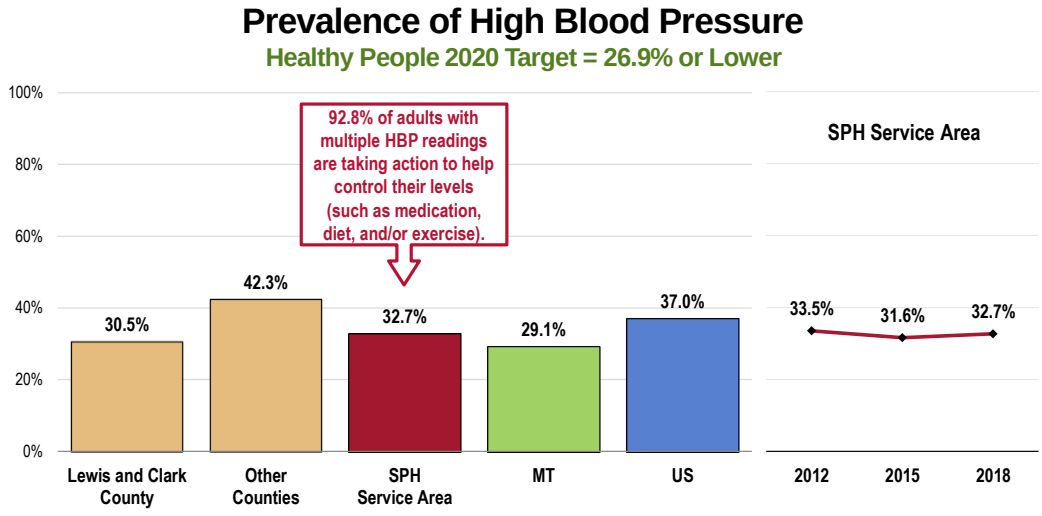
High Blood Pressure

Prevalence of High Blood Pressure

One-third (32.7%) of SPH Service Area adults have been told at some point that their blood pressure was high.

- Similar to the statewide and national prevalence.
- Fails to satisfy the Healthy People 2020 target (26.9% or lower).
- Highest in the Other Counties area.
- TREND: Statistically unchanged since 2012.

Among adults with multiple high blood pressure readings, 92.8% are taking action to lower their blood pressure (such as medication, change in diet, and/or exercise).



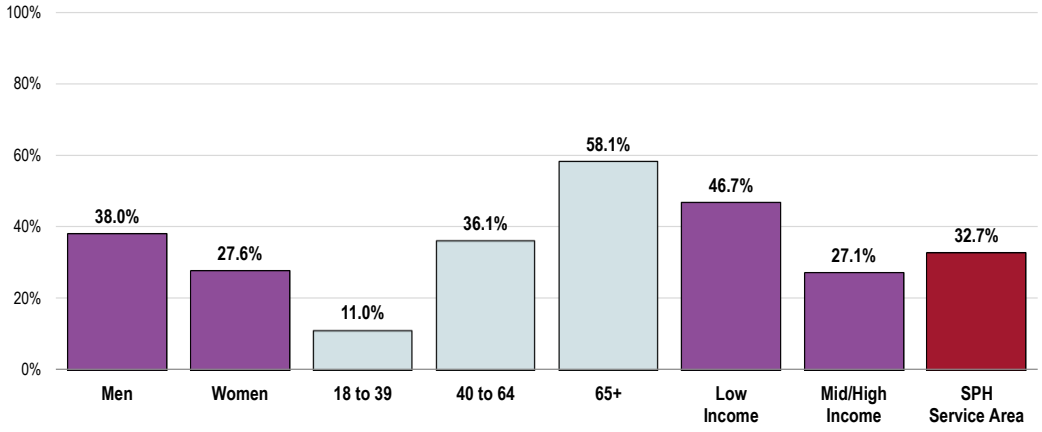
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 39, 41]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

High blood pressure is more prevalent among:

- Men.
- Adults age 40 and older, and especially those age 65+ (strong positive correlation with age).
- Those with lower incomes.

Prevalence of High Blood Pressure
(SPH Service Area, 2018)
Healthy People 2020 Target = 26.9% or Lower



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

High Blood Cholesterol

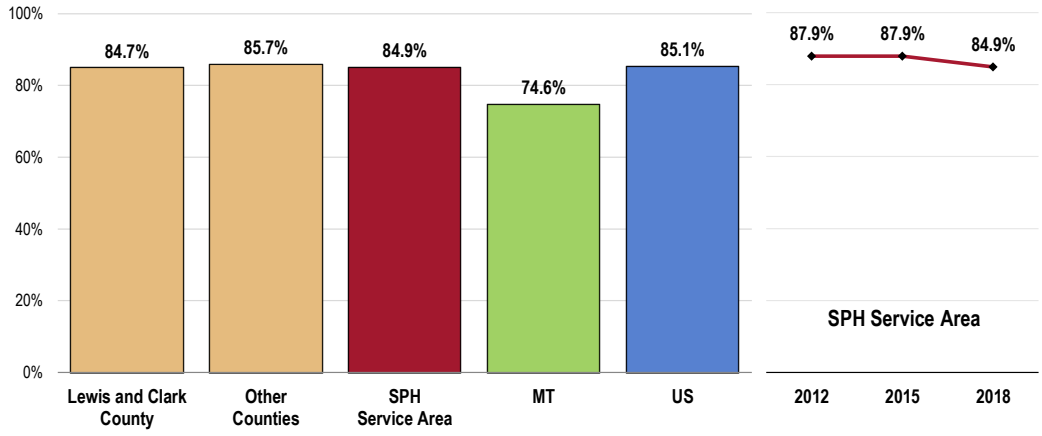
Blood Cholesterol Testing

A total of 84.9% of SPH Service Area adults have had their blood cholesterol checked within the past five years.

- More favorable than Montana findings.
- Nearly identical to the national findings.
- Similar to the Healthy People 2020 target (82.1% or higher).
- Similar by county area.
- TREND: The decrease over time is not statistically significant.

Have Had Blood Cholesterol Levels Checked in the Past Five Years

Healthy People 2020 Target = 82.1% or Higher



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 45]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-6]

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Prevalence of High Blood Cholesterol

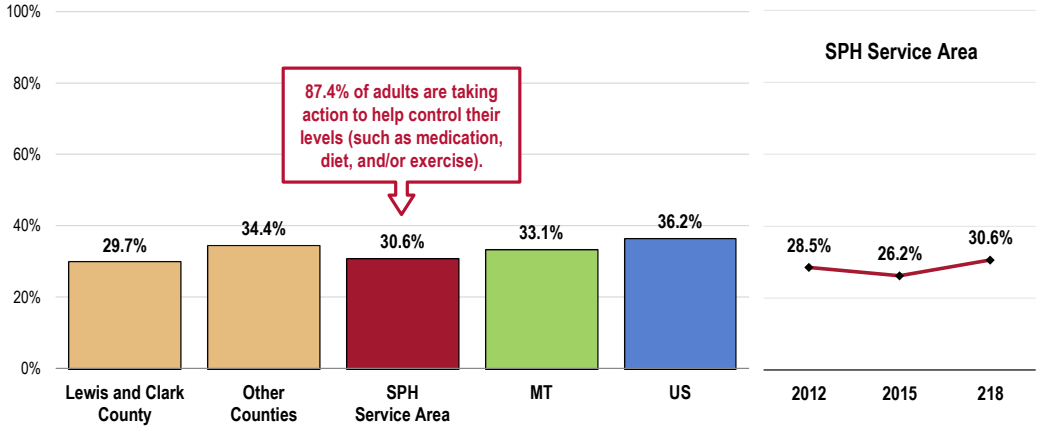
A total of 30.6% of adults have been told by a health professional that their cholesterol level was high.

- Similar to the state prevalence.
- Lower than what is seen nationwide.
- More than twice the Healthy People 2020 target (13.5% or lower).
- Similar by community.
- TREND: Statistically unchanged since 2012.

Among adults with high blood cholesterol readings, 87.4% are taking action to lower their numbers (such as medication, change in diet, and/or exercise).

Prevalence of High Blood Cholesterol

Healthy People 2020 Target = 13.5% or Lower



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 44, 130]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2015 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

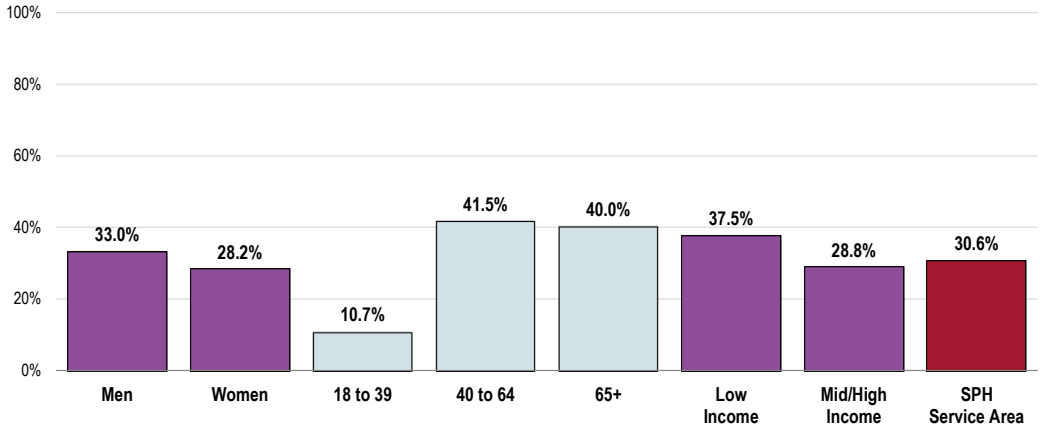
Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- There is a higher prevalence of high blood cholesterol among those age 40+.

Prevalence of High Blood Cholesterol

(SPH Service Area, 2018)

Healthy People 2020 Target = 13.5% or Lower



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 130]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

About Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

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

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US.

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

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

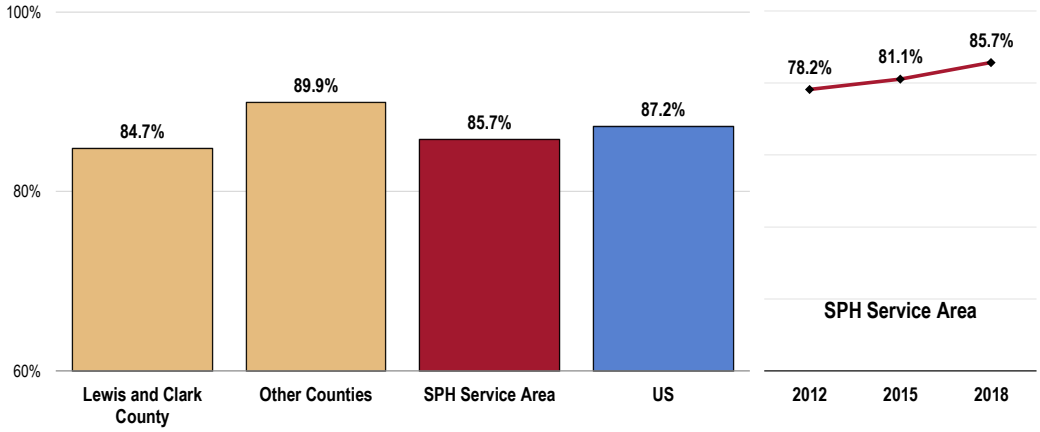
Total Cardiovascular Risk

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

A total of 85.7% of SPH Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

- Similar to national findings.
- Differences by county area are not significant.
- TREND: Statistically higher than 2012 findings.

Present One or More Cardiovascular Risks or Behaviors



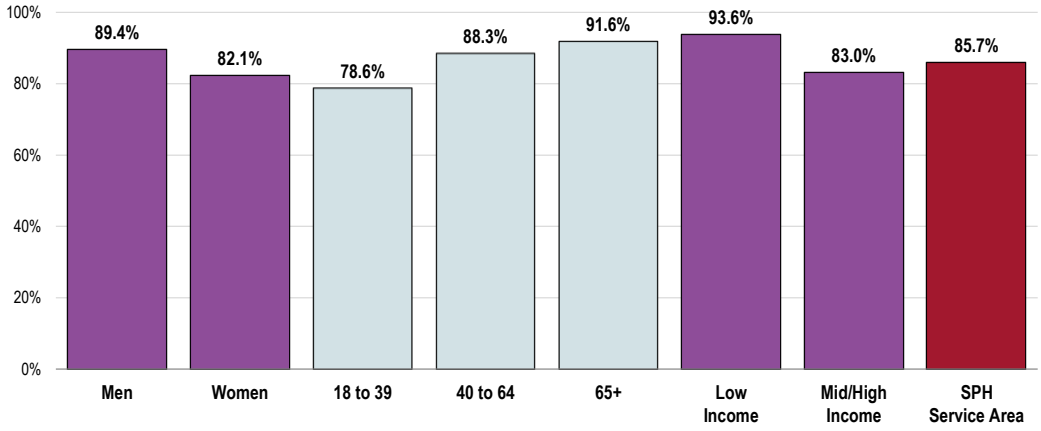
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 131]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Adults more likely to exhibit cardiovascular risk factors include:

- Men.
- Adults age 40 and older (especially those age 65+).
- Those with lower incomes.

Present One or More Cardiovascular Risks or Behaviors
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 131]

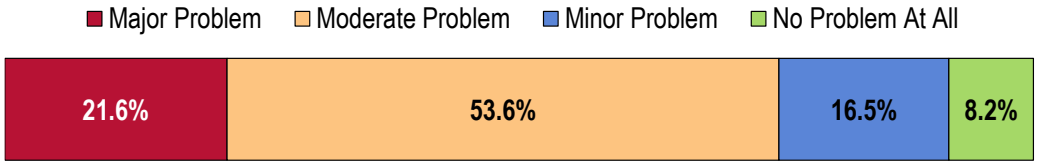
Notes:
- Asked of all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

Over half (53.6%) 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, 2018)



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

Top Concerns

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

Leading Cause of Death

Heart disease is one of the leading causes of death in Montana, and I assume it is very high in Lewis and Clark County. – Other Health Provider

It is one of the leading causes of death in our county. More often as our populations ages. – Public Health Representative

Heart disease and stroke are a major cause of death and morbidity throughout our nation, and Montana is no exception. Past health assessments have shown that over 20% of all deaths in Montana are due to heart disease. – Social Services Provider

Heart disease and cancer are the two leading causes of death in Montana. The last PRC community survey found that about one in four Lewis and Clark County residents has high cholesterol. – Public Health Representative

Heart attack and stroke are the leading killers of women in the USA. The increased number of obese individuals in our community have increased the number of our residents that are at risk. – Other Health Provider

The leading cause of death. – Physician

I believe that heart disease is the number one killer in our country at this time. – Social Services Provider

Comorbidities

As the obesity trend rises, more people will continue to experience cardiovascular problems. – Other Health Provider

I think it's a problem because diabetes is so high and rampant. – Community Leader

We have a large number of binge drinking, and it affects heart health and blood pressure. How do we make this connection to those suffering from addiction? – Social Services Provider

Lack of Providers

No facilities for major surgery. – Community Leader

We need better facilities to educate and treat people with issues, and more doctors to help. – Community Leader

Lifestyle

> *We have a high rate of heart disease and stroke due to poor diets, and lack of exercise. – Public Health Representative*
>
> *Aging population and out of shape people. – Community Leader*

Prevalence/Incidence

> *Just because I've heard a lot about them. – Public Health Representative*
>
> *They are nationwide. They are also serious, costly, and disabling. – Public Health Representative*

Health Awareness/Education

> *Patient education for awareness of signs and symptoms is lacking. Immediate access to care is difficult in rural communities. – Community Leader*

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

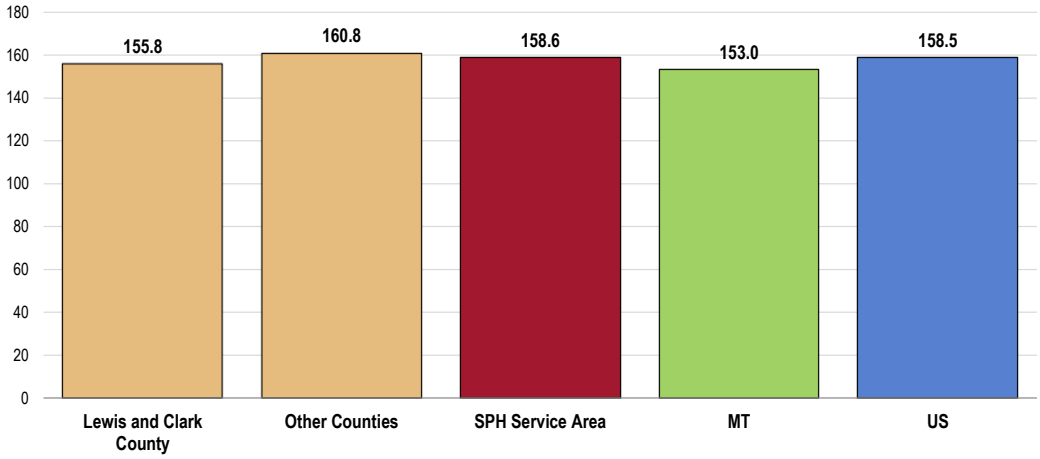
Between 2014 and 2016, there was an annual average age-adjusted cancer mortality rate of 158.6 deaths per 100,000 population in the SPH Service Area.

- Similar to the statewide and national rates.
- Similar to the Healthy People 2020 target of 161.4 or lower.
- No significant difference by community.

Cancer: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 161.4 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

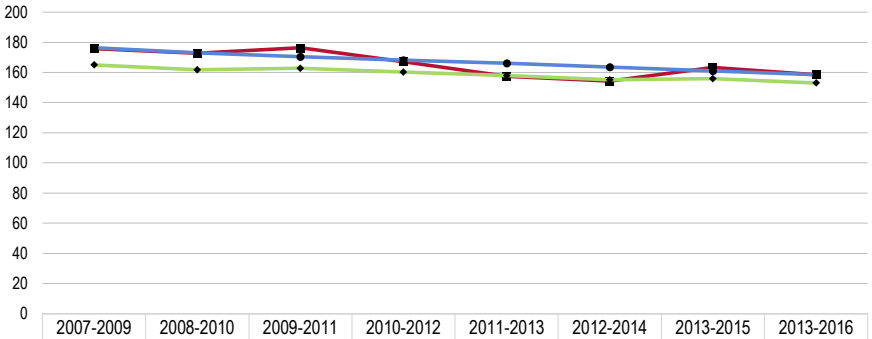
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- TREND: It appears that cancer mortality in the service area has declined slightly over the past decade, although not as consistently as is seen statewide and nationwide.

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 161.4 or Lower



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2013-2016
SPH Service Area	175.9	172.8	176.4	167.2	157.4	154.3	163.2	158.6
MT	165.0	161.8	162.9	160.3	158.0	155.2	155.8	153.0
US	176.4	173.0	170.5	168.2	166.2	163.6	161.0	158.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

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

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in the SPH Service Area.

Other leading sites include breast cancer among women, colorectal cancer (both sexes), and prostate cancer among men.

As evident in the following chart (referencing 2014-2016 annual average age-adjusted death rates):

- The SPH Service Area **lung, female breast, and colorectal cancer** death rates are similar to the state and national rates.
- The SPH Service Area **prostate cancer** death rate is significantly higher than both the state and national rates.
- Note that of all the death rates detailed in the following chart, only **prostate cancer** does not satisfy the related Healthy People 2020 target.

Age-Adjusted Cancer Death Rates by Site

(2014-2016 Annual Average Deaths per 100,000 Population)

	SPH Service Area	Montana	US	HP2020
ALL CANCERS	158.6	153.0	158.5	161.4
Lung Cancer	41.9	38.2	40.3	45.5
Female Breast Cancer	19.7	20.0	20.3	20.7
Colorectal Cancer	15.1	14.1	14.4	14.5
Prostate Cancer	26.5	21.5	19.0	21.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov

Cancer Incidence

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

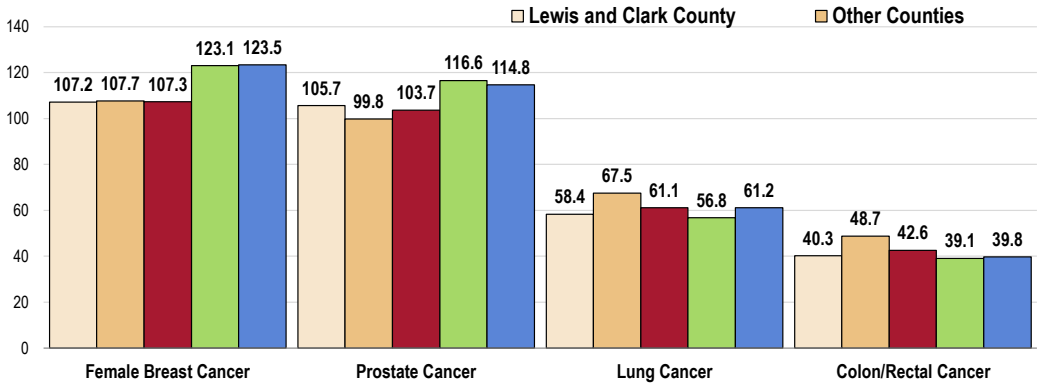
Incidence rate" or "case rate" is the number of new cases of a disease occurring during a given period of time.

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

- The 2014-2016 SPH Service Area annual average age-adjusted **female breast cancer** incidence rate is better than the US rate.
- No significant differences in incidence rates when compared to the state.
- Within the SPH Service Area, the **lung** and **colorectal cancer** incidence rates are higher in the Other Counties area.

Cancer Incidence Rates by Site

(Annual Average Age-Adjusted Incidence per 100,000 Population, 2014-2016)



Sources:
- State Cancer Profiles.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

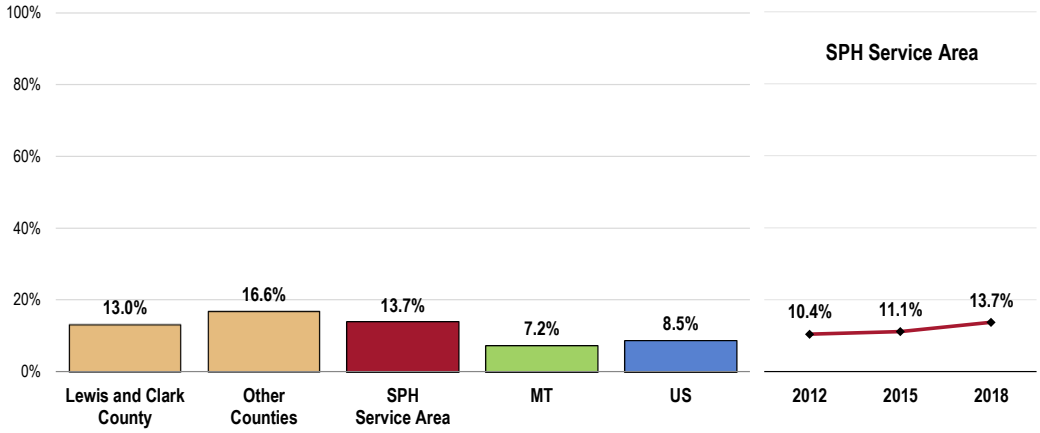
Skin Cancer

Prevalence

A total of 13.7% of surveyed SPH Service Area adults report having been diagnosed with skin cancer.

- Higher than what is found state- and nationwide.
- Statistically similar by county area.
- TREND: The prevalence of skin cancer has remained statistically unchanged over time.

Prevalence of Skin Cancer



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 28]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

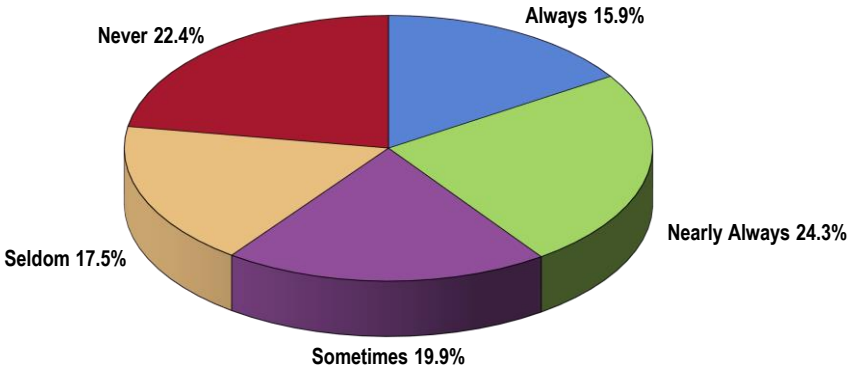
Sunscreen

When asked how often they wear sunscreen on a sunny day, 4 in 10 adults (40.2%) gave "always" or "nearly always" responses.

- On the other hand, 22.4% report "never" wearing sunscreen on a sunny day.

Frequency of Sunscreen Use on a Sunny Day

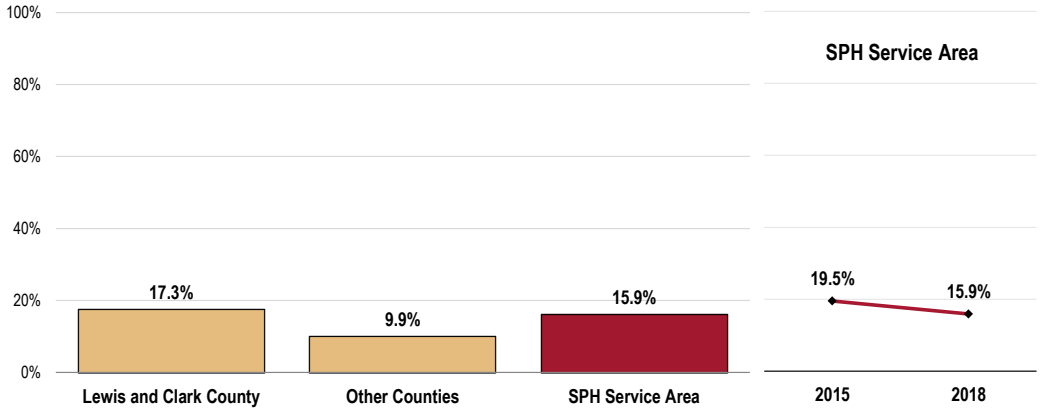
(SPH Service Area, 2018)



Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 302]
Notes: ● Asked of all respondents.

- The prevalence of area adults who "always" use sunscreen while outside on a sunny day is lower in the Other Counties area.
- TREND: The decrease over time is not statistically significant.

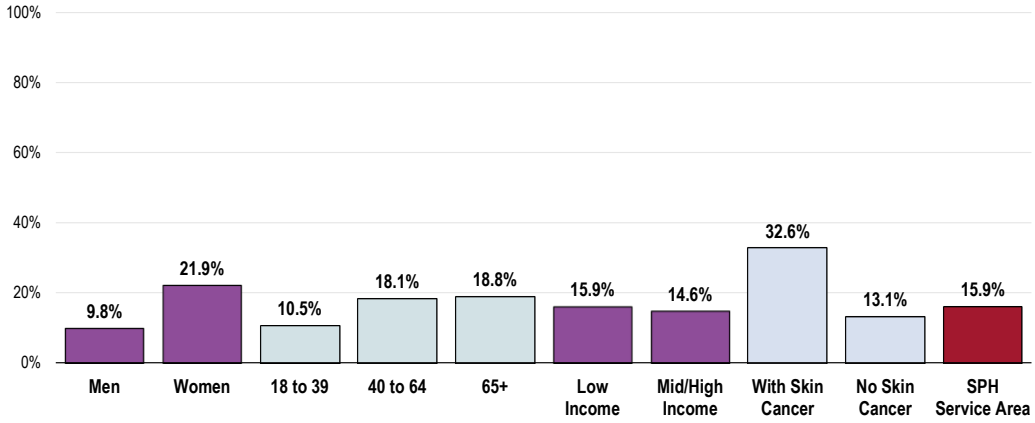
"Always" Use Sunscreen Outside on a Sunny Day



Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 301]
Notes: ● Asked of all respondents.
● "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Sunscreen use is significantly less common among men and those without a skin cancer diagnosis.

"Always" Use Sunscreen Outside on a Sunny Day
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 302]

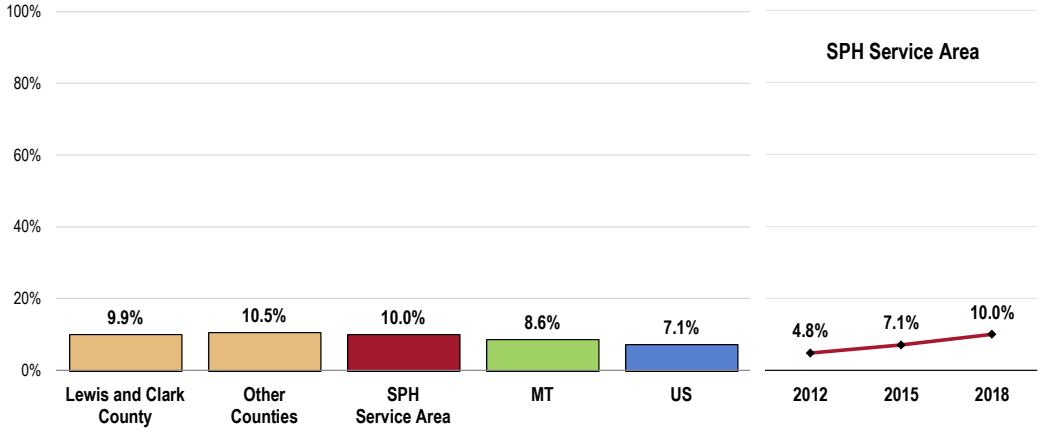
Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Other Cancer

One in 10 survey respondents (10.0%) have been diagnosed with some type of (non-skin) cancer.

- Similar to the statewide and national percentages.
- Similar by county area.
- TREND: The prevalence of cancer has doubled over time.

Prevalence of Cancer (Other Than Skin Cancer)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 27]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Cancer Risk

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

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.

Screening levels in the community were measured in the PRC Community Health Survey relative to two cancer sites: female breast cancer (mammography) and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Female Breast Cancer Screening

About Screening for Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

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

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

Mammography

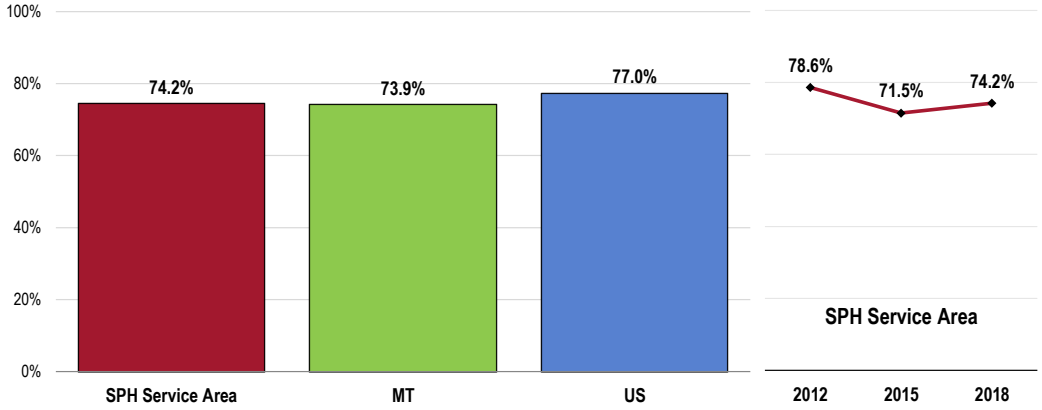
Among women age 50-74, three-quarters (74.2%) have had a mammogram within the past 2 years.

- Similar to statewide and national findings.
- Statistically similar to the Healthy People 2020 target (81.1% or higher).
- TREND: Statistically unchanged since 2012.

Have Had a Mammogram in the Past Two Years

(Among Women Age 50-74)

Healthy People 2020 Target = 81.1% or Higher



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 133]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

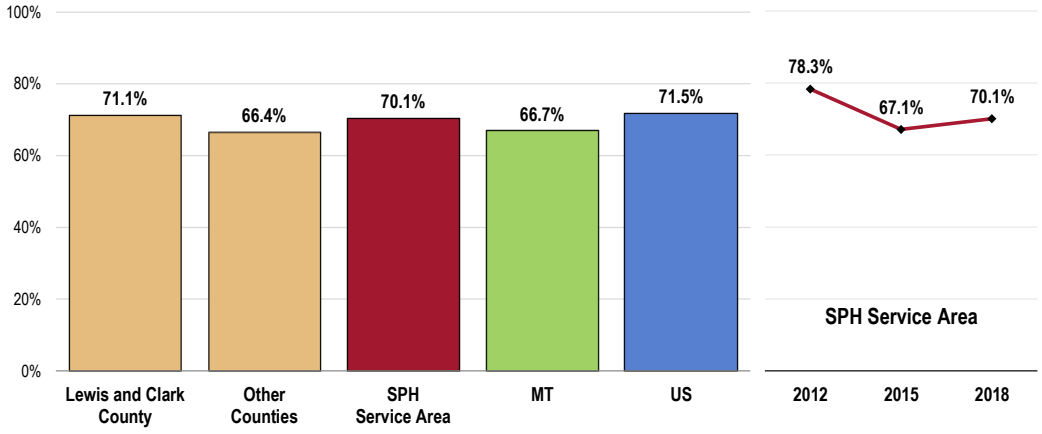
Notes:
- Reflects female respondents 50-74.

Among women age 40+, this percentage decreases to 70.1%.

- Similar to state and national data.
- Statistically similar by county area.
- The decrease since 2012 is not statistically significant.

Have Had a Mammogram in the Past Two Years

(Among Women Age 40+)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 133]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects female respondents age 40 or older.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (fecal occult blood testing, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

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

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

Colorectal Cancer Screening

Three-quarters (74.9%) of adults age 50-75 have had an appropriate colorectal cancer screening.

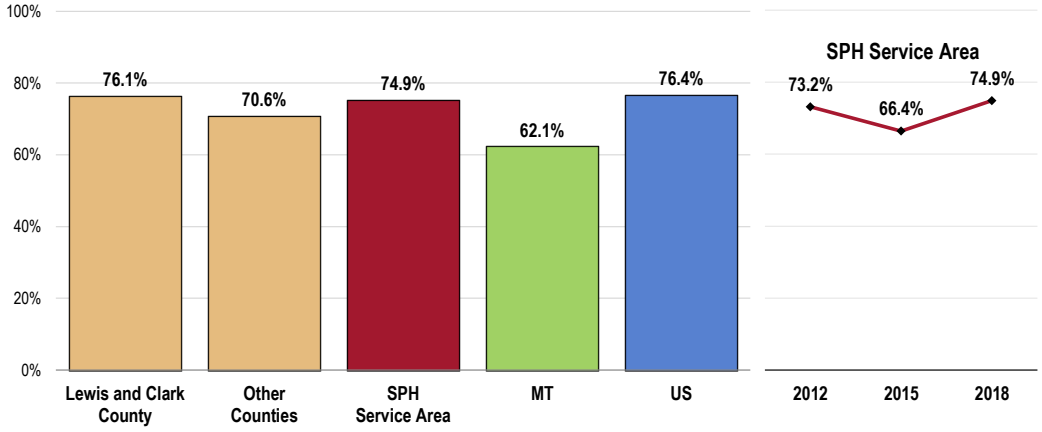
"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

- Similar to national findings, though higher than state findings.
- Statistically similar to the Healthy People 2020 target (70.5% or higher).
- No significant difference by county area.
- TREND: No clear trend over time, though significantly higher than 2015 findings.

Have Had a Colorectal Cancer Screening

(Among Adults Age 50-75)

Healthy People 2020 Target = 70.5% or Higher



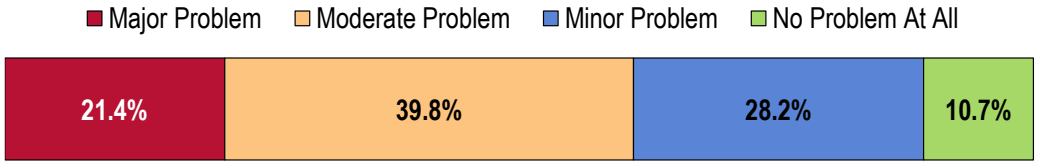
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]

Notes:
- Asked of all respondents age 50 through 75.
- In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Key Informant Input: Cancer

The greatest share of 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, 2018)



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

Top Concerns

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

Prevalence/Incidence

I personally have friends and neighbors who have been recently diagnosed with various cancers. They have gone to Seattle for surgeries, diagnostic workups, and continued treatment. And, without hesitation, I might add. – Community Leader

Cancer screening is a major concern amongst the community, specifically breast, colorectal, and cervical cancer screening. – Public Health Representative

It is such a serious illness which affects so many families. Additionally, it's very expensive to treat successfully. – Community Leader

With the many different types of cancer; there isn't a week that goes by that someone hasn't been diagnosed with some type of cancer. – Social Services Provider

There are very few people in any community that have not been affected by cancer. There is a considerable need not only for care when diagnosed, but education to all parties regarding the disease. – Community Leader

The cancer center here has grown 10-fold in recent years. I don't have any other facts other than this in cancer-related issues. – Community Leader

I hear about so many people who have or had cancer. It is probably similar to other areas. – Social Services Provider

We seem to have a high incidence of cancer in the community, including frequency of rarer cancer types. Pancreatic cancer, etc. Cancer is a major problem because of its ability to overwhelm families. Frequently loss of employment and income. – Social Services Provider

Access to Care/Services

It seems we have many cases of cancer, and treatment is sometimes hard to get. – Community Leader

Many of my friends have had cancer and have gone out of state to be treated for their cancer. – Community Leader

Low screening rates for low income, so people can't afford screening and treatment. – Other Health Provider

Leading Cause of Death

Leading cause of morbidity and death. – Physician

High death rate and very expensive treatment. – Community Leader

Health Awareness/Education

> *Education on cancer is a need. We have one or two very good doctors, but I am concerned what will happen when their services become available due to age or other circumstances. – Community Leader*

> *I think that all forms of cancer can and should be detected as early as possible and that this can be accomplished via a strong public education campaign. – Social Services Provider*

Contributing Factors

> *Large population of current tobacco users, obesity, physical inactivity. – Other Health Provider*

Lack of Providers

> *Significant cancer burden with only one oncologist. – Physician*

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 Respiratory Disease Deaths

Chronic Lower Respiratory Disease Deaths (CLRD)

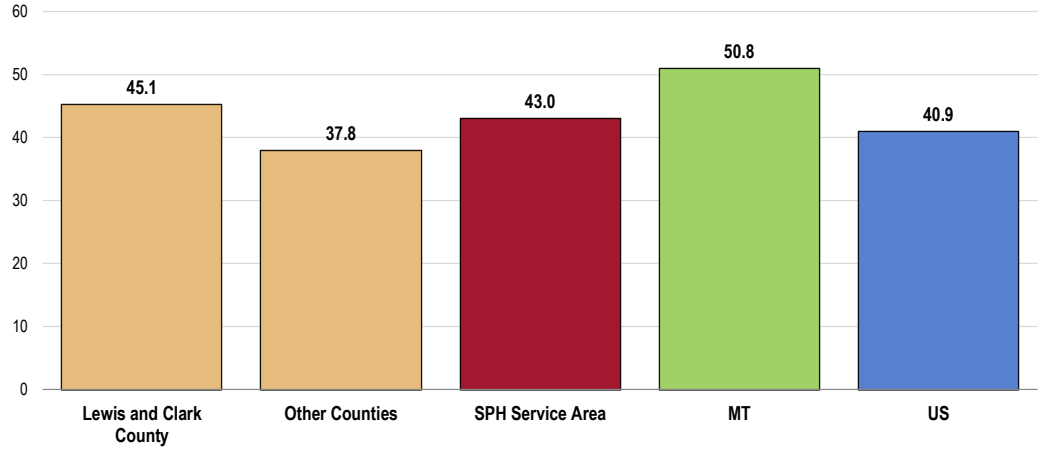
Note: COPD was changed to chronic lower respiratory disease (CLRD) in 1999 with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.

Between 2014 and 2016, there was an annual average age-adjusted CLRD mortality rate of 43.0 deaths per 100,000 population in the SPH Service Area.

- Lower than found statewide.
- Similar to the national rate.
- Higher in Lewis and Clark County.

CLRD: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)



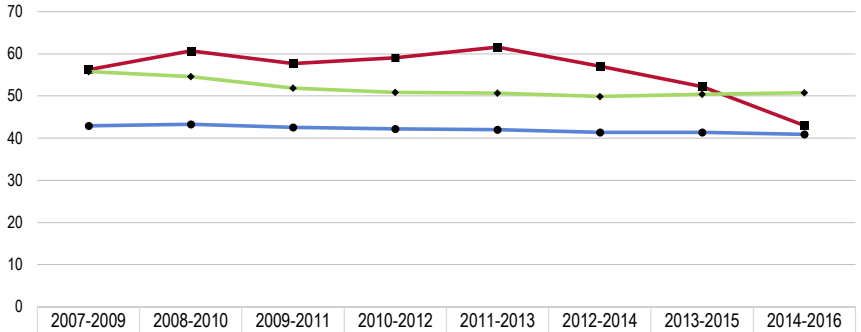
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- CLRD is chronic lower respiratory disease.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- TREND: Despite fluctuations, CLRD mortality in SPH Service Area has decreased over time and at a greater level than the trends reported both statewide and nationwide.

CLRD: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	56.2	60.7	57.7	59.1	61.6	57.1	52.2	43.0
MT	55.8	54.6	51.9	50.9	50.7	49.9	50.4	50.8
US	42.9	43.3	42.6	42.2	42.0	41.4	41.4	40.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.

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

Pneumonia/Influenza Deaths

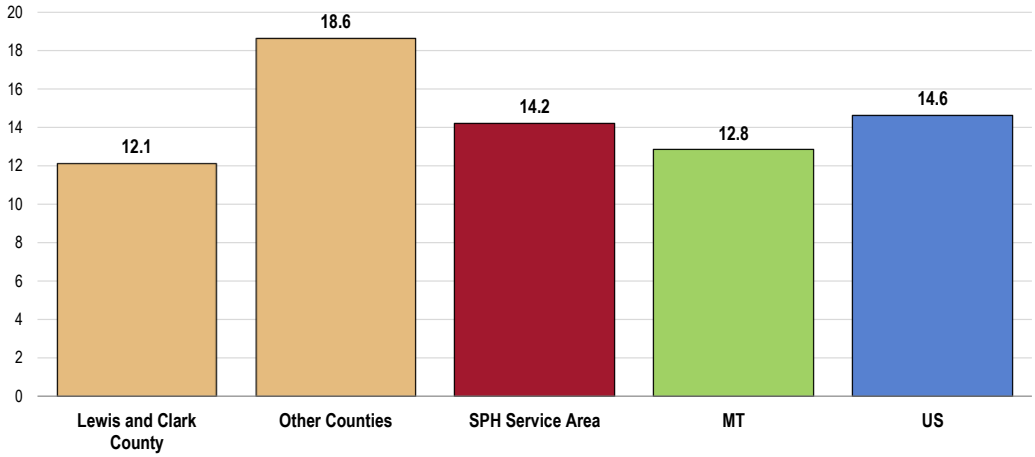
Between 2014 and 2016, the SPH Service Area reported an annual average age-adjusted pneumonia influenza mortality rate of 14.2 deaths per 100,000 population.

- Similar to that found statewide and nationally.
- Much higher in the Other Counties area.

For prevalence of vaccinations for pneumonia and influenza, see also *Immunization & Infectious Diseases* in the **Infectious Disease** section of this report.

Pneumonia/Influenza: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)



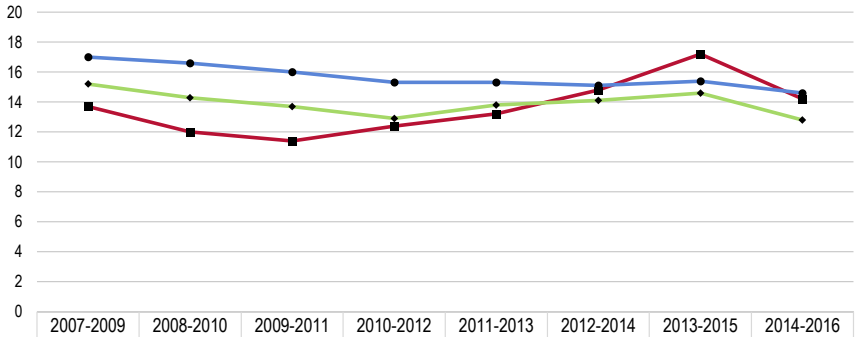
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- TREND: Increase in SPH Service Area pneumonia/influenza mortality since 2009. Nationally and statewide, pneumonia/influenza death rates have decreased.

Pneumonia/Influenza: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	13.7	12.0	11.4	12.4	13.2	14.8	17.2	14.2
MT	15.2	14.3	13.7	12.9	13.8	14.1	14.6	12.8
US	17.0	16.6	16.0	15.3	15.3	15.1	15.4	14.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.

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

Prevalence of Respiratory Disease

Asthma

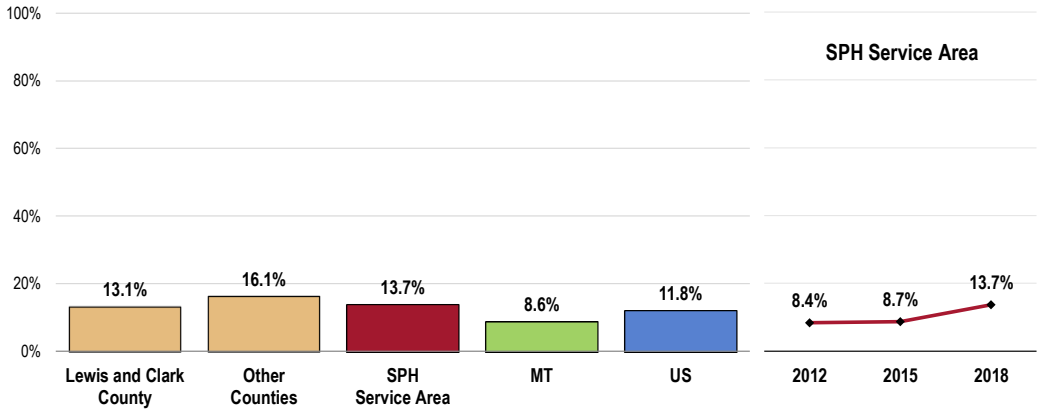
Adults

Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

A total of 13.7% of SPH Service Area adults currently suffer from asthma.

- Higher than the statewide prevalence.
- Similar to the national prevalence.
- Statistically similar by community.
- TREND: The prevalence of adults with current asthma has increased changed significantly since 2012.

Adult Asthma: Current Prevalence



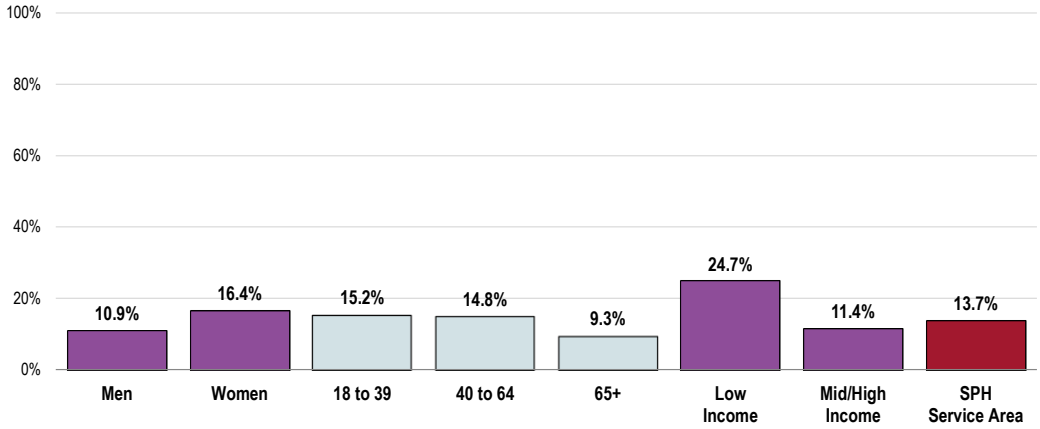
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Adults with lower incomes are more likely to report suffering from asthma.

Currently Have Asthma

(SPH Service Area, 2018)



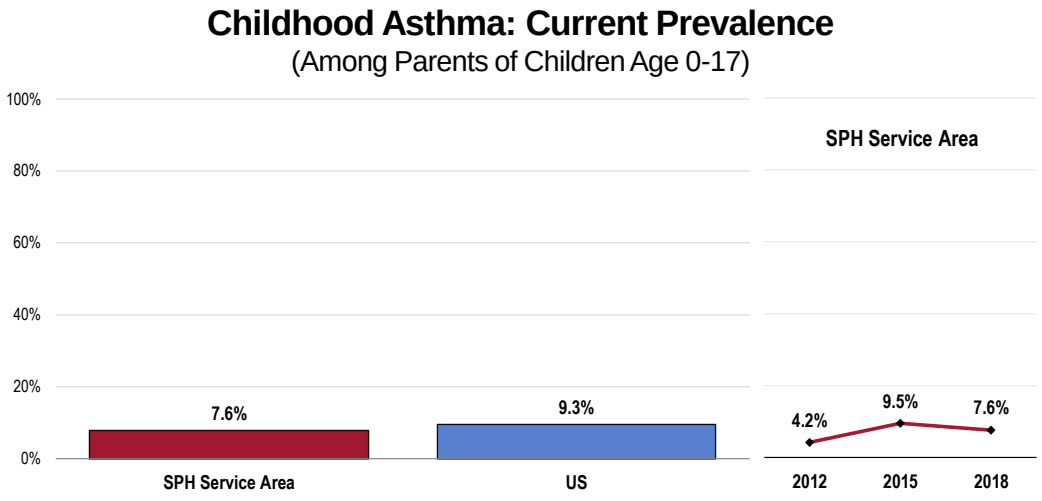
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

Among SPH Service Area children under age 18, 7.6% currently have asthma.

- Similar to national findings.
- TREND: Statistically unchanged over time.



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 139]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

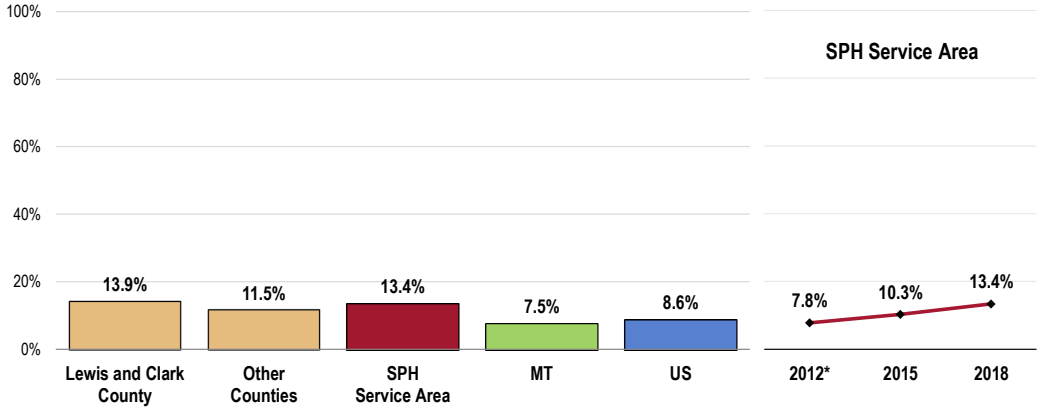
Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

A total of 13.4% of SPH Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

- Higher than state and national prevalence.
- Similar by county area.
- TREND: The change in prevalence has steadily increased over time.
- *NOTE: In prior data, this question was asked slightly differently; respondents in 2012 were asked if they had ever been diagnosed with "chronic lung disease, including bronchitis or emphysema," rather than "COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema," as is asked currently.*

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
- *In 2012 data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Wood-Burning Stoves

Stove Prevalence

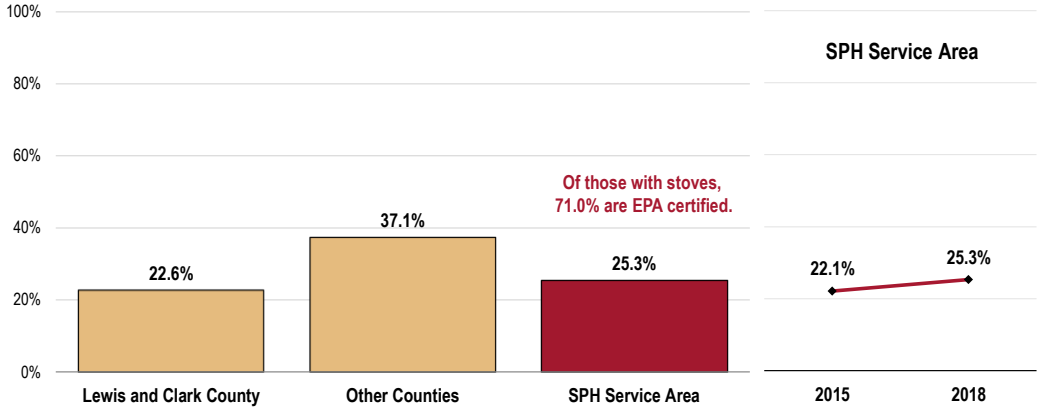
Wood smoke can affect everyone, but children, teenagers, older adults, people with lung disease, including asthma and COPD or people with heart diseases are the most vulnerable. A major health threat from smoke comes from fine particles (also called particle pollution, particulate matter, or PM). These microscopic particles can get into your eyes and respiratory system, where they can cause health problems such as burning eyes, runny nose, and illnesses such as bronchitis. In addition to particle pollution, wood smoke contains several toxic harmful air pollutants including: benzene, formaldehyde, acrolein and ethane (EPA).

One-quarter (25.3%) of service area adults use a wood-burning stove to heat their homes.

- The prevalence is higher in the Other Counties area.
- TREND: No significant difference over time.

Respondents with stoves report that a total of 71.0% of these stoves are EPA-certified.

Use a Wood-Burning Stove to Heat the Home



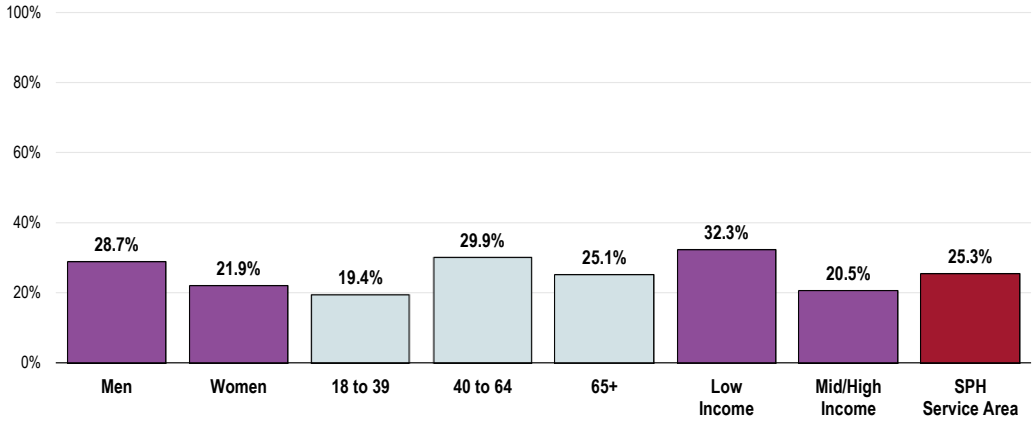
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 309-310]

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Differences by demographics are not statistically significant.

Use a Wood-Burning Stove to Heat the Home

(SPH Service Area, 2018)



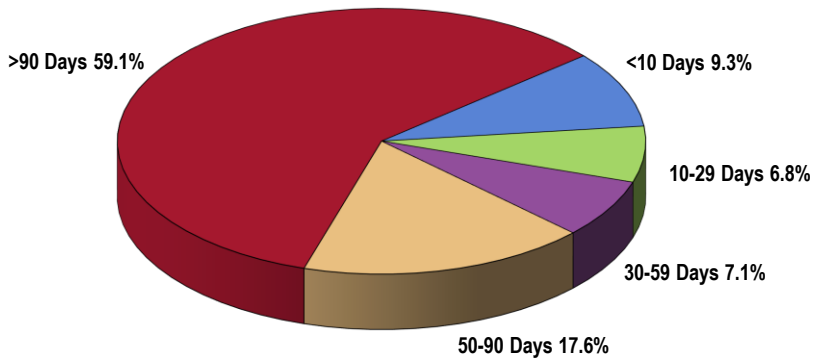
Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 309]
Notes: ● Asked of all respondents.
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Stove Use

Among SPH Service Area residents who use wood-burning stoves to heat their homes, 6 in 10 (59.1%) used the stove more than 90 days in the past year.

Frequency of Wood-Burning Stove Use in the Past Year

(SPH Service Area Respondents With Wood-Burning Stoves, 2018)



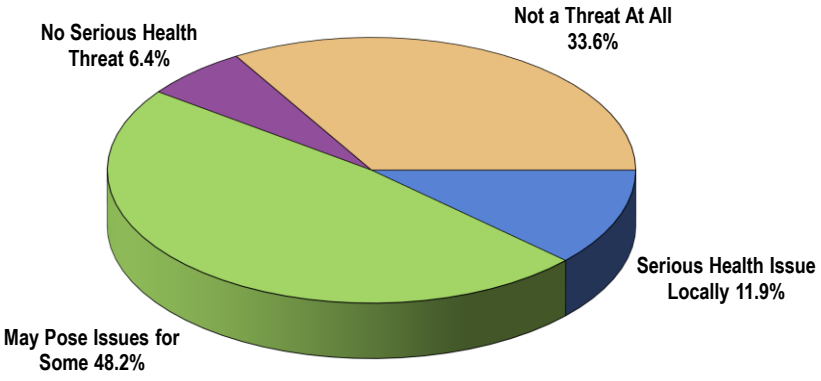
Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 311]
Notes: ● Asked of all respondents.

Perceptions of Wood Smoke

Of all respondents, 39.9% do not think the smoke poses a serious health issue to community members; this increases to 58.0% among those who have wood-burning stoves (not shown).

- On the other hand, 11.9% consider wood smoke to be a **serious health issue** locally.

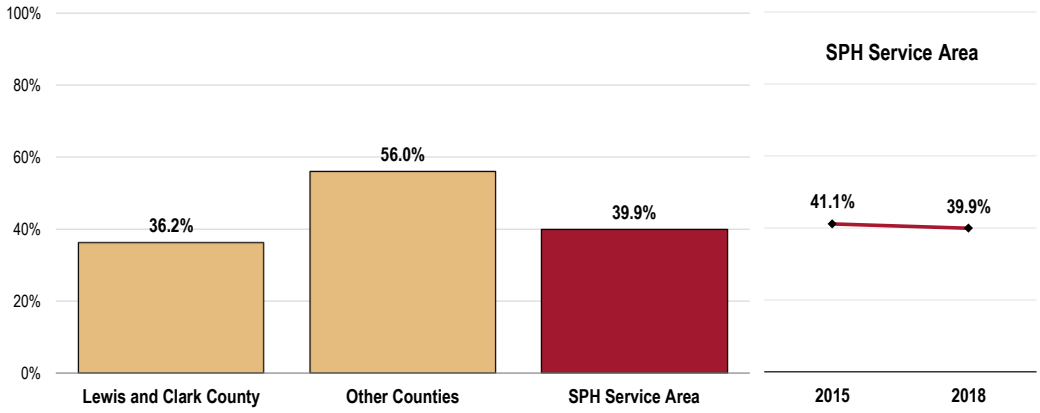
Opinion of Wood Smoke as a Serious Health Issue
(SPH Service Area, 2018)



Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 312]
Notes: ● Asked of all respondents.

- Residents in the Other Counties area are more likely to believe that wood smoke is not a threat to local health.

Do Not Think Wood Smoke Poses a Serious Health Issue

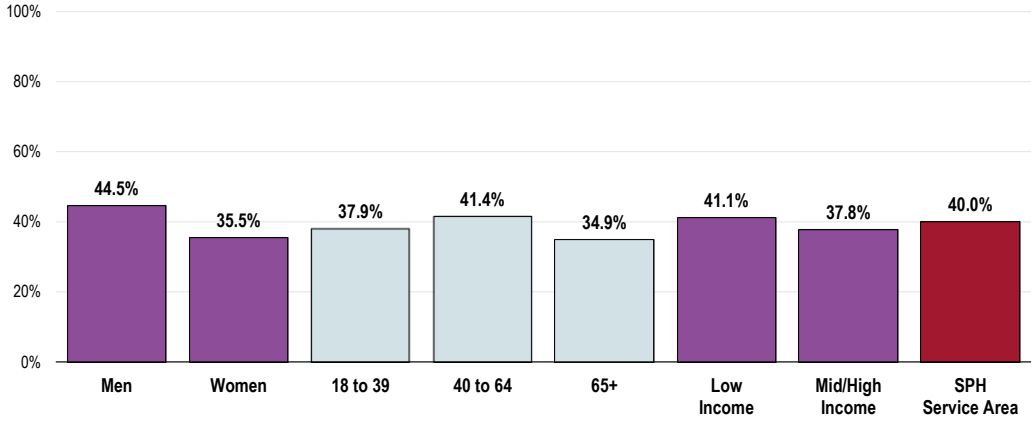


Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 312]
Notes: ● Asked of all respondents.
● Includes "Does not pose any serious health threat" and "Is not a threat to health in this area" responses.
● "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Perception of the health impact of wood smoke does not significantly differ by demographics.

Do Not Think Wood Smoke Poses a Serious Health Issue

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 312]

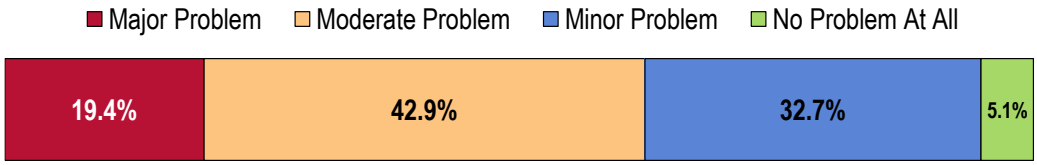
Notes:
- Asked of all respondents.
- Includes "Does not pose any serious health threat" and "Is not a threat to health in this area" responses.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Respiratory Disease

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

Perceptions of Respiratory Diseases as a Problem in the Community

(Key Informants, 2018)



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

Notes:
- Asked of all respondents.

Top Concerns

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

Environmental Contributors

> *The fire season is hard on our community. It's difficult as an employer for employees suffering from illness to come to work when the air is so bad. – Social Services Provider*
>
> *I am very concerned about air quality in Helena. Summer fires, in the winter there is wood smoke, which is not healthy for people in the homes that burn wood or for those of us who breathe it in the air. Also, the dry air and fine dust. – Community Leader*

Need more street sweeping. PPM particulate loads in the air in the winter are amazing. Smoke from fires in the summer and inversions in the winter. – Physician

We have poor air quality in the winter because of temperature inversions and wood stove. We have poor air quality in the summers because of wild fires. We have more lung diseases such as asthma than many places in Montana. – Public Health Representative

Poor air quality, due to inversions in the winter. Non-modern efficient wood burning stoves. Helena valley consistently year after year has poor air quality due to wood stove smoke during inversions. – Public Health Representative

Wildfire smoke. Numbers show that we have a higher rate of respiratory illness in our community compared to the nation. We need to work to make sure vulnerable populations are protected during smoke events. – Other Health Provider

Lack of Specialists

We do not have a pulmonologist. Have had five come and go in the last 20 years. – Physician

No pulmonologist. – Physician

We have no pulmonology services in our community. – Physician

No pulmonologist. – Physician

We have no pulmonologist in Helena. Lung patients have to travel out of town. Also, Helena has some of the worst air quality in the nation. – Physician

No access to pulmonologist. – Physician

Lack of pulmonology services and physicians. – Physician

Prevalence/Incidence

With the amount of people that get admitted for COPD/respiratory issues it only makes sense to have a pulmonologist running a clinic and rounding in the Intensive Care Unit. – Physician

These illnesses result in frequent, recurring hospitalizations. – Physician

Respiratory issues among young and old seem to be increasing. Among older residents, effects of smoking and/or occupational exposure to environmental respiratory risks contribute to later respiratory issues. Asthma seems to be a growing problem. – Social Services Provider

The most recent community health assessment showed that our county has comparatively high rates of lung cancer, COPD, and asthma. Air quality monitoring also shows that the county often has poor air quality due to wood smoke in the winter. – Public Health Representative

Injury & Violence

About Injury & Violence

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

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

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

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

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

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

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

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

Efforts to prevent violence may focus on:

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

- Healthy People 2020 (www.healthypeople.gov)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

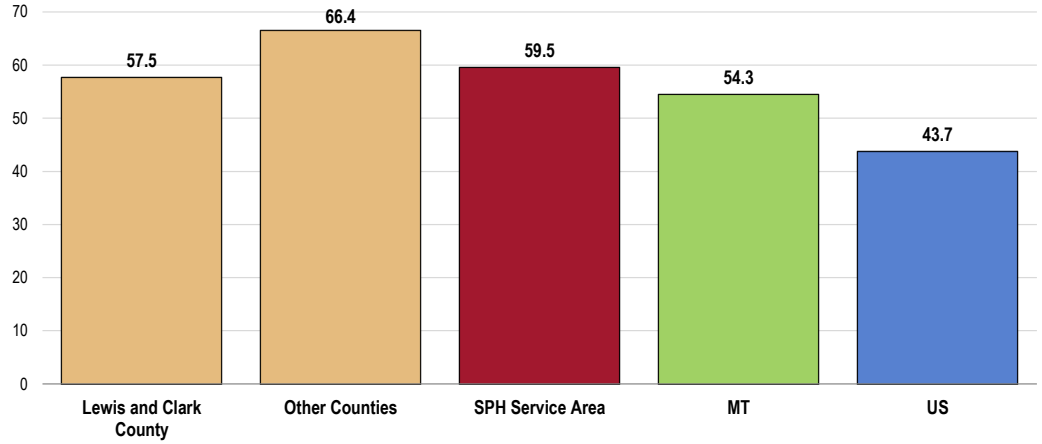
Between 2014 and 2016, there was an annual average age-adjusted unintentional injury mortality rate of 59.5 deaths per 100,000 population in the SPH Service Area.

- Similar to the Montana rate and much higher than the national rate.
- Fails to satisfy the Healthy People 2020 target (36.4 or lower).
- Higher in the Other Counties area.

Unintentional Injuries: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.4 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

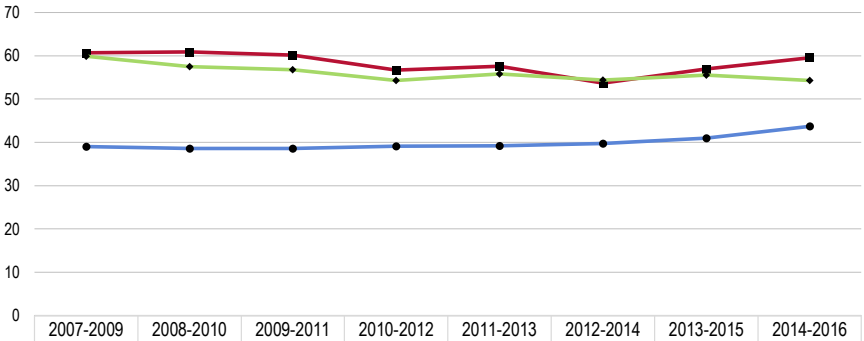
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- TREND: There appears to be no clear trend in the unintentional injury mortality rate in the SPH Service Area.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 36.4 or Lower



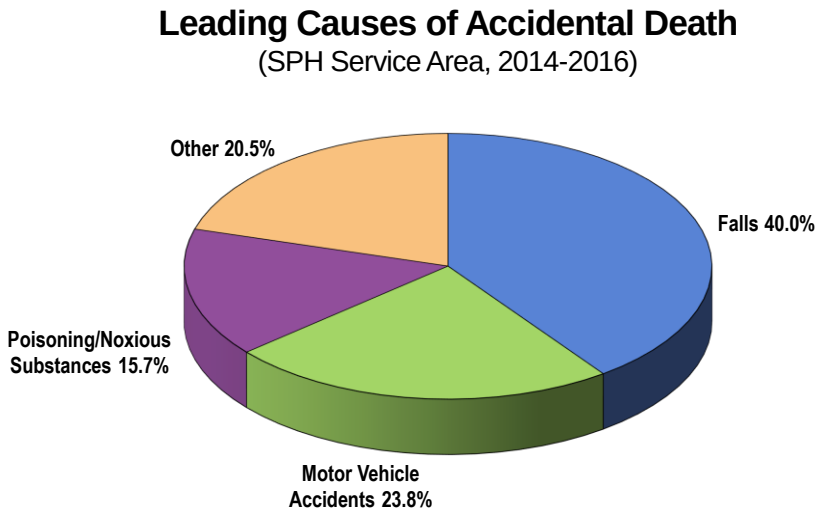
	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	60.7	60.9	60.2	56.7	57.6	53.7	57.0	59.5
MT	59.9	57.5	56.8	54.3	55.8	54.4	55.5	54.3
US	39.0	38.6	38.6	39.1	39.2	39.7	41.0	43.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]

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

Leading Causes of Accidental Death

Falls, motor vehicle accidents, and poisoning (including accidental drug overdose) accounted for most accidental deaths in the SPH Service Area between 2014 and 2016.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Selected Injury Deaths

The following chart outlines mortality rates for unintentional drug-related deaths, motor vehicle crashes, and falls (among adults age 65 and older).

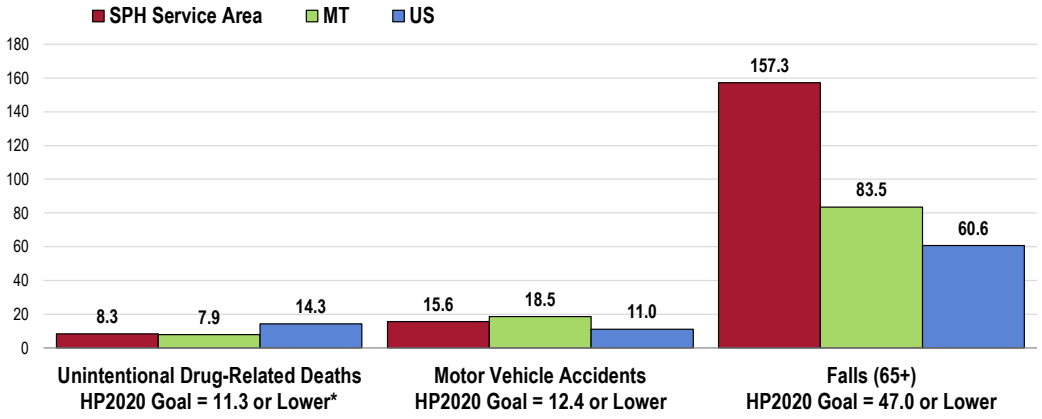
These SPH Service Area annual average age-adjusted mortality rates are worse than US rates for:

- Motor vehicle accidents.
- Falls.

SPH Service Area mortality rates are worse than state rates for falls.

Select Injury Death Rates

(By Cause of Death; 2014-2016 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1, IVP-23.2, SA-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- *Healthy People 2020 goal reflects all drug-induced deaths, both intentional and unintentional.

Seat Belt Usage

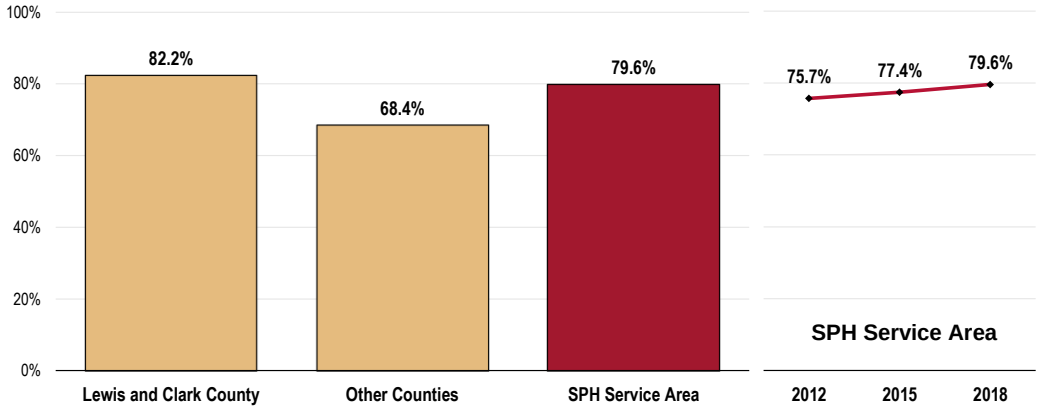
Adults

Eight in 10 area adults (79.6%) report "always" wearing a seat belt when driving or riding in a vehicle.

- Fails to satisfy the Healthy People 2020 target of 92.0% or higher.
- Lower in the Other Counties area.
- TREND: The increase since 2012 is not statistically significant.

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle

Healthy People 2020 Target = 92.0% or Higher

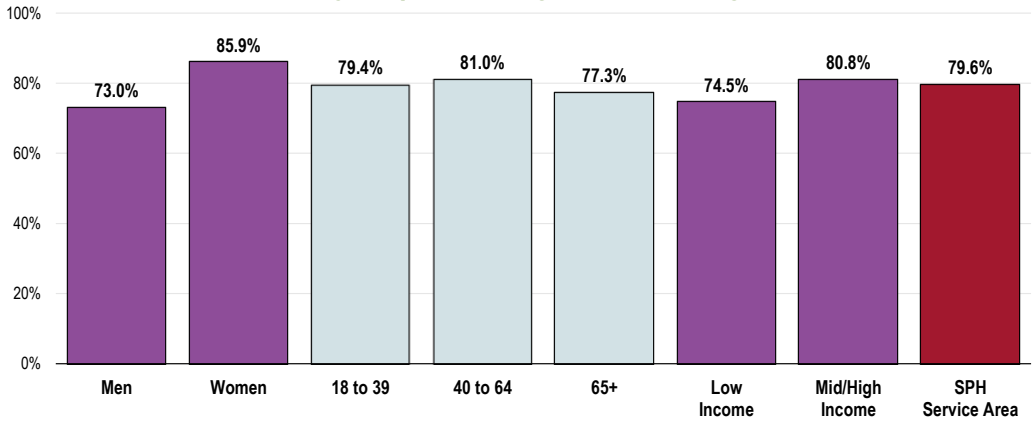


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 303]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-15]

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Men are less likely to always wear a seat belt in a vehicle.

"Always" Wear a Seat Belt When Driving or Riding in a Vehicle
(SPH Service Area, 2018)
Healthy People 2020 Target = 92.0% or Higher



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 303]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-15]

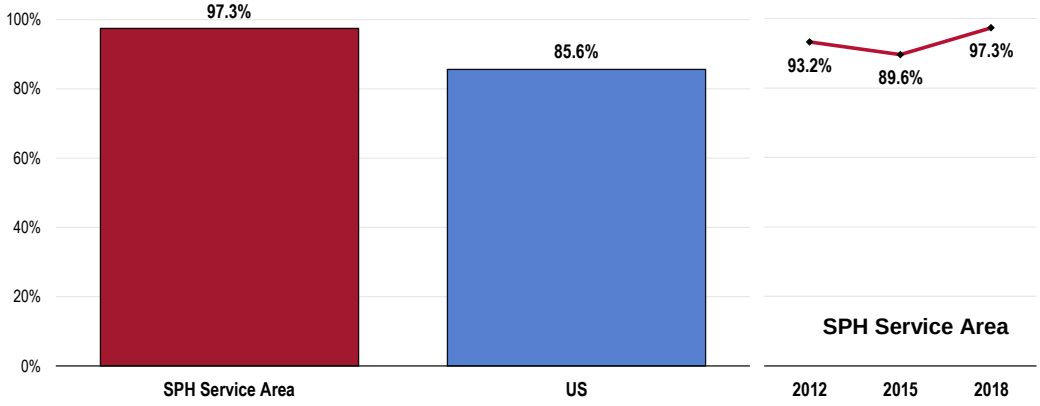
Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

An overwhelming majority (97.3%) of SPH Service Area parents report that their child "always" wears a seat belt (or appropriate car seat for younger children) when riding in a vehicle.

- Statistically similar to the national percentage.
- TREND: No clear trend, though much higher than 2015 data.

Child "Always" Wears a Seat Belt or Appropriate Restraint When Riding in a Vehicle
(Among Parents of Children Age 0-17)



Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 328]
● 2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Helmet Use

Adults

Among respondents who rode a motorcycle in the past year, 62.5% "always" wore a helmet when doing so, and 7.3% "nearly always" did so.

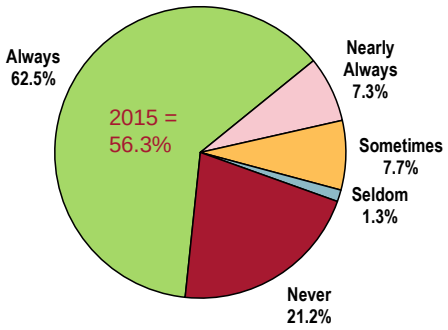
- Conversely, 21.2% of area motorcycle riders "never" wore a helmet when riding a motorcycle in the past year.

Of those respondents who rode a bicycle in the past year, 35.5% "always" wore a helmet when doing so, and 11.5% "nearly always" did so.

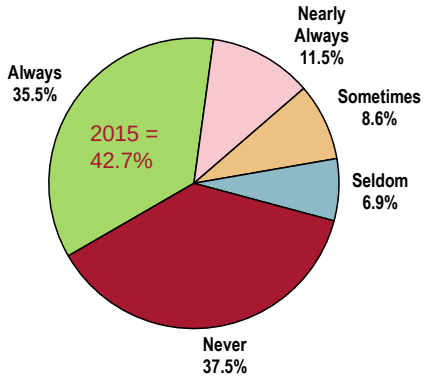
- In contrast, 37.5% of service area bicycle riders "never" wore a helmet when riding a bicycle in the past year.

Adult Helmet Use

(SPH Service Area, 2018)



Frequency of Motorcycle Helmet Use in the Past Year



Frequency of Bicycle Helmet Use in the Past Year

Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 304-305]
Notes: ● Asked of those respondents who ride bicycles and/or motorcycles.

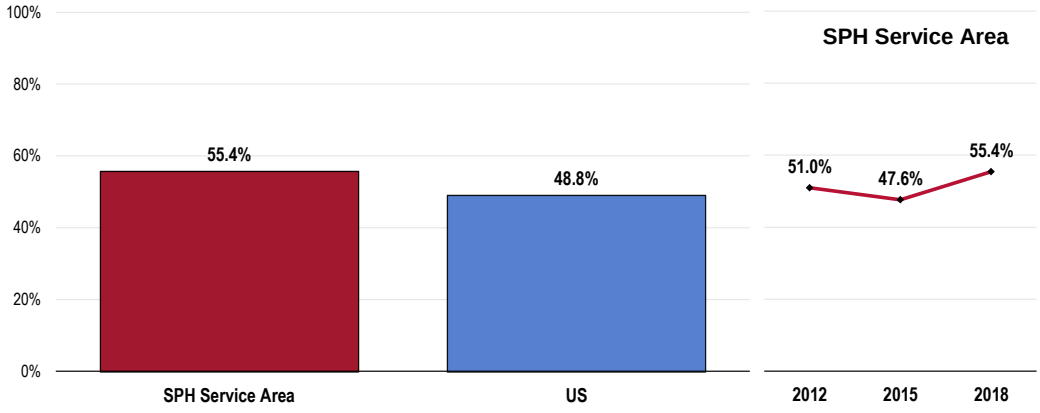
Children

Just over half of parents of children age 5-17 reported that their child "always" wears a helmet when riding a bicycle.

- Statistically similar to the national prevalence.
- TREND: The increase over time is not statistically significant.

Child "Always" Wears a Helmet When Riding a Bicycle

(Among Parents of Children Age 5-17)



Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 327]
● 2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children age 5 to 17 at home.

Falls

Falls

Each year, an estimated one-third of older adults fall, and the likelihood of falling increases substantially with advancing age. In 2005, a total of 15,802 persons age ≥65 years died as a result of injuries from falls.

Falls are the leading cause of fatal and nonfatal injuries for persons aged ≥65 years … In 2006, approximately 1.8 million persons aged ≥65 years (nearly 5% of all persons in that age group) sustained some type of recent fall-related injury. Even when those injuries are minor, they can seriously affect older adults' quality of life by inducing a fear of falling, which can lead to self-imposed activity restrictions, social isolation, and depression.

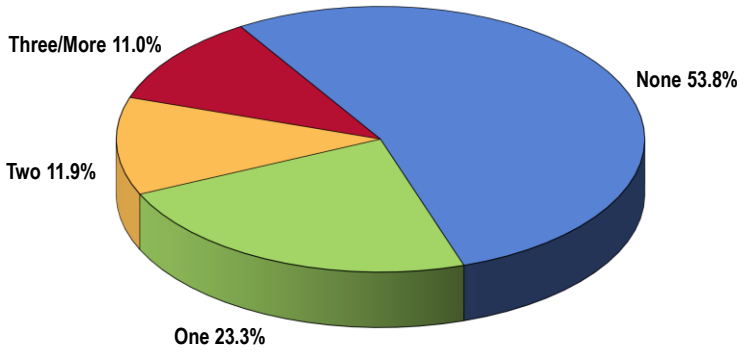
In addition, fall-related medical treatment places a burden on US healthcare services. In 2000, direct medical costs for fall-related injuries totaled approximately $19 billion. A recent study determined that 31.8% of older adults who sustained a fall-related injury required help with activities of daily living as a result, and among them, 58.5% were expected to require help for at least 6 months.

Modifiable fall risk factors include muscle weakness, gait and balance problems, poor vision, use of psychoactive medications, and home hazards. Falls among older adults can be reduced through evidence-based fall-prevention programs that address these modifiable risk factors. Most effective interventions focus on exercise, alone or as part of a multifaceted approach that includes medication management, vision correction, and home modifications.

- Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC

Among surveyed SPH Service Area adults age 45 and older, 46.2% fell at least once in the past year, including 11.0% who fell three or more times.

Number of Falls in Past 12 Months
(Among Adults Age 45 and Older; SPH Service Area, 2018)



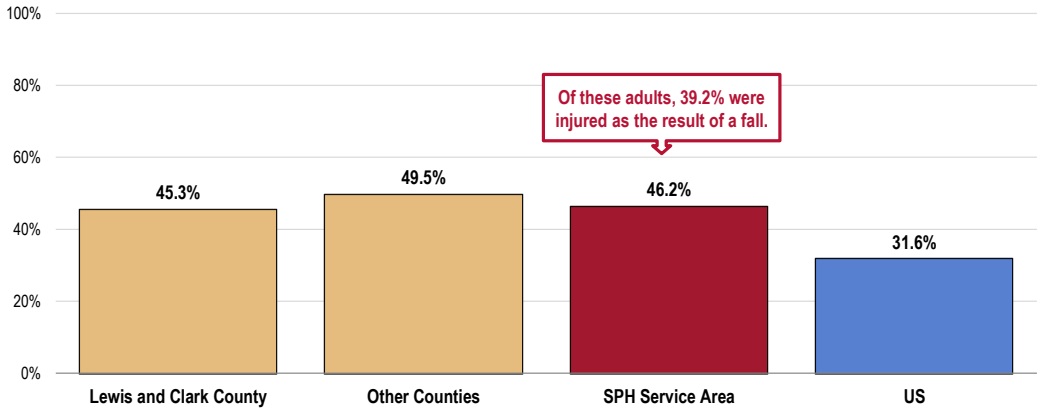
Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 107]
Notes: ● Asked of all respondents age 45+.

- The prevalence of adults age 45+ who fell at least once in the past year is higher than the national proportion.
- Similar by county area.

Among those who fell in the past year, 39.2% were injured as a result of the fall.

Fell One or More Times in the Past Year

(Among Respondents Age 45 and Older)



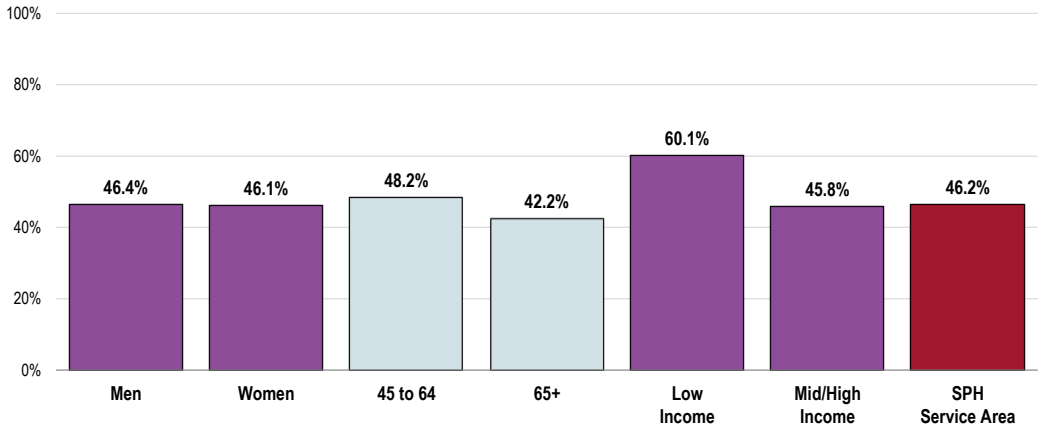
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 107-108]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of those respondents age 45 and older.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Low-income adults (age 45+) are more likely to have fallen in the past year:

Fell One or More Times in the Past Year

(Among Respondents Age 45 and Older; SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 107]

Notes:
- Asked of those respondents age 45 and older.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Firearm Safety

Age-Adjusted Firearm-Related Deaths

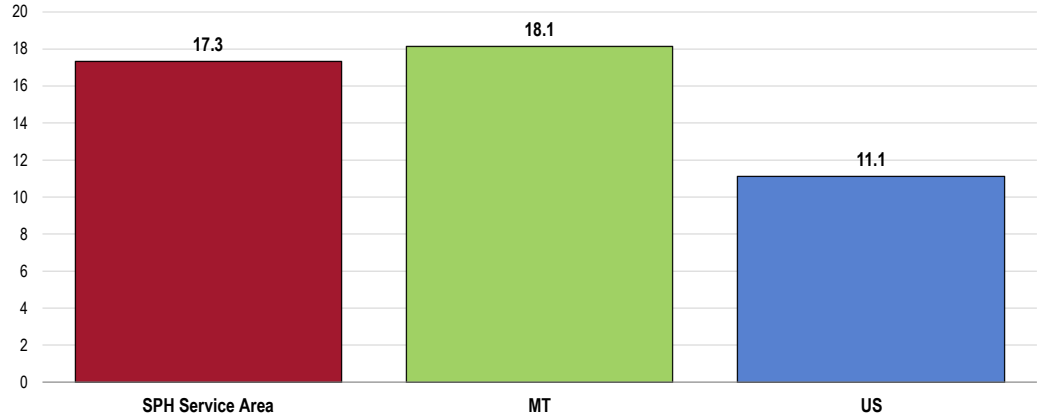
Between 2014 and 2016, firearms in the SPH Service Area contributed to an annual average age-adjusted rate of 17.3 deaths per 100,000 population.

- Similar to that found statewide.
- Much higher than found nationally.
- Fails to satisfy the Healthy People 2020 objective (9.3 or lower).

Firearms-Related Deaths: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 9.3 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-30]

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

Presence of Firearms in Homes

Survey respondents were asked about the presence of weapons in the home:

"Are there any firearms now kept in or around your home, including those kept in a garage, outdoor storage area, truck, or car? For the purposes of this inquiry, 'firearms' include pistols, shotguns, rifles, and other types of guns, but do NOT include starter pistols, BB guns, or guns that cannot fire."

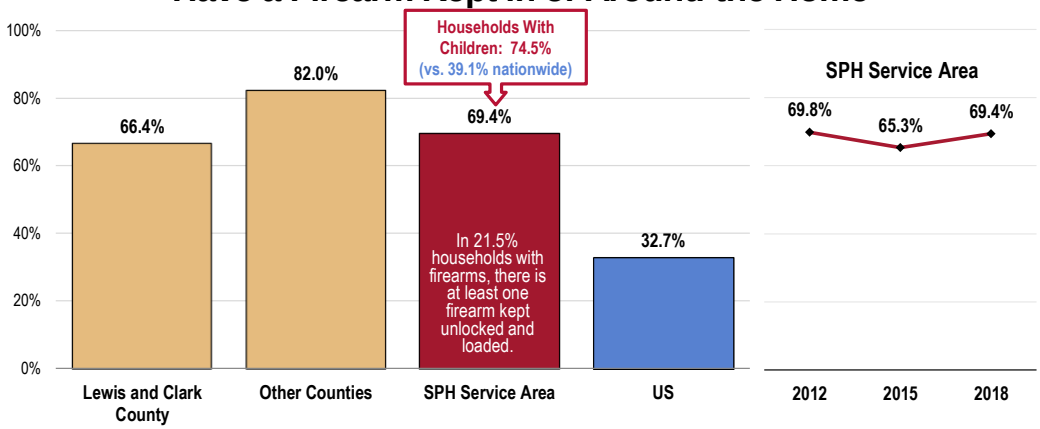
Overall, 7 in 10 SPH Service Area adults (69.4%) have a firearm kept in or around their home.

- More than double the national prevalence.
- Highest in the Other Counties area.
- TREND: The prevalence of firearms in the SPH Service Area homes has not significantly changed over time.

In households with firearms, one-fifth of firearms is kept unsecured.

Among SPH Service Area households with children, three-quarters (74.5%) have a firearm kept in or around the house (much higher than reported nationally).

Have a Firearm Kept in or Around the Home



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 306, 332-333]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- In this case, firearms include pistols, shotguns, rifles, and other types of guns; this does not include starter pistols, BB guns, or guns that cannot fire.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

Between 2014 and 2016, there was an annual average age-adjusted homicide rate of 2.5 deaths per 100,000 population in the SPH Service Area.

- Much lower than the state rate, but especially lower than the national rate.
- Satisfies the Healthy People 2020 target of 5.5 or lower.

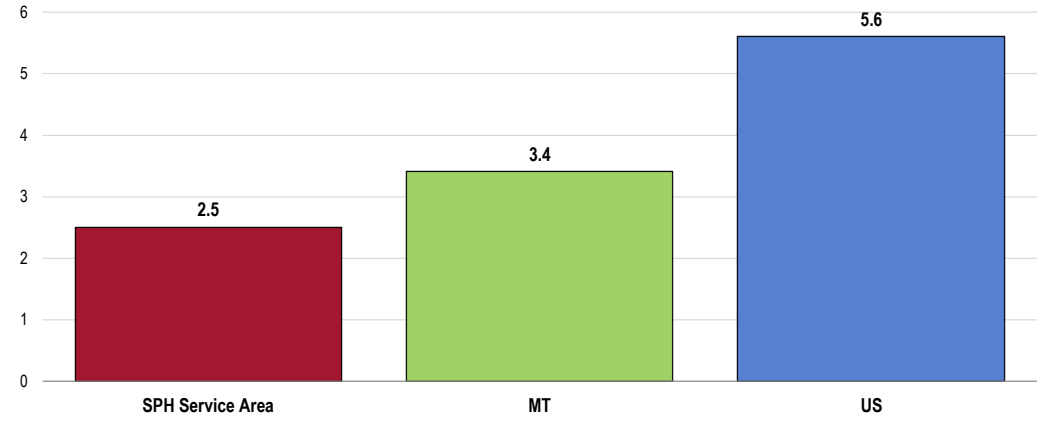
RELATED ISSUE:

See also *Mental Health*: *Suicide* in the **General Health Status** section of this report.

Homicide: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 5.5 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-29]

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

Violent Crime

Violent Crime Rates

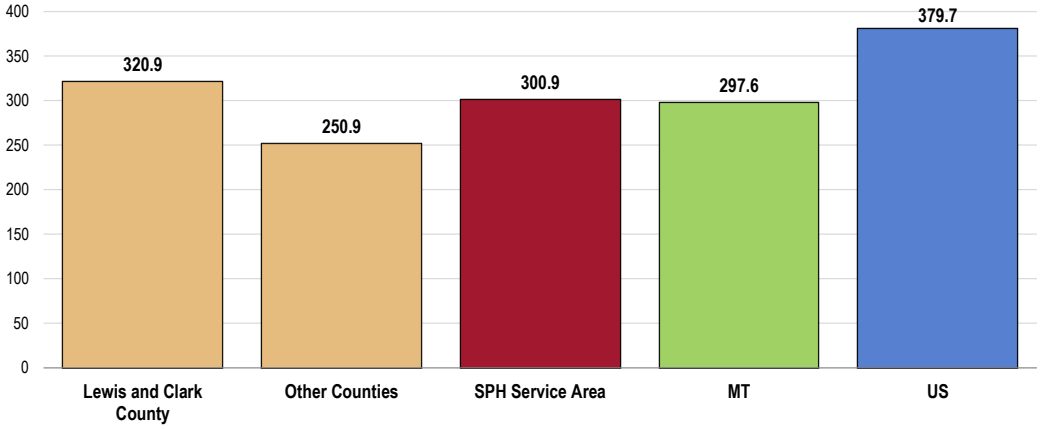
Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

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

Between 2012 to 2014, there were a reported 300.9 violent crimes per 100,000 population in the SPH Service Area.

- Similar to the Montana rate for the same period.
- Lower than the national rate.
- Higher in Lewis and Clark County.

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



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

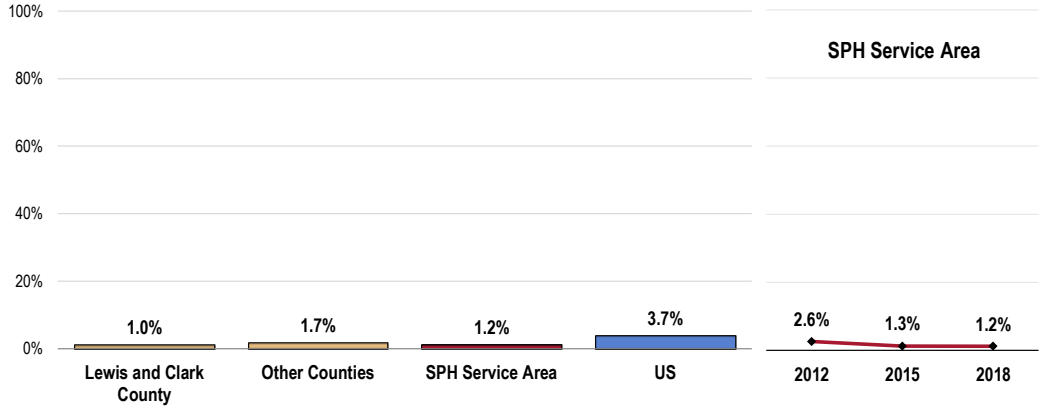
Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation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

Community Violence

A total of 1.2% of surveyed SPH Service Area adults acknowledge being the victim of a violent crime in the area in the past five years.

- Lower than national findings.
- Similar by county area.
- TREND: The decrease since 2012 is not statistically significant.

Victim of a Violent Crime in the Past Five Years

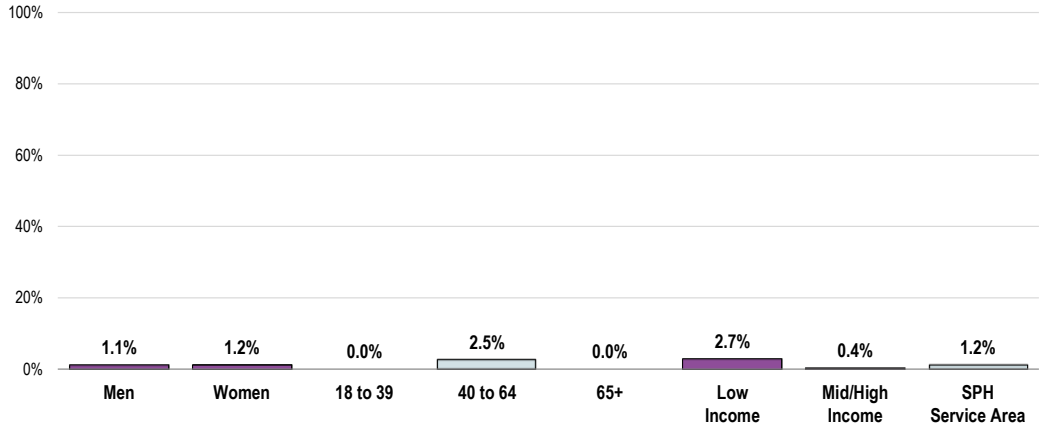


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 46]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- No significant differences in violent crime prevalence by demographics.

Victim of a Violent Crime in the Past Five Years
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 46]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Family Violence

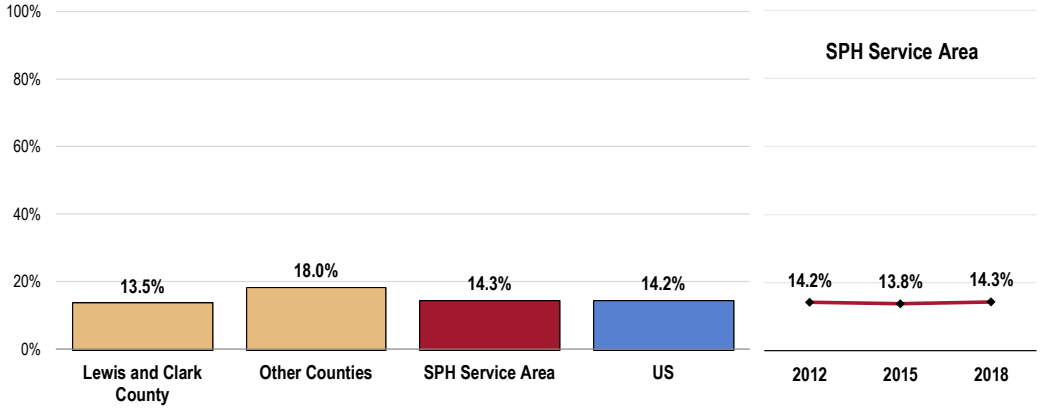
A total of 14.3% of SPH Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

Respondents were read:

"By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

- Almost identical to national findings.
- Statistically similar by community.
- TREND: The prevalence of acknowledged domestic violence in the SPH Service area has remained constant over time.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 47]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

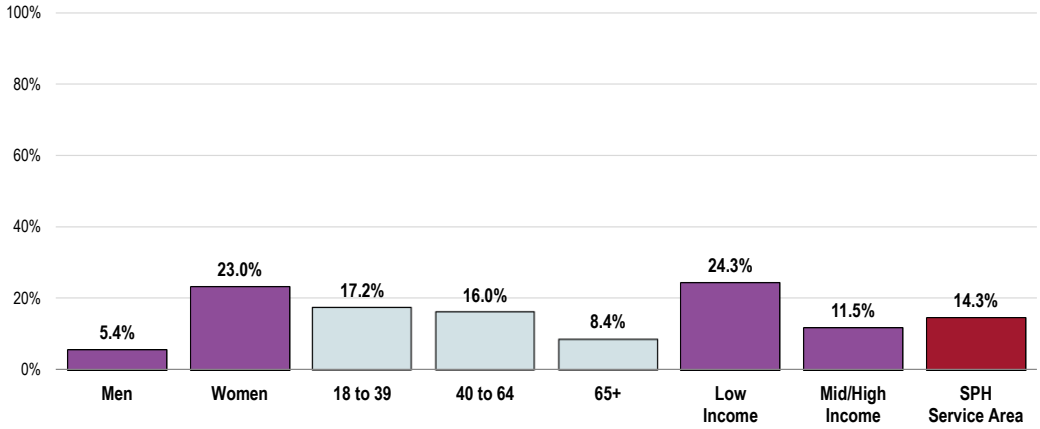
Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Reports of domestic violence are also notably higher among:

- Women.
- Adults under the age of 65.
- Those with lower incomes.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 47]

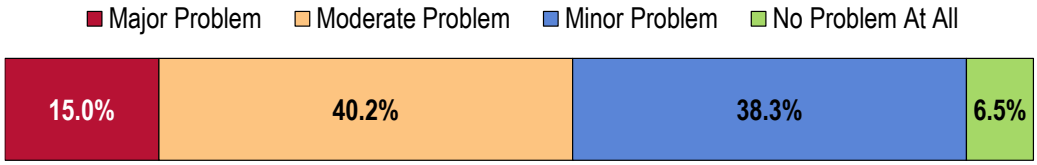
Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

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, 2018)



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

Top Concerns

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

Prevalence/Incidence

Montana as a whole has problems with domestic violence, workplace injury, and vehicle fatalities. In the Helena community, violent crimes have made the news recently and domestic violence and abuse is constantly in the arrest log. – Other Health Provider

I read the news and see all the people being arrested for violence, particularly violence against family members and recently a son murdering his own parents. – Other Health Provider

So many reports of bullying, domestic violence, and sexual assault. – Other Health Provider

I believe injury and violence are major problems in Helena because… I hear more about what's happening in Helena than I did before. – Social Services Provider

Violence is a major problem. Culture acclimated and now devoted to violence through aggressive governmental, military, and administrative policies. – Community Leader

The newspaper is full of stories of people engaging in family or partner violence or violence among friends or acquaintances and among strangers. Children are severely injured or killed routinely. Guns are too available. – Community Leader

Access to Care/Services

This is Montana, the fourth largest state. Access to healthcare and health services may require airlifting in many cases. Accidents on highways or assaults in rural communities often require more than an ambulance. – Community Leader

Lack of treatment facilities for those suffering from alcohol and drug, addiction. The violence in our community continues to increase. We also don't have safe places for our children to go and they are left with adults who hurt them. – Social Services Provider

Lack of education on the cycle of violence in the courts. Lack of resources for women to leave violence. – Social Services Provider

Contributing Factors

In rural states with lots of roads, high speed limits, lots of drinking and weak seat belt laws, this is the case. Further, we have lots of guns and high suicide rates. – Public Health Representative

We have the worst drivers in the country. Our legal system does not take drunk drivers off the streets. – Physician

> *Acceptance of youth drinking and doing other drugs until a crisis occurs. Youths not treated for ACEs after home-based trauma. Only one in the family who gets care is the perpetrator. – Other Health Provider*

Firearm Prevalence

> *Percentage of homes with firearms and an inadequate recognition of the threat they pose to those who live in them. Accessibility of firearms hugely magnifies the lethality of suicide attempts, which is a chronic long-term problem in this community. – Physician*

> *Too many guns that are not used for hunting. Available that are used for violent actions by old and young alike. Suicides, murders, assaults, and robberies. – Community Leader*

Co-Occurrences

> *Violence is very difficult to describe, it correlates with mental health. – Social Services Provider*

Head Trauma

> *Head trauma, TBI. – Other Health Provider*

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.
- 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)

Age-Adjusted Diabetes Deaths

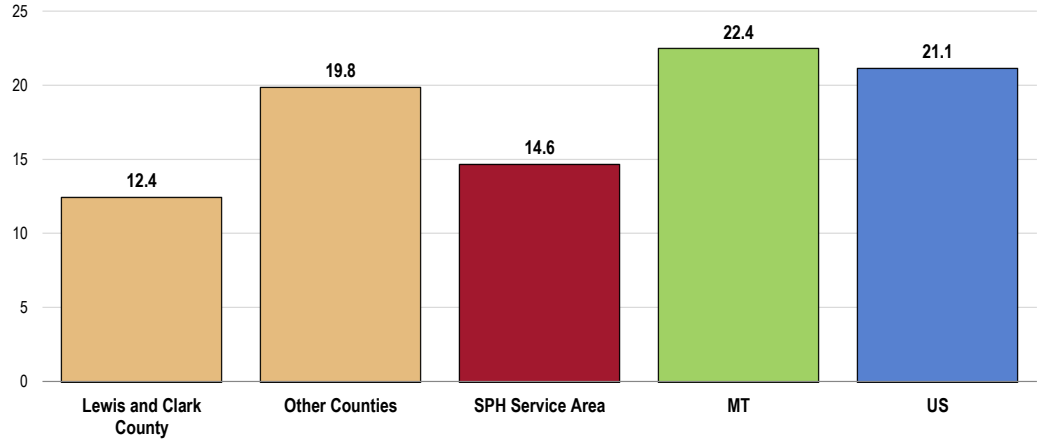
Between 2014 and 2016, there was an annual average age-adjusted diabetes mortality rate of 14.6 deaths per 100,000 population in the SPH Service Area.

- More favorable than that found statewide or nationally.
- Satisfies the Healthy People 2020 target (20.5 or lower, adjusted to account for diabetes mellitus-coded deaths).
- Higher in the Other Counties area.

Diabetes: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 20.5 or Lower (Adjusted)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

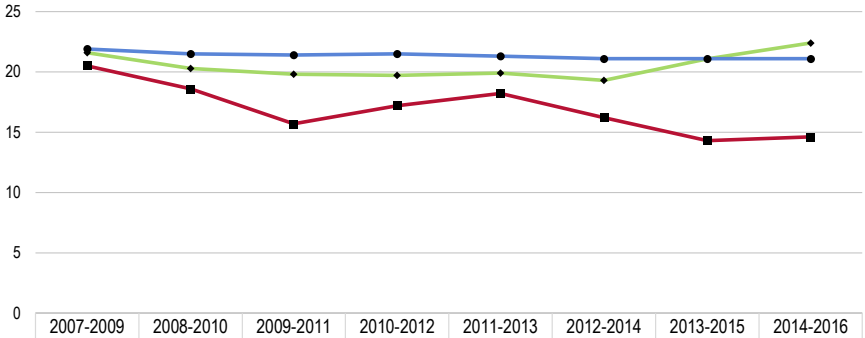
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- TREND: Despite some fluctuation, diabetes mortality has overall trended downward over time in the SPH Service Area. Statewide, the rate appears to have increased recently, while remaining stable in the US.

Diabetes: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 20.5 or Lower (Adjusted)



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	20.5	18.6	15.7	17.2	18.2	16.2	14.3	14.6
MT	21.6	20.3	19.8	19.7	19.9	19.3	21.1	22.4
US	21.9	21.5	21.4	21.5	21.3	21.1	21.1	21.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

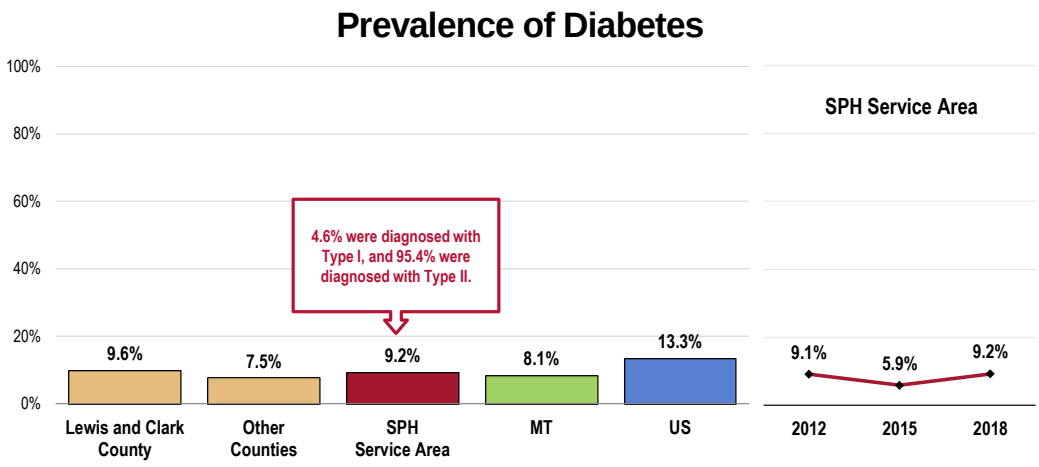
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

A total of 9.2% of SPH Service Area adults report having been diagnosed with diabetes.

- Similar to the statewide proportion.
- Below the national proportion.
- Statistically similar by community.
- TREND: Statistically unchanged since 2012.

Of those diagnosed with diabetes, 4.6% were diagnosed with Type I, and 95.4% were diagnosed with Type II.

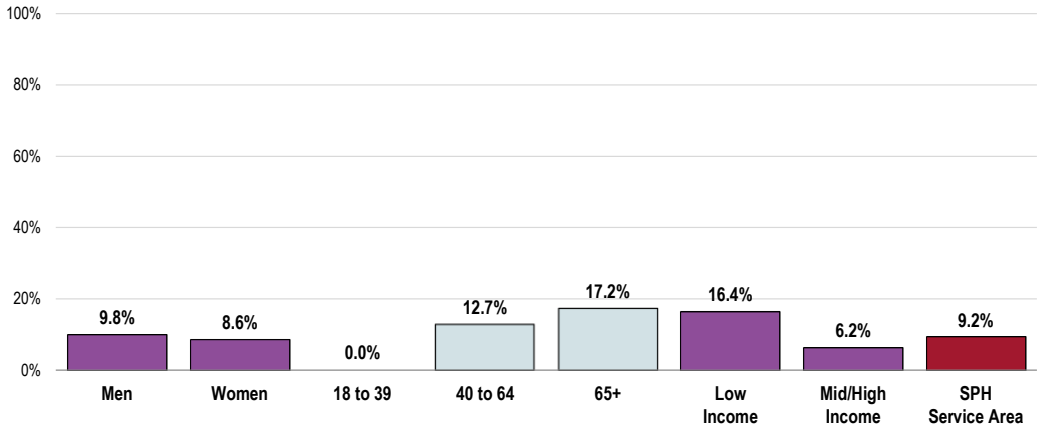


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 140, 301]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Note the correlations with both age and income level.

Prevalence of Diabetes
(SPH Service Area, 2018)



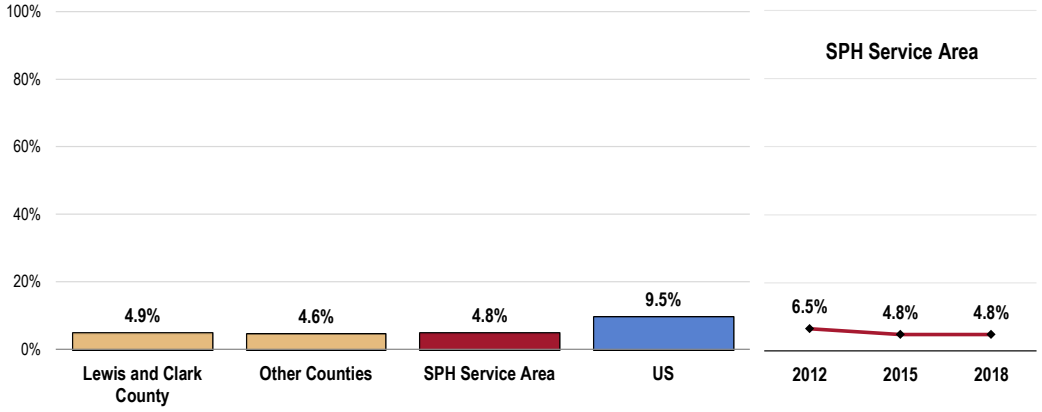
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 140]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excludes gestational diabetes (occurring only during pregnancy).

In addition to the prevalence of diagnosed diabetes referenced above, another 4.8% of SPH Service Area adults report that they have "pre-diabetes" or "borderline diabetes."

- Below the US prevalence.
- Similar findings by area.

Prevalence of Pre-Diabetes



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 140]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

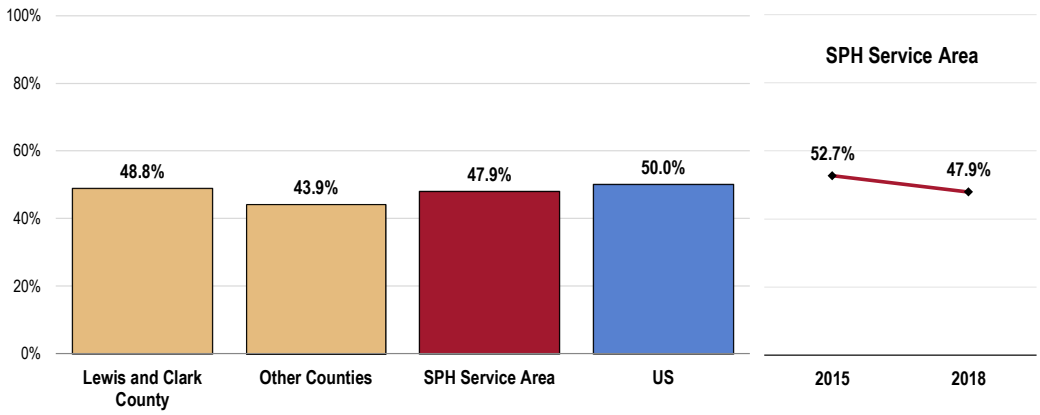
Diabetes Testing

Of area adults who have <u>not</u> been diagnosed with diabetes, 47.9% report having had their blood sugar level tested within the past three years.

- Similar to the national proportion.
- Statistically similar by community.
- TREND: Statistically unchanged since 2015.

Have Had Blood Sugar Tested in the Past Three Years

(Among Nondiabetics)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 37]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

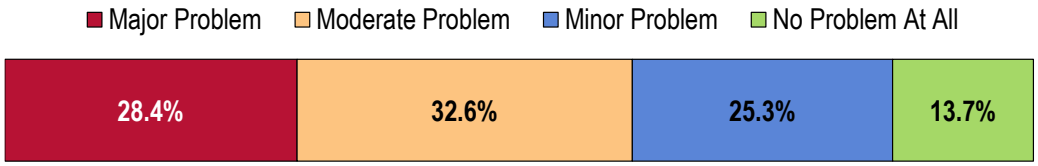
Notes:
- Asked of respondents who have not been diagnosed with diabetes.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Key Informant Input: Diabetes

One-third of key informants taking part in an online survey characterized *Diabetes* as a "moderate problem" in the community.

Perceptions of Diabetes as a Problem in the Community

(Key Informants, 2018)



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

Notes:
- Asked of all respondents.

Top Concerns

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

Health Awareness/Education

Knowing how to care for themselves properly and having the willpower to stick to the recommended nutrition guidelines. – Public Health Representative

I'm concerned that many people who are diabetic or pre-diabetic don't even know it. Workplace wellness screenings can help with this. I think there are many people who actually don't want to find out their blood sugar levels. – Public Health Representative

Continued education to people who are at risk for diabetes such as pre-diabetes. Also continued education on how physical activity and diet are related to diabetes. – Public Health Representative

Education and disease community building. – Physician

Education regarding morbidity factors, the lack of access to dental care. Definitive link exists between oral inflammation and the ability to control diabetic conditions, yet many of those afflicted have no dental insurance and medical insurance. – Other Health Provider

Education in how to prevent/control Type II diabetes. – Community Leader

Recognizing systems. – Community Leader

Education. – Community Leader

Lifestyle

I think it's hard for people to adopt lifestyle changes in Helena, especially related to diet. Need more educational support and access to healthy foods. For those with limited self-care ability and low incomes eating appropriately is a real challenge. – Social Services Provider

Many patients overweight, poor diet. – Physician

Minimal opportunities and understanding of incorporating physical activity into daily lifestyles. Healthy foods can be far more expensive than fast food and less healthy food, making it more difficult for people to manage their diet. – Other Health Provider

Their own behavior. Too many fast food options. – Physician

Access to Care/Services

Access to endocrinologist, ongoing care. – Community Leader

Access and affordability to diabetic supplies, medications, and education. – Public Health Representative

I think people don't know or access resources available. – Social Services Provider

Access to Healthy Food

Lack of affordable healthy food options and physical inactivity due to lack of community indoor gym options. – Public Health Representative

Lack of healthy food options and the current stores charge a lot for eating healthier foods. – Community Leader

Access to healthy, affordable foods that can help keep blood sugar levels at a healthy point. – Public Health Representative

Disease Management

Diabetes is a complex issue, and there are many factors in controlling and treating the disease. It's not just go see your physician, but rather building a team of healthcare professionals to help. – Public Health Representative

Understanding and appropriate self-management. – Physician

Diagnosis, treatment, education, and support. – Other Health Provider

Prevalence/Incidence

Diabetes is more prevalent in the community than most people realize and there needs to be more education about the disease and what it does and does not mean for the person who is diagnosed with the problem. – Community Leader

I read a lot about the increase in diabetes. Not just in our area, but all over the United States. My husband was diagnosed with Type II diabetes recently. – Social Services Provider

Early Diagnosis/Prevention

> *I see the biggest challenge as prevention of the disease. With lifestyle changes, Type 2 diabetes is preventable. We need to expand access to the diabetes prevention program led by the state health department. – Public Health Representative*

Lack of Specialty Care

> *Only one endocrinologist. Education and understanding of the disease is poor. – Physician*

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.

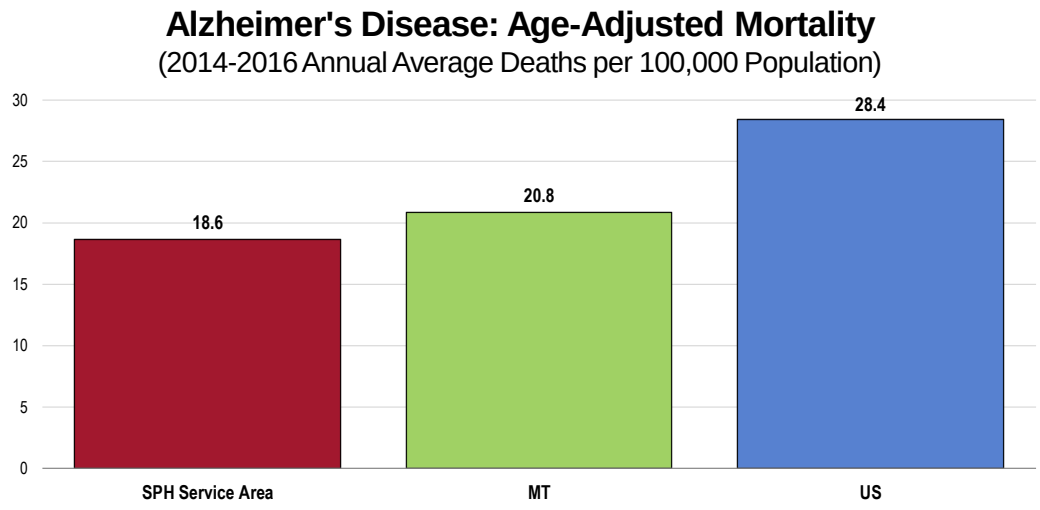
Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat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

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Between 2014 and 2016, there was an annual average age-adjusted Alzheimer's disease mortality rate of 18.6 deaths per 100,000 population in the SPH Service Area.

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



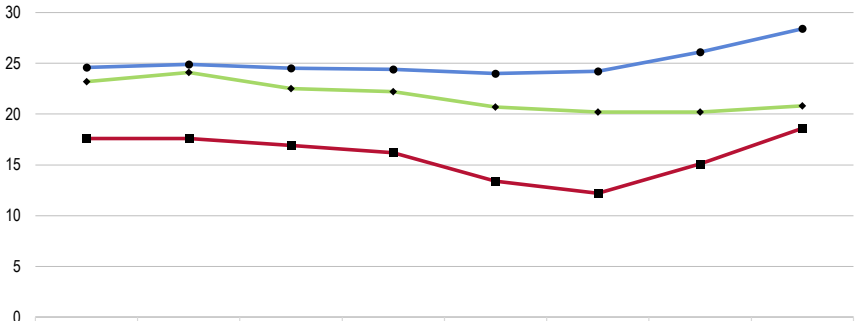
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.

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

- TREND: The Alzheimer's disease mortality rate in the SPH Service Area has increased in recent years, echoing the national trend. Across Montana, rates have overall decreased over time.

Alzheimer's Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	17.6	17.6	16.9	16.2	13.4	12.2	15.1	18.6
MT	23.2	24.1	22.5	22.2	20.7	20.2	20.2	20.8
US	24.6	24.9	24.5	24.4	24.0	24.2	26.1	28.4

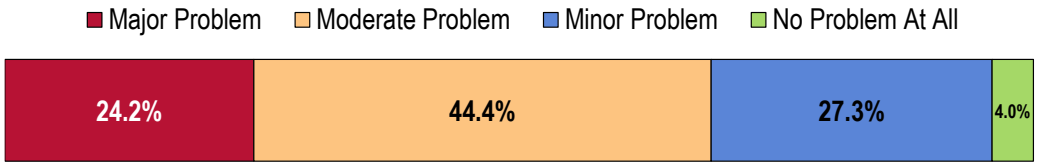
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Key Informant Input: 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, 2018)



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

Top Concerns

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

Aging Population

> *We have an aging population in the Helena area, and the number of people affected by this disease continues to increase. – Community Leader*
>
> *The aging population. – Community Leader*

Helena- like the rest of Montana and the US overall- is rapidly aging. Montana and Helena percentage of elderly is growing, the over 85 population where dementia and Alzheimer's disease incidence rises. Don't believe we have the array of resources. – Social Services Provider

This county has a high proportion of older citizens and the resources for family help and care for people with dementia are limited. – Physician

Increased incidence/diagnosis of these problems, aging population, lack of high level diagnostic/treatment services. – Community Leader

Aging population. – Physician

My feelings about this issue are related to the fact that I have been caring for a parent with dementia for the past three years. As our area population ages, and it is quickly doing so, we are highly likely to see an increase. – Public Health Representative

Access to Care/Services

The major area that provides support are nursing homes that have Medicaid support. That is not enough to provide the support that is necessary. – Other Health Provider

I think it is a misunderstood disease and there are not enough resources available as the baby boomers continue to age. Also important is resources for the caregivers of those inflicted with the disease. – Community Leader

Limited access to supportive services in the community for respite care or placement in assisted living or skilled nursing facilities. The skilled nursing facilities in this area will not consistently treat or accept persons with behavioral difficulties. – Other Health Provider

We don't have many high-quality nursing homes or home health systems in place. – Physician

We have a new memory center called Edgewood. – Community Leader

24-hour care is expensive, so low-income folks have few options. – Other Health Provider

Few resources and they are costly. – Other Health Provider

Prevalence/Incidence

The number of individuals affected seems to be growing and the need for services is not keeping pace. – Other Health Provider

This is growing in exponential proportions and will continue to do so. We are without community resources to address these issues and to help families cope. – Public Health Representative

High rate of occurrence in the population with very few treatment options. – Community Leader

I have had friends whose parents have dementia and realize its significance in our community. – Social Services Provider

Lack of Specialty Care

We do not have neuropsychiatry access at this time. This service is the most valuable for dementia. – Physician

Psychiatric care is in very limited supply, neuropsychiatric testing is almost impossible to get. – Physician

We have no access to neuropsychiatric services in the community and currently having only one neurologist. – Physician

Impact on Caregivers/Families

Caring for a patient with Alzheimer's disease is very difficult. For families caring for their loved ones it is often too much to bear. To have my mother look at me with a blank stare and no sign of recognition was heartbreaking. – Community Leader

It doesn't seem like there are very many services in place to help families out. Other options may be out there and just not well known. – Social Services Provider

Kidney Disease

About 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)

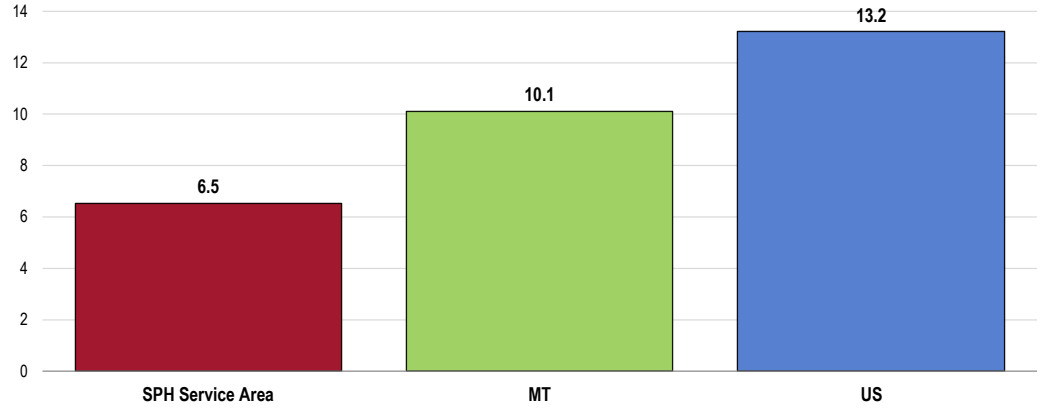
Age-Adjusted Kidney Disease Deaths

Between 2014 and 2016, there was an annual average age-adjusted kidney disease mortality rate of 6.5 deaths per 100,000 population in the SPH Service Area.

- Lower than both state and national rates.

Kidney Disease: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)



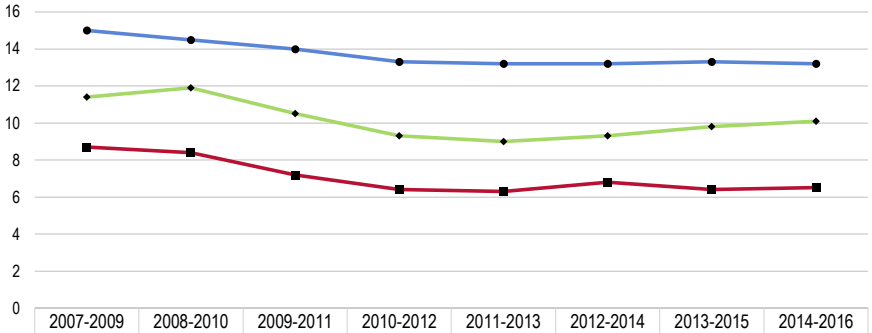
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.

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

- TREND: The death rate due to kidney disease has decreased over the past decade in the SPH Service Area.

Kidney Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	8.7	8.4	7.2	6.4	6.3	6.8	6.4	6.5
MT	11.4	11.9	10.5	9.3	9.0	9.3	9.8	10.1
US	15.0	14.5	14.0	13.3	13.2	13.2	13.3	13.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.

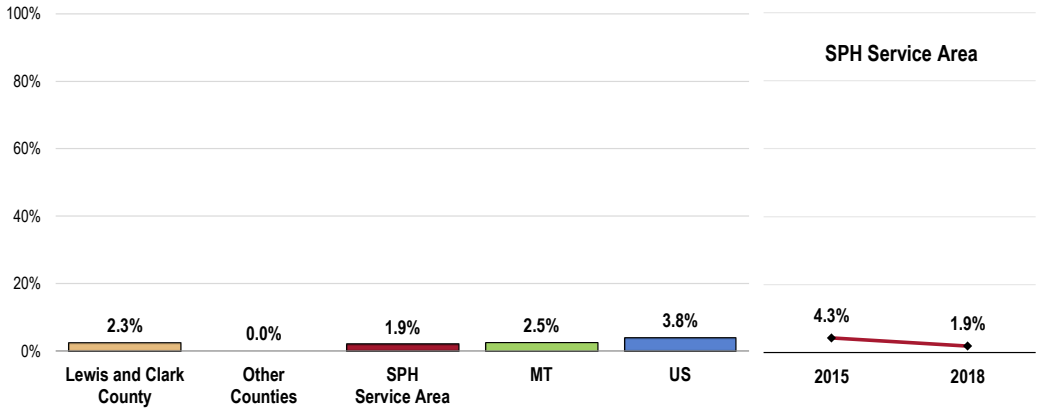
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

A total of 1.9% of SPH Service Area adults report having been diagnosed with kidney disease.

- Similar to the state proportion.
- Lower than what is seen nationally.
- Highest in Lewis and Clark County.
- TREND: This prevalence has decreased since 2015.

Prevalence of Kidney Disease

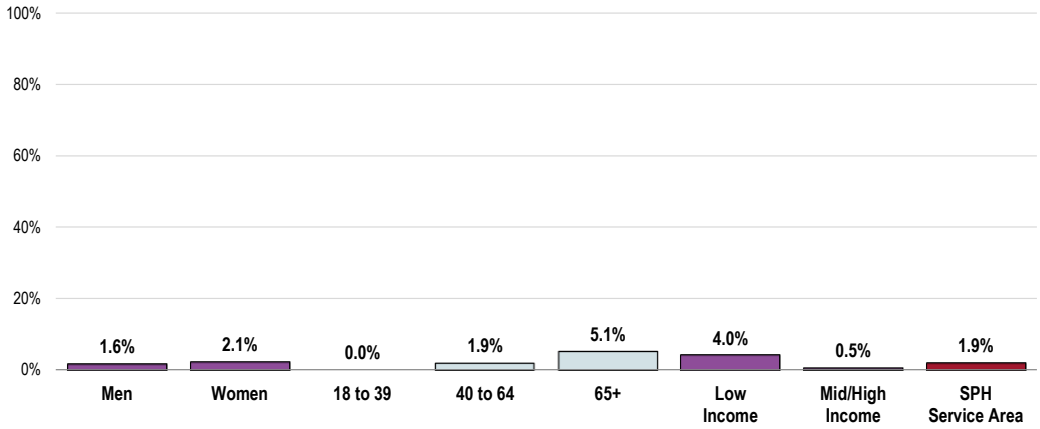


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Note the correlation of age with kidney disease prevalence in the SPH Service Area.

Prevalence of Kidney Disease
(SPH Service Area, 2018)

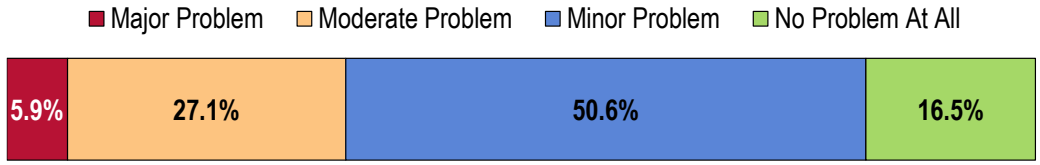


Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 30]
Notes: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Kidney Disease

Half of key informants taking part in an online survey generally characterized *Kidney Disease* as a "minor problem" in the community.

Perceptions of Kidney Disease as a Problem in the Community
(Key Informants, 2018)



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

Top Concerns

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

Access to Care/Services

> *No specialist to treat. – Social Services Provider*
>
> *We don't have a nephrologist. – Physician*
>
> *So, where is a dialysis facility in Helena? Is there a nephrologist here? If not, why not? How can we attract physicians to come here? – Community Leader*

Alcohol Use/Abuse

> *High rates of alcohol abuse in this area. – Community Leader*

Potentially Disabling Conditions

Arthritis, Osteoporosis, & Chronic Back 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)

A total of 37.7% of SPH Service Area adults age 50 and older report suffering from arthritis or rheumatism.

- Similar to the prevalence found nationwide.

RELATED ISSUE:

See also *Overall Health Status: Activity Limitations* in the **General Health Status** section of this report.

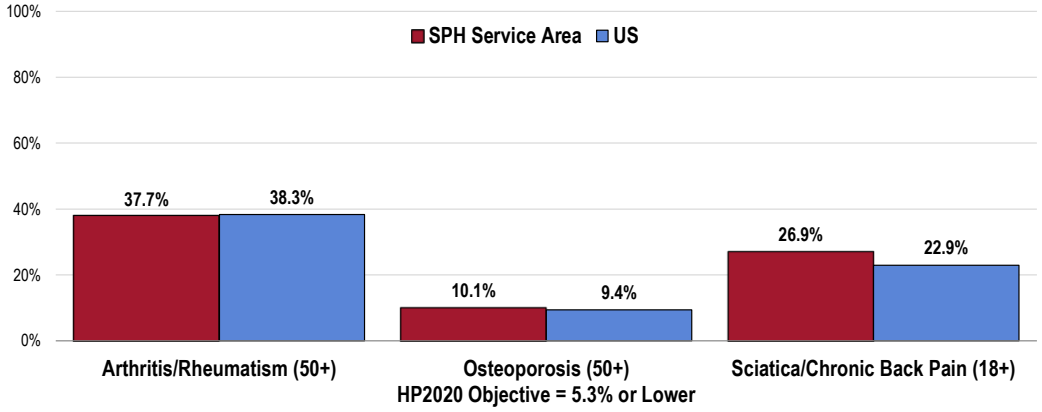
One in 10 SPH Service Area adults age 50 and older (10.1%) have osteoporosis.

- Similar to that found nationwide.
- Fails to satisfy the Healthy People 2020 target of 5.3% or lower.

A total of 26.9% of SPH Service Area adults (age 18 and older) suffer from chronic back pain or sciatica.

- Statistically comparable to that found nationwide.

Prevalence of Potentially Disabling Conditions



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 26, 141-142]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AOCBC-10]

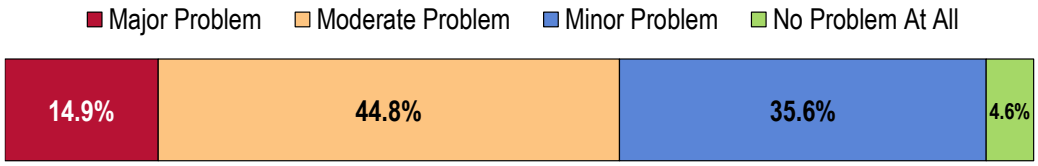
Notes:
- The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

A plurality 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, 2018)



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

Notes:
- Asked of all respondents.

Top Concerns

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

Lack of Specialists

> *We are underserved in both rheumatology and orthopedic spine physicians in our community. – Physician*
>
> *There are not enough qualified specialists to meet the need of the aging population. – Social Services Provider*
>
> *No access to a rheumatologist in Helena. Primary care, pain management specialists and orthopedic surgeons are handling cases. – Community Leader*
>
> *No back surgeon in town. – Physician*
>
> *We don't have a spinal surgeon. Many patients who needs intervention of any kind has to leave Lewis and Clark county for help. – Physician*

> *Limited access to physicians dealing with back problems. – Physician*
>
> *Manpower. – Physician*

Obesity

> *I think it's probably related to the obesity and other related diseases that result in these conditions growing. – Community Leader*
>
> *Obesity and inactive lifestyle. – Physician*

Aging Population

> *The population of the Helena area is aging rapidly. These conditions are often associated with aging, and they can compromise quality of life significantly. They also can lead to falls and other dangerous outcomes. – Public Health Representative*

Work Conditions

> *People who work in physically taxing occupations are prone to chronic pain and back issues which make it hard for them to work. It's hard to get SS disability and if they do it pays too little to live on. People need safer jobs and training. – 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)

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.

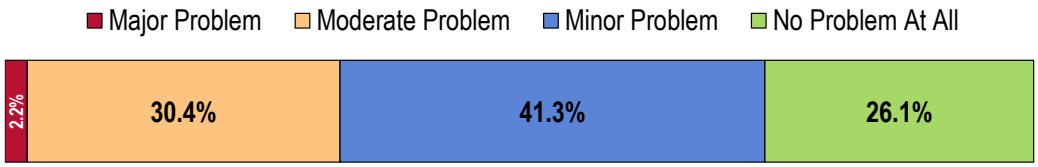
As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

- Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Vision & Hearing

Key informants taking part in an online survey most often characterized *Vision & Hearing* as a "minor problem" in the community.

Perceptions of Vision and Hearing as a Problem in the Community
(Key Informants, 2018)



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

Top Concerns

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

Lack of Providers

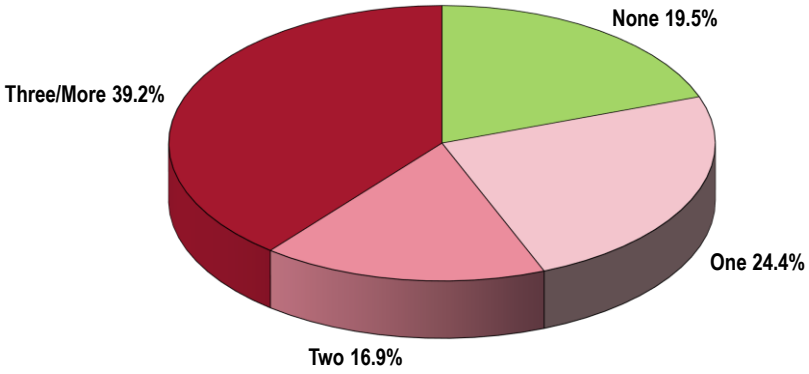
> *Severe shortage of in-town ophthalmologists and financial barriers to hearing aids. – Physician*

Multiple Chronic Conditions

Among SPH Service Area survey respondents, most report currently having at least one chronic health condition, including 24.4% with one condition, 16.9% with two conditions, and 39.2% with <u>three or more chronic conditions</u>.

For the purposes of this assessment, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression. Multiple chronic conditions are concurrent conditions.

Number of Current Chronic Conditions
(SPH Service Area, 2018)

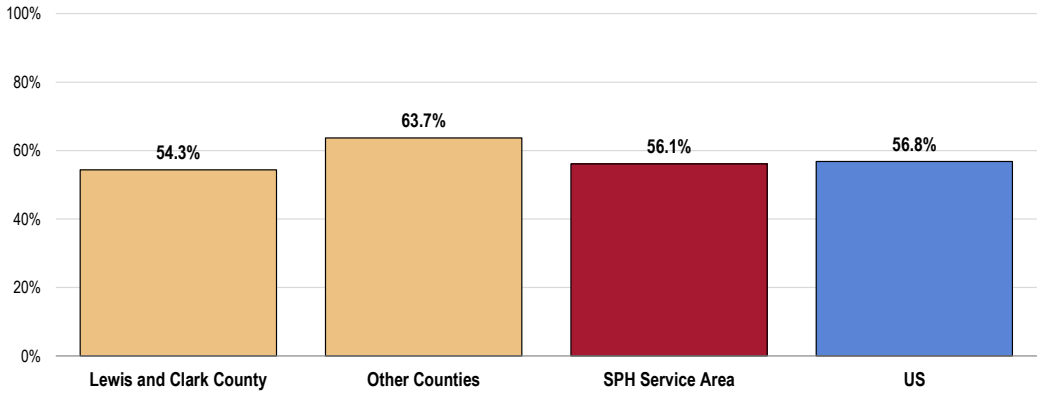


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 143]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

- The prevalence of multiple chronic conditions among SPH Service Area residents (56.1%) is similar to the US prevalence.
- Viewed by area, this prevalence is statistically comparable.

Currently Suffer From Multiple Chronic Conditions



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 143]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

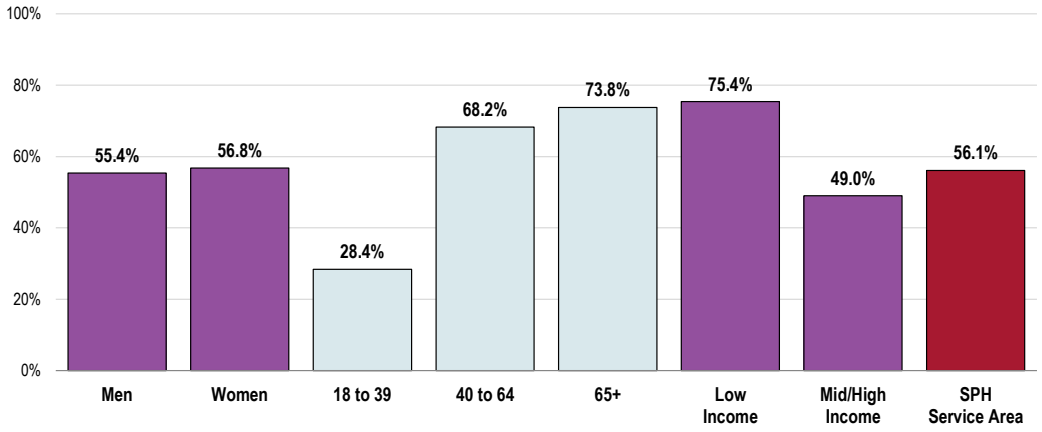
Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

The following population segments are more likely to report suffering from multiple chronic conditions:

- Older adults (note the positive correlation with age).
- Adults in low-income households.

Currently Suffer From Multiple Chronic Conditions

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 143]

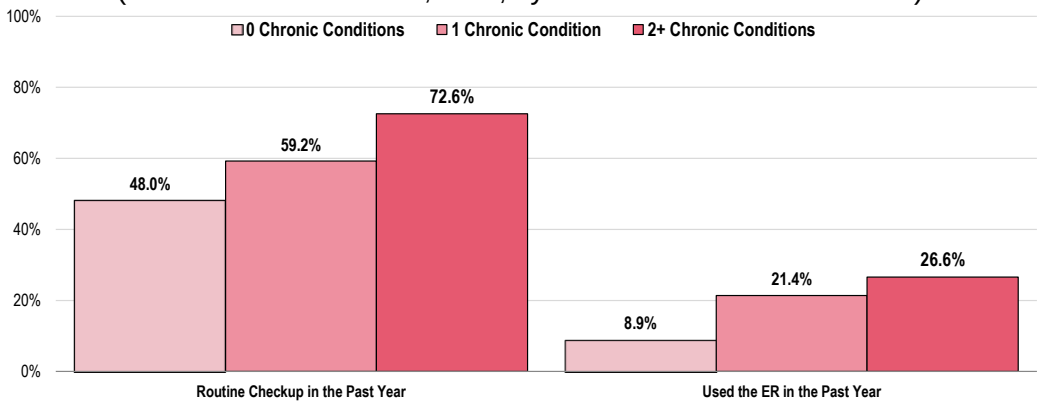
Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

Chronic Conditions & Healthcare Access

Although adults with chronic conditions are more likely to get routine preventive care, they are also heavier users of emergency departments.

Chronic Conditions and Healthcare Access

(SPH Service Area Adults, 2018; By Number of Chronic Conditions)



Sources:
- 2018 PRC National Health Survey, Professional Research Consultants, Inc.
- In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, hypertension, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

Infectious Disease

Professional Research Consultants, Inc.

Influenza 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)

Among SPH Service Area seniors, 72.0% received a flu shot within the past year.

- Much higher than the Montana finding.
- Similar to the national finding.
- Similar to the Healthy People 2020 target (70% or higher).
- TREND: Steady increase since 2012.

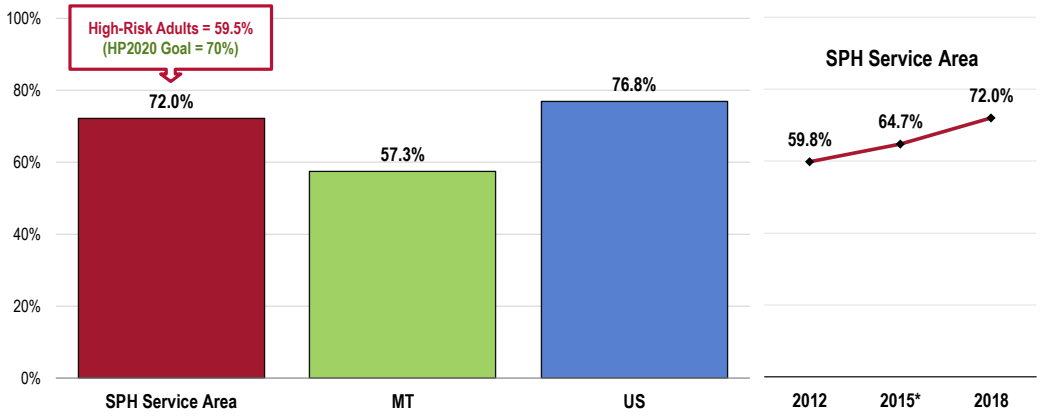
"High-risk" includes adults who report having been diagnosed with heart disease, diabetes, or respiratory disease.

A total of 59.5% of high-risk adults age 18 to 64 received a flu shot within the past year.

Older Adults: Have Had a Flu Vaccination in the Past Year

(Among Adults Age 65+)

Healthy People 2020 Target = 70.0% or Higher



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 144-145]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.12]

Notes:
- Reflects respondents 65 and older.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes, or respiratory disease.
- *2015 data includes FluMist as a form of vaccination.

HIV

About Human Immunodeficiency Virus (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)

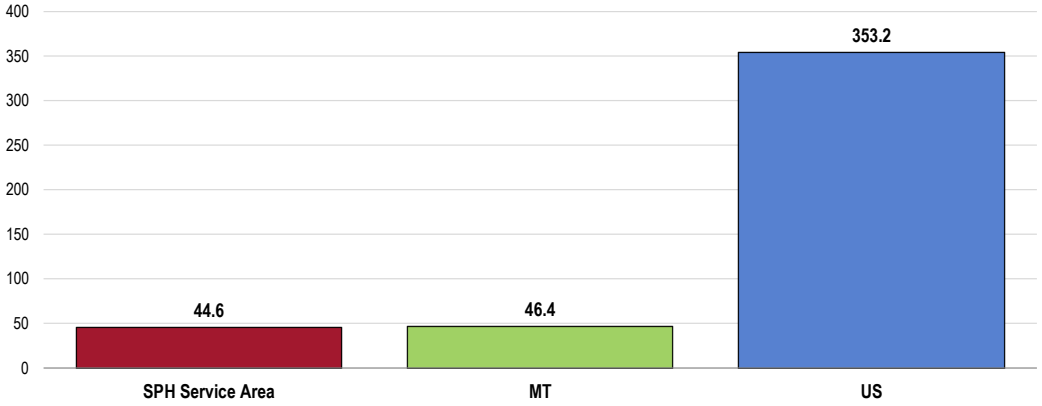
HIV Prevalence

In 2013, there was a prevalence of 44.6 HIV cases per 100,000 population in the SPH Service Area.

- Similar to the statewide prevalence.
- Much more favorable than the national prevalence.

HIV Prevalence

(Prevalence Rate of HIV per 100,000 Population, 2013)



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

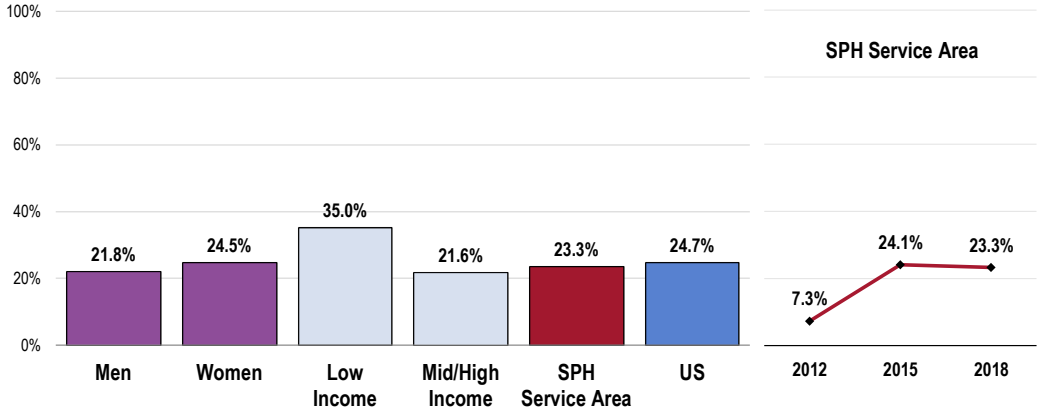
Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

HIV Testing

Among SPH Service Area adults age 18-44, 23.3% report that they have been tested for HIV in the past year.

- Nearly identical to the proportion found nationwide.
- HIV testing is lower among those with higher incomes.
- TREND: Though testing has increased since 2012, it is similar to 2015 data.

Tested for HIV in the Past Year
(Among Adults Age 18-44)

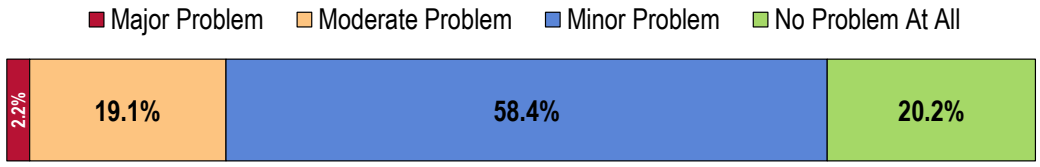


Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 318]
● 2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Reflects respondents age 18 to 44.

Key Informant Input: HIV/AIDS

Key informants taking part in an online survey most often characterized *HIV/AIDS* as a "minor problem" in the community.

Perceptions of HIV/AIDS as a Problem in the Community
(Key Informants, 2018)



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

Top Concerns

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

Lack of Providers

> *The volume of the problem is low, but expertise in the medical community is entirely lacking for people who are affected. – Physician*

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)

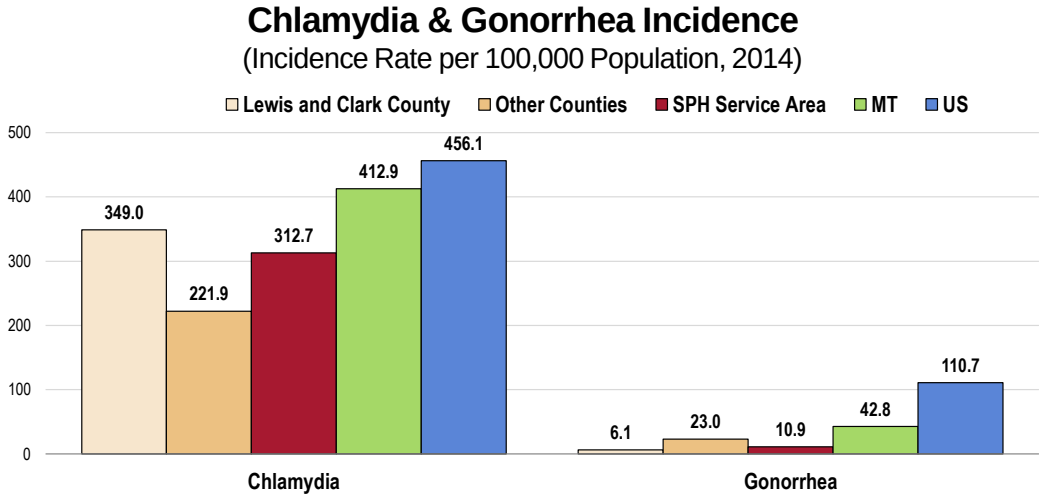
Chlamydia & Gonorrhea

In 2014, the chlamydia incidence rate in the SPH Service Area was 312.7 cases per 100,000 population.

- Notably lower than both the Montana and national incidence rates.
- Highest in Lewis and Clark County.

The SPH Service Area gonorrhea incidence rate in 2014 was 10.9 cases per 100,000 population.

- Lower than the Montana and national incidence rates.
- Highest in the Other Counties.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Safe Sexual Practices

Among unmarried SPH Service Area adults under the age of 65, the majority cites having one (42.9%) or no (43.3%) sexual partners in the past 12 months (not shown). However, 6.8% report three or more sexual partners in the past year.

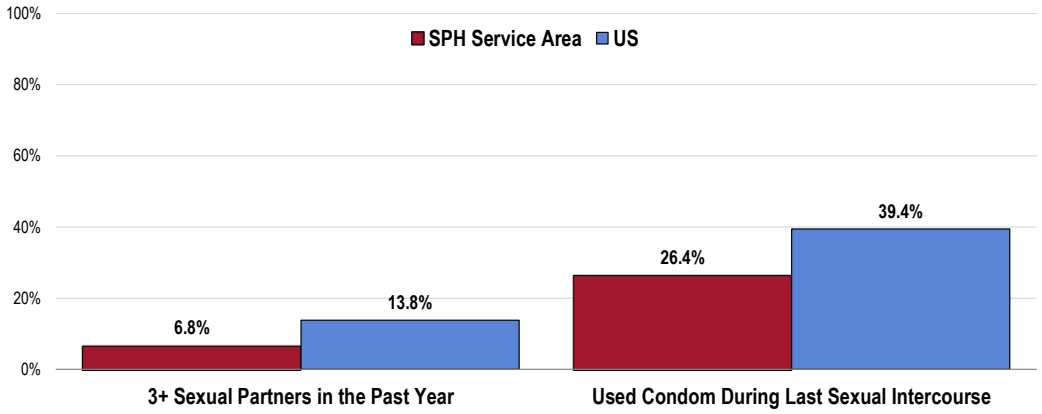
- More favorable than that reported nationally.

A total of 26.4% of unmarried SPH Service Area adults age 18 to 64 report that a condom was used during their last sexual intercourse.

- Less favorable than national findings.

Sexual Risk

(Unmarried Adults Age 18-64)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 316-317]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

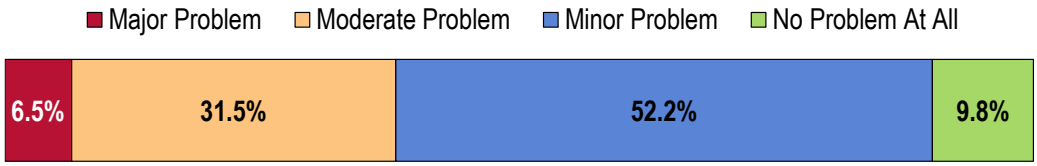
Notes:
- Reflects unmarried respondents under the age of 65.

Key Informant Input: Sexually Transmitted Diseases

Over half of 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, 2018)



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

Notes:
- Asked of all respondents.

Top Concerns

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

Health Awareness/Education

> *Rarely any information on medium especially about HPV. Many do not understand how young must get treatment before they are sexually active. – Other Health Provider*
>
> *The Helena community is resistant to fact based, medically accurate health approach to sex education. Teens and young adults fail to take proper health precautions leading to increasing STD rates. STD rates are increasing in older populations as well. – Social Services Provider*
>
> *There is only one doctor for HIV/Aids, community doesn't know of Ryan White program. Cannot access free condoms or unknown resources for this. Stigma is big in this as well. – Social Services Provider*

Prevalence/Incidence

> *See the reports from the various health departments and they identify this. – Community Leader*

Unprotected Sex

> *Unsafe sexual practices. – Physician*

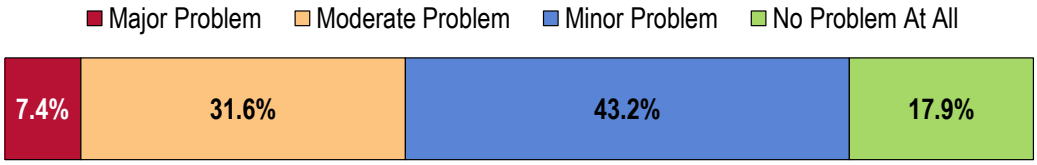
Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

Key informants taking part in an online survey most often 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, 2018)



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

Top Concerns

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

Health Awareness/Education

> *Past conversations with public health professionals indicate it is an ongoing battle to get the right messages across related to the importance of vaccinations for community health. – Other Health Provider*
>
> *People need information, education, transportation, and treatment that they can afford. – Other Health Provider*

Immunization Rates

> *Not enough people are getting the recommended immunizations. – Public Health Representative*
>
> *This is a major problem in our community because we don't have a 100% immunization rate and our rates of preventable STDs are too high. – Other Health Provider*

Lack of Providers

> *We are about to lose our one and only infectious disease specialist who saw patients on an outpatient basis. – Physician*

Poverty

> *High population of homeless and indigent people without access to health care. – Community Leader*

Births

Professional Research Consultants, Inc.

Birth Outcomes & Risks

About Infant & Child Health

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

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

- Healthy People 2020 (www.healthypeople.gov)

Low-Weight Births

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

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

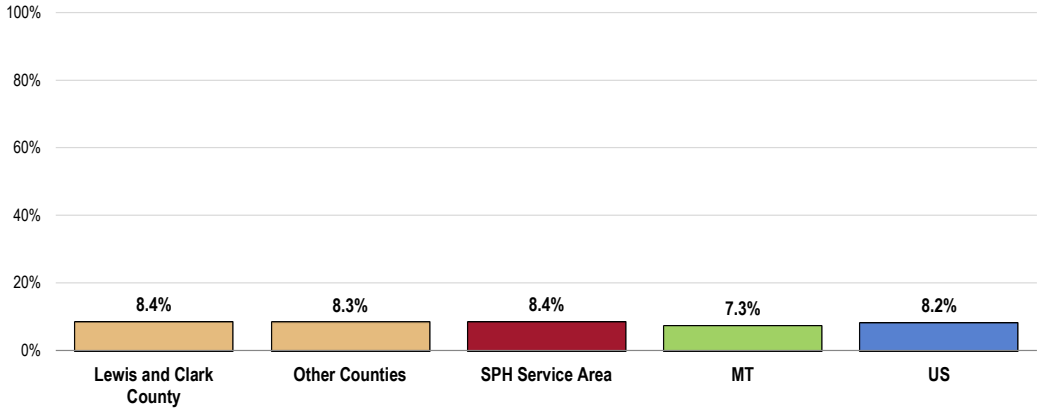
A total of 8.4% of 2006-2012 SPH Service Area births were low-weight.

- Comparable to both the Montana and national proportions.
- Similar to the Healthy People 2020 target (7.8% or lower).
- No significant differences by community.

Low-Weight Births

(Percent of Live Births, 2006-2012)

Healthy People 2020 Target = 7.8% or Lower



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
- Retrieved 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]

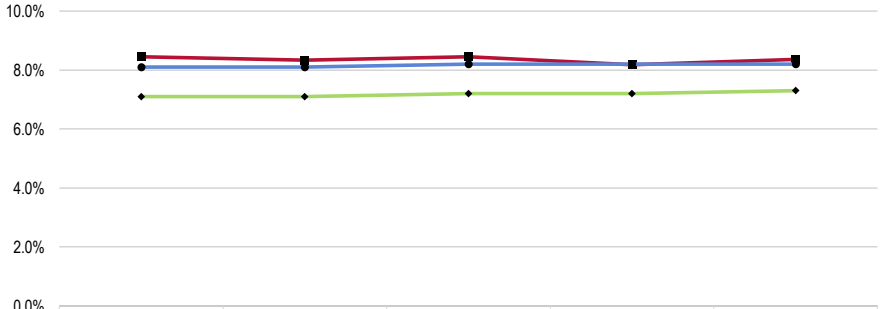
Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- TREND: The proportion of low-weight births in the SPH Service Area has remained relatively constant over time, echoing Montana and national trends.

Low-Weight Births

(Percent of Live Births)

Healthy People 2020 Target = 7.8% or Lower



	2002-2008	2003-2009	2004-2010	2005-2011	2006-2012
SPH Service Area	8.5%	8.3%	8.5%	8.2%	8.4%
MT	7.1%	7.1%	7.2%	7.2%	7.3%
US	8.1%	8.1%	8.2%	8.2%	8.2%

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
- Retrieved 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

Between 2014 and 2016, there was an annual average of 4.8 infant deaths per 1,000 live births in the SPH Service Area.

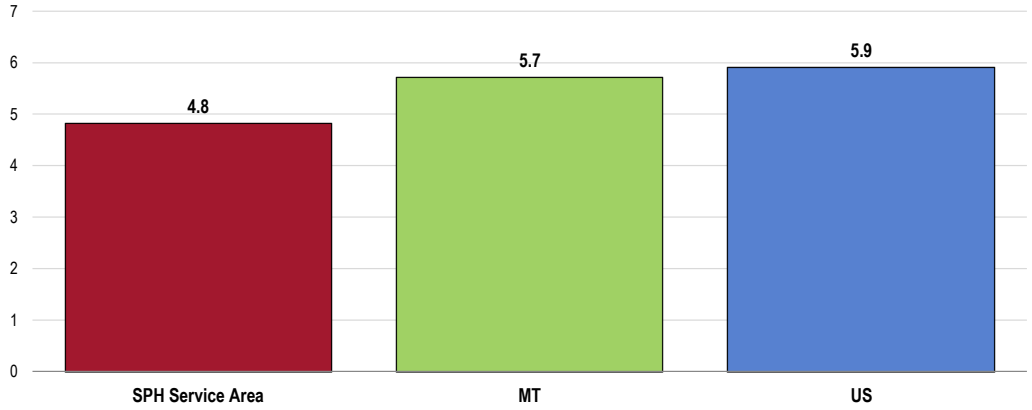
- More favorable than both the state and national rates.
- Satisfies the Healthy People 2020 target of 6.0 per 1,000 live births or lower.

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

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2014-2016)

Healthy People 2020 Target = 6.0 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

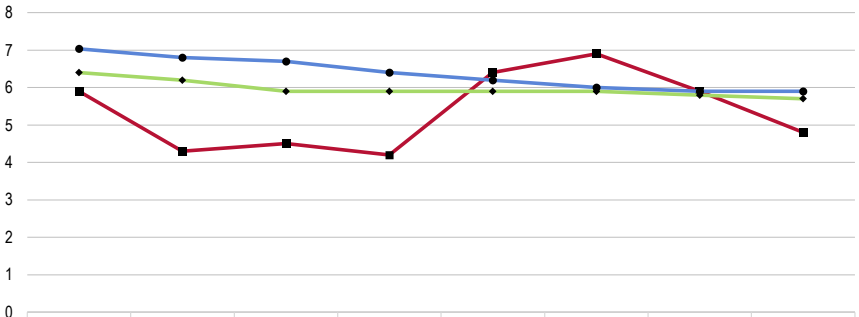
Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

- TREND: Infant mortality in the area has decreased over the past few years, though the rate over the past decade shows no clear trend.

Infant Mortality Rate

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

Healthy People 2020 Target = 6.0 or Lower



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	5.9	4.3	4.5	4.2	6.4	6.9	5.9	4.8
MT	6.4	6.2	5.9	5.9	5.9	5.9	5.8	5.7
US	7.0	6.8	6.7	6.4	6.2	6.0	5.9	5.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2018.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

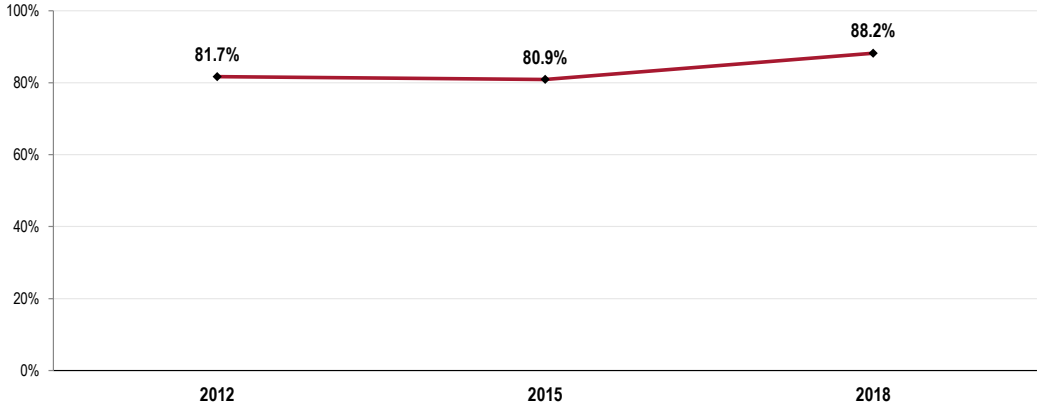
Breastfeeding

A total of 88.2% of surveyed parents reported that their child was breastfed or fed breastmilk as an infant.

- TREND: The increase over time is not statistically significant.

Child Was Breastfed or Fed Breastmilk as an Infant

(SPH Service Area Parents, 2018)

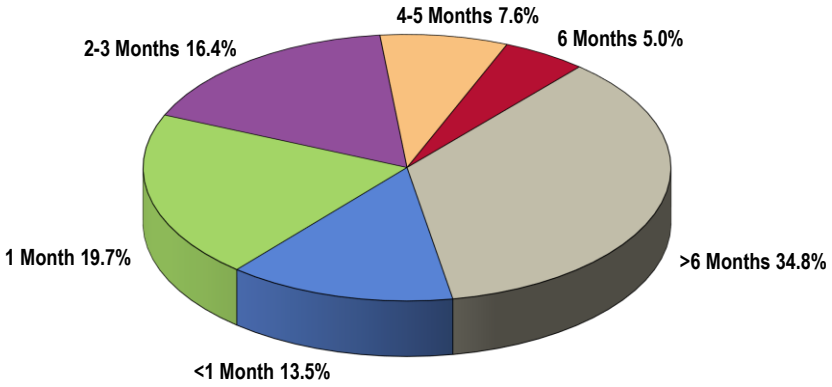


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 325]

Notes:
- Asked of all respondents with children under 18 at home.

Among those parents who breast-fed their child, 39.8% did so exclusively for at least the first 6 months of the child's life.

Age at Which Child Was First Fed Something Other Than Breastmilk
(SPH Service Area Parents Whose Child Was Fed Breastmilk, 2018)



Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 326]
Notes: • Asked of all parents of children who were fed breastmilk as an infant.

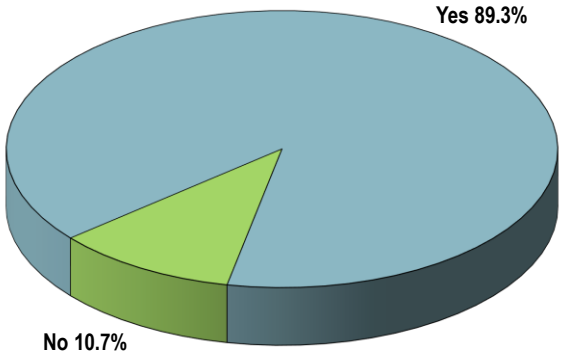
Childhood Vaccinations

Nine in 10 surveyed parents (89.3%) would want a newborn to receive all recommended vaccinations.

- TREND: No significant difference from 2015 findings.
- Parents who would not want a newborn to receive all recommended vaccinations cited *vaccine safety*, the *quantity of vaccines*, *personal choice, vaccine effectiveness,* and *serious side effects*.

Would Want Newborn to Receive All Recommended Vaccines

(SPH Service Area Parents, 2018)



2015= 92.2%

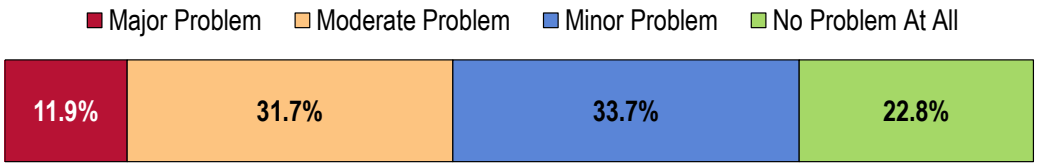
Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 329]
Notes: • Asked of all respondents with children under 18 at home.

Key Informant Input: Infant & Child Health

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

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

(Key Informants, 2018)



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

Top Concerns

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

Poverty

> *Infant and child health is a major problem for those living in poverty, struggling with addictions, particularly the young and uneducated. Outreach needs to be assertive to families who struggle to properly address health needs. – Social Services Provider*
>
> *I hear about infant and child health to be a problem especially in lower income people from the area. – Social Services Provider*
>
> *Food insecurity and poverty often directly correlate to poorer health outcomes. – Social Services Provider*
>
> *Care isn't equitable. If you are young, low income you don't know where to access services that are available. Plus, the stigma of accessing services. – Social Services Provider*

Child Abuse/Neglect

The number of kids being removed from their families due to abuse or neglect continues to rise in our community. Obviously, there are many factors that contribute, but infant and child health is falling through the cracks. – Other Health Provider

Child abuse and neglect. Research has shown that traumas of childhood have a major impact on physical and mental health throughout lifetime. Improving the quality of life of our youngest residents through education, good nutrition, reduced exposure. – Public Health Representative

Substance Use/Abuse

The increasing epidemic in substance abuse and increase gap in incomes, the resources for childcare. The recognized needs for infant and child health may go ignored and/or unknown. – Community Leader

We have a growing drug problem among youth and younger adults. – Community Leader

Access to Care

Special needs and mental illness are only available for acute problems, not continuing care for their lives. There are too few beds. – Other Health Provider

Health Awareness/Education

Kids need parents who have education and information about kids' health. Then they need a place to get services that they can afford and that they can get to if they are working parents. – Other Health Provider

Prenatal Care

Inconsistent care due to lack of parent follow through and prenatal care. – Community Leader

Family Planning

Births to Teen Mothers

About Teen Births

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

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

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

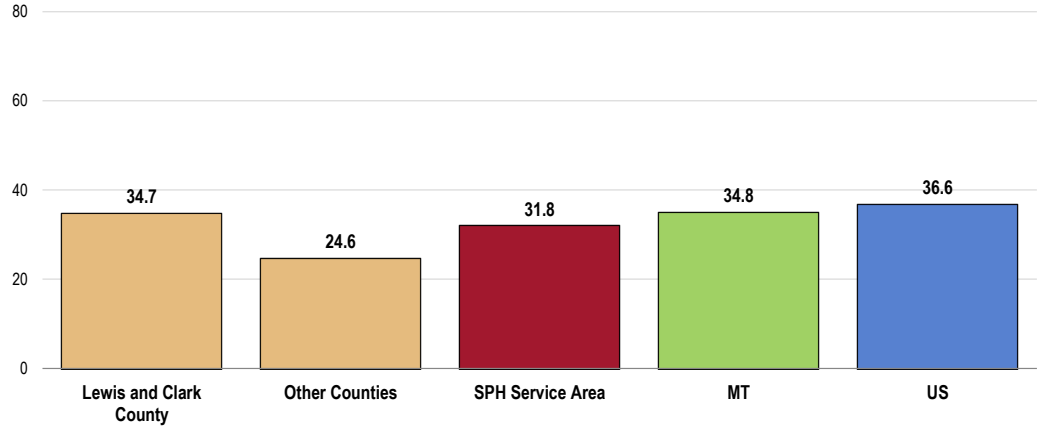
- Healthy People 2020 (www.healthypeople.gov)

Between 2006 and 2012, there were 31.8 births to women age 15 to 19 per 1,000 women age 15 to 19 in the SPH Service Area.

- Similar to the Montana rate.
- Lower than the national rate.
- Higher in Lewis and Clark County.

Teen Birth Rate

(Births to Women Age 15-19 Per 1,000 Female Population Age 15-19, 2006-2012)

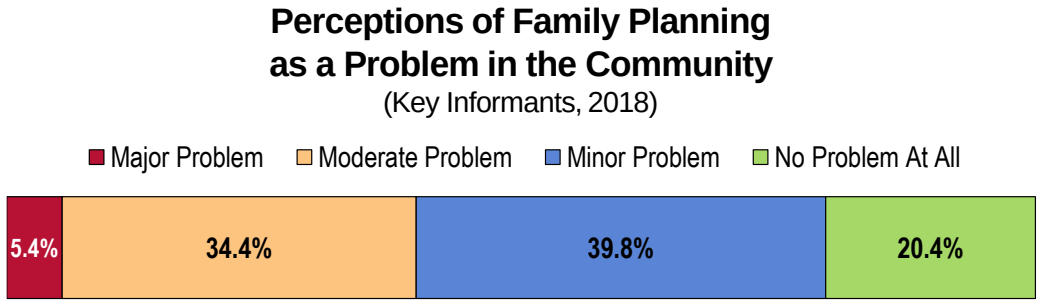


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
- Retrieved from Community Commons at http://www.chna.org.

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

Key Informant Input: Family Planning

Key informants taking part in an online survey characterized *Family Planning* as a "minor problem" in the community slightly more often than they did a "moderate problem."



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

Top Concerns

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

Affordable Care/Services

> *Low income individuals have maybe three resources and have to work when they are open. – Other Health Provider*

Insurance Issues

> *Some major health insurers do not cover birth control. – Physician*

Policy

> *Laws. – Social Services Provider*

Unplanned Pregnancies

> *Too many pregnancies are unplanned leading to a variety of health and societal problems. – Public Health Representative*

Modifiable Health Risks

Professional Research Consultants, Inc.

Access to Fresh Produce

Difficulty Accessing Fresh Produce

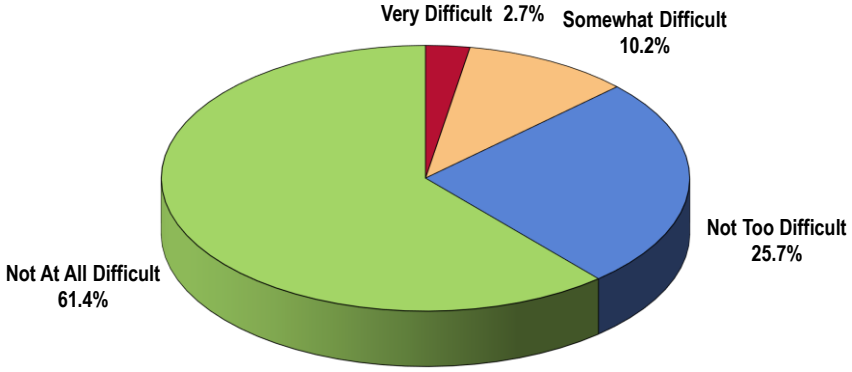
While most report little or no difficulty, 12.9% of SPH Service Area adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

Respondents were asked:

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

Level of Difficulty Finding Fresh Produce at an Affordable Price

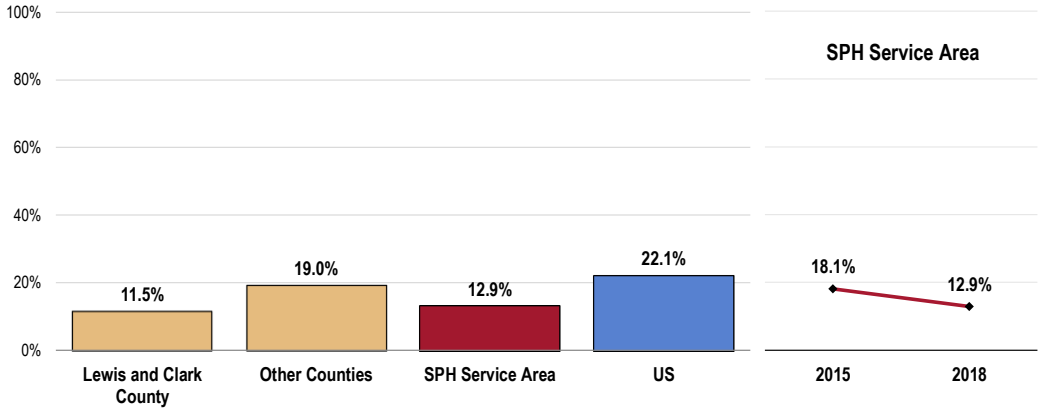
(SPH Service Area, 2018)



Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
Notes: • Asked of all respondents.

- More favorable than national findings.
- Statistically comparable by county area.
- TREND: Difficulty accessing fresh produce has trended downward since 2015.

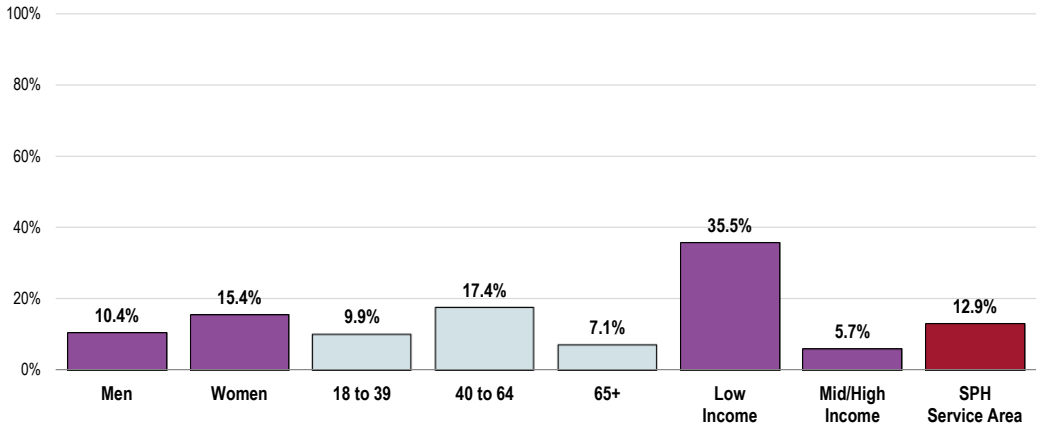
Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce



Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]
• 2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.
• "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Those more likely to report difficulty getting fresh fruits and vegetables include area residents at lower incomes, as well as adults age 40-64.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 86]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Low Food Access (Food Deserts)

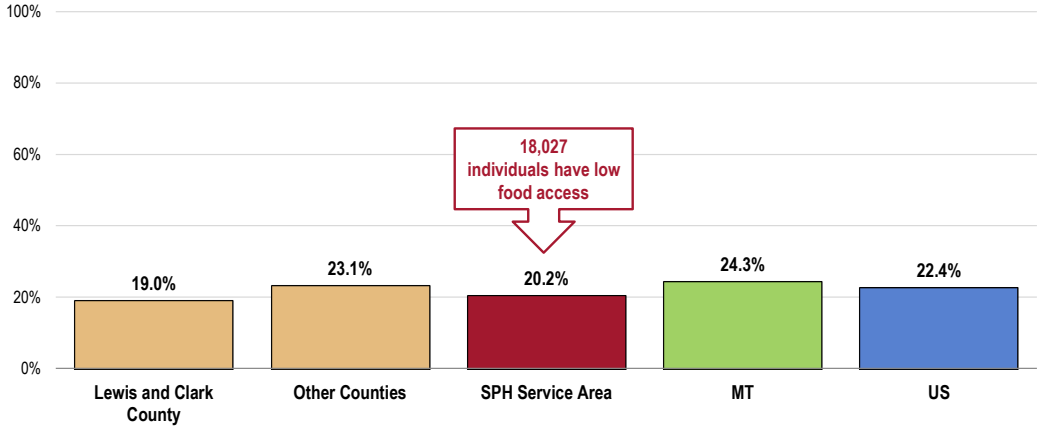
A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas.

US Department of Agriculture data show that one-fifth (20.2%) of the SPH Service Area population (representing over 18,000 residents) have low food access or live in a "food desert," meaning that they do not live near a supermarket or large grocery store.

- More favorable than statewide findings.
- Similar to national findings.
- Higher in the Other Counties area.

Population With Low Food Access

(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2015)

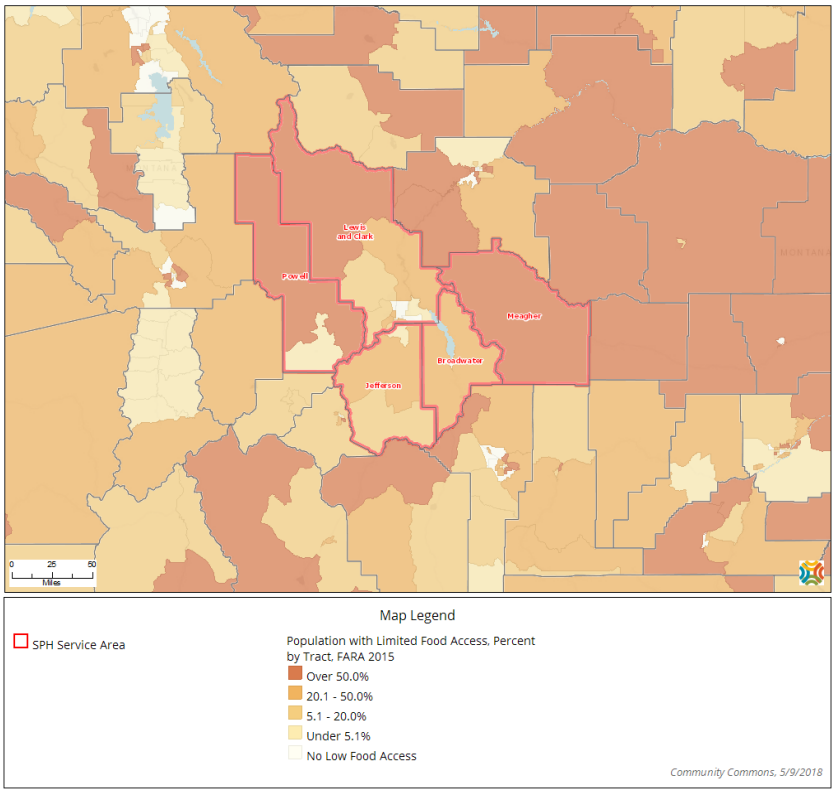


Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Retrieved April 2018 from Community Commons at http://www.chna.org.

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.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- The following map provides an illustration of food deserts by census tract. Note the large share of residents with limited food access in Meagher and Powell counties, as well as the northern part of Lewis and Clark County.

Population with Limited Food Access, Percent by Tract, FARA 2015



Physical Activity

About Physical Activity

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

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

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

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

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Leisure-Time Physical Activity

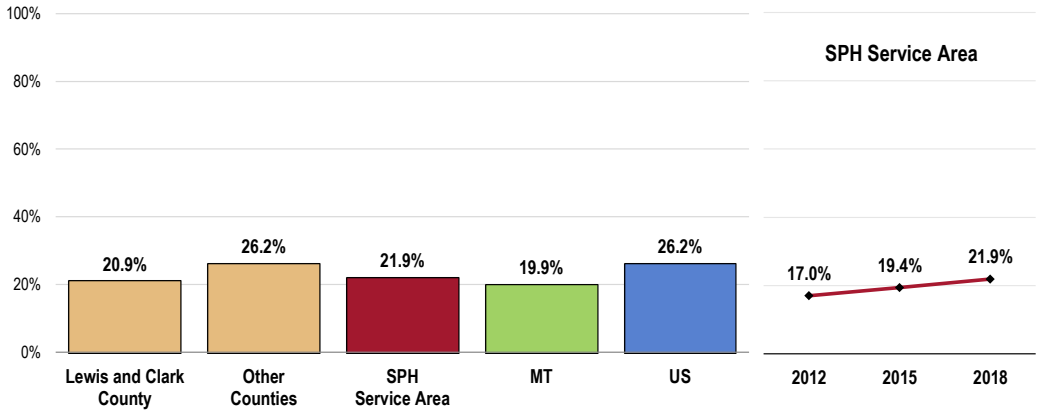
Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

A total of 21.9% of SPH Service Area adults report no leisure-time physical activity in the past month.

- Similar to statewide and national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).
- Similar by community.
- TREND: Statistically unchanged since 2012.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 Target = 32.6% or Lower

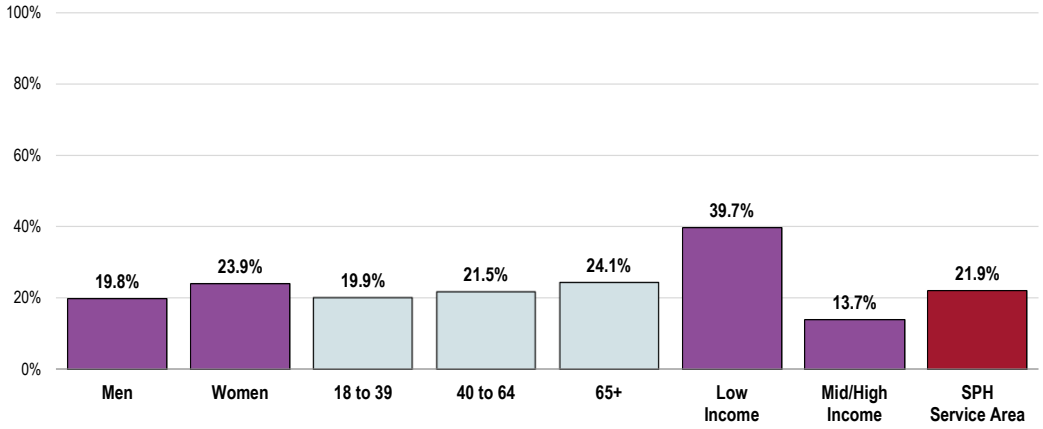


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 89]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Those with lower incomes in the area are more likely to lack leisure-time physical activity.

No Leisure-Time Physical Activity in the Past Month
(SPH Service Area, 2018)
Healthy People 2020 Target = 32.6% or Lower



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 89]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Levels

Recommended Levels of Physical Activity

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity
- Learn more about CDC's efforts to promote walking by visiting http://www.cdc.gov/vitalsigns/walking.

Aerobic & Strengthening Physical Activity

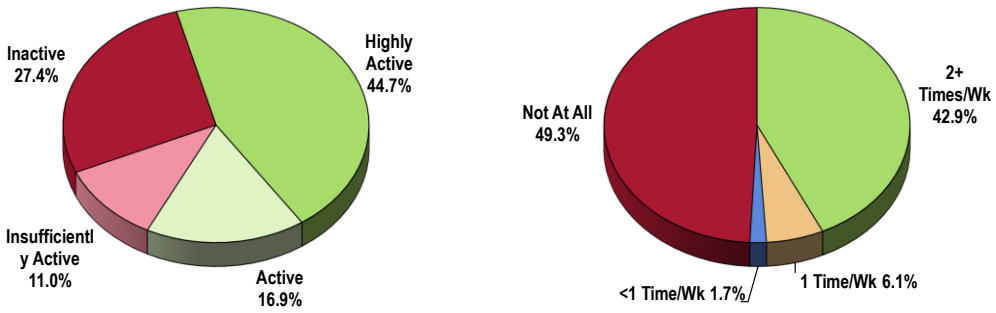
Survey respondents were asked about the types of physical activities they engaged in during the past month, as well as the frequency and duration of these activities.

- "Inactive" includes those reporting no aerobic physical activity in the past month.
- "Insufficiently active" includes those with the equivalent of 1-150 minutes of aerobic physical activity per week.
- "Active" includes those with 150-300 minutes of weekly aerobic physical activity.
- "Highly active" includes those with >300 minutes of weekly aerobic physical activity.

Based on reported physical activity intensity, frequency, and duration over the past month, two-thirds (65.8%) of SPH Service Area adults are found to be "insufficiently active" or "inactive."

Half (49.3%) of SPH Service Area adults do not participate in any types of physical activities or exercises to strengthen their muscles.

Participation in Physical Activities
(SPH Service Area, 2018)



Aerobic Activity | **Strengthening Activity**

Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 96, 150]
Notes: ● Reflects the total sample of respondents.
● In this case, "inactive" aerobic activity represents those adults participating in no aerobic activity in the past week; "insufficiently active" reflects those respondents with 1–149 minutes of aerobic activity in the past week; "active" adults are those with 150–300 minutes of aerobic activity per week; and "highly active" adults participate in 301+ minutes of aerobic activity weekly.

Recommended Levels of Physical Activity

One-third (32.1%) of SPH Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activities:

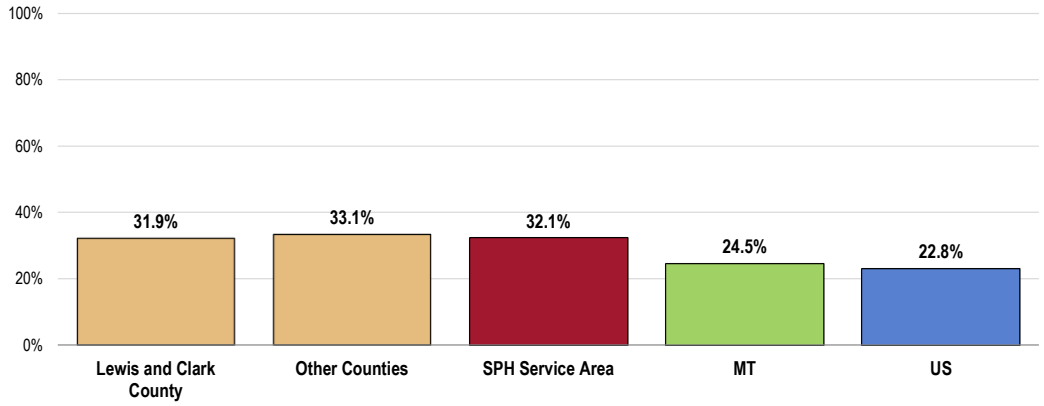
Aerobic activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

- More favorable than both state and national findings.
- Similar by community.
- Satisfies the Healthy People 2020 target (20.1% or higher)

Meets Physical Activity Recommendations

Healthy People 2020 Target = 20.1% or Higher



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-2.4]

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

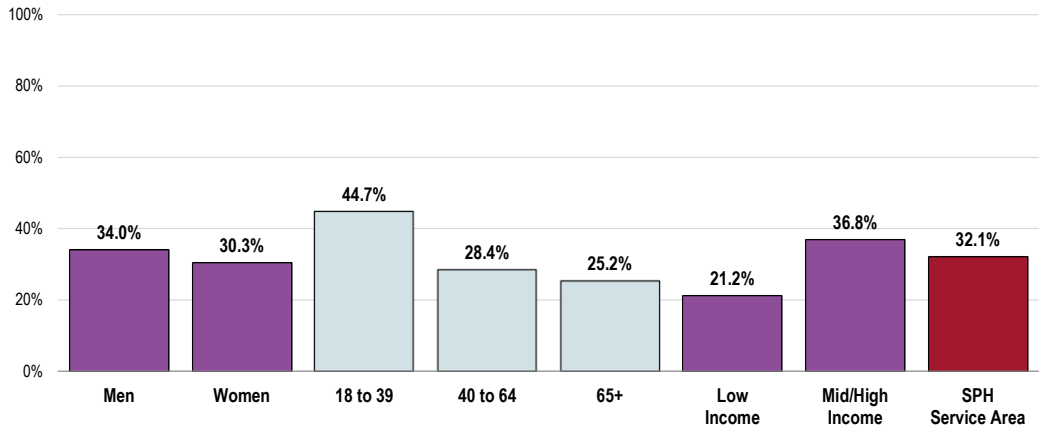
Those less likely to meet physical activity requirements include:

- Seniors (age 65+; negative correlation with age).
- Low-income residents.

Meets Physical Activity Recommendations

(SPH Service Area, 2018)

Healthy People 2020 Target = 20.1% or Higher



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-2.4]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Access to Physical Activity

In 2015, there were 17.9 recreation/fitness facilities for every 100,000 population in the SPH Service Area.

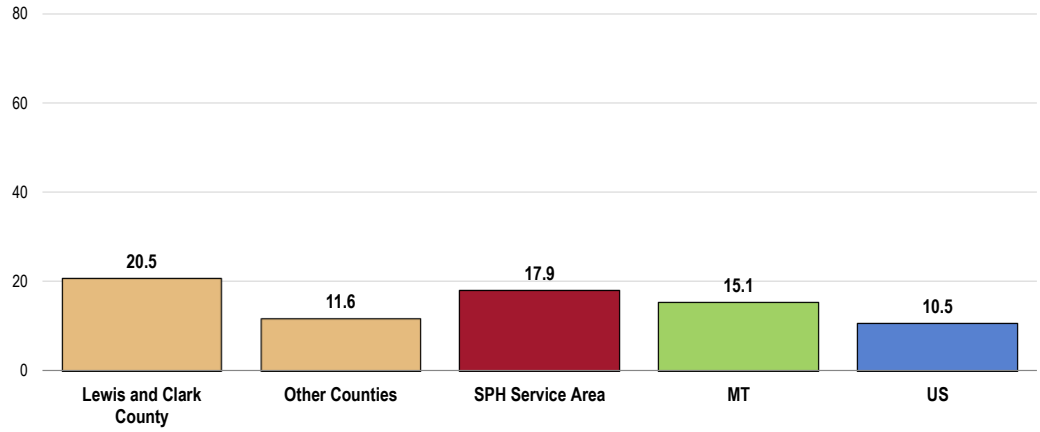
- Above what is found statewide and nationally.
- Lower in the Other Counties.

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.

Population With Recreation & Fitness Facility Access

(Number of Recreation & Fitness Facilities per 100,000 Population, 2015)



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

Notes:
- Recreation and fitness facilities are 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.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Weight Status

About Overweight & Obesity

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

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

- Healthy People 2020 (www.healthypeople.gov)

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

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

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

Adult Weight Status

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.

Overweight Status

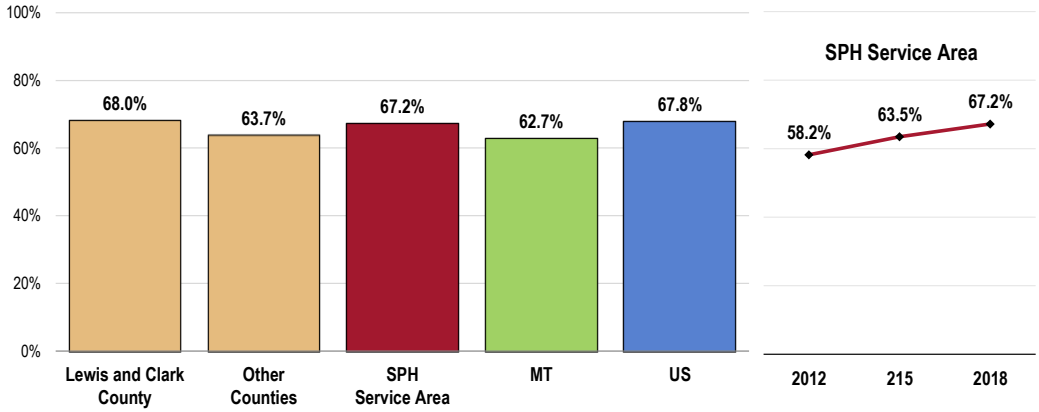
Two-thirds (67.2%) of SPH Service Area adults are overweight.

Here, "overweight" includes those respondents with a BMI value ≥25.

- Comparable to the Montana and US overweight prevalence.
- Similar by community.
- TREND: Much higher than 2012 findings.

Prevalence of Total Overweight (Overweight or Obese)

(Percent of Adults With a Body Mass Index of 25.0 or Higher)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Further, 29.7% of SPH Service Area adults are obese.

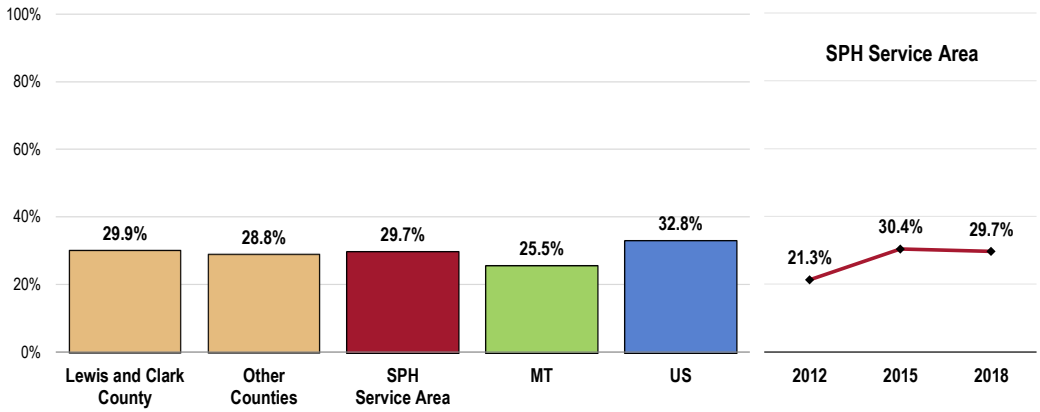
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

- Similar to state and national findings.
- Similar to the Healthy People 2020 target (30.5% or lower).
- No significant difference by community.
- TREND: Denotes a statistically significant increase in obesity since 2012, though similar to 2015 findings.

Prevalence of Obesity

(Percent of Adults With a Body Mass Index of 30.0 or Higher)

Healthy People 2020 Target = 30.5% or Lower



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

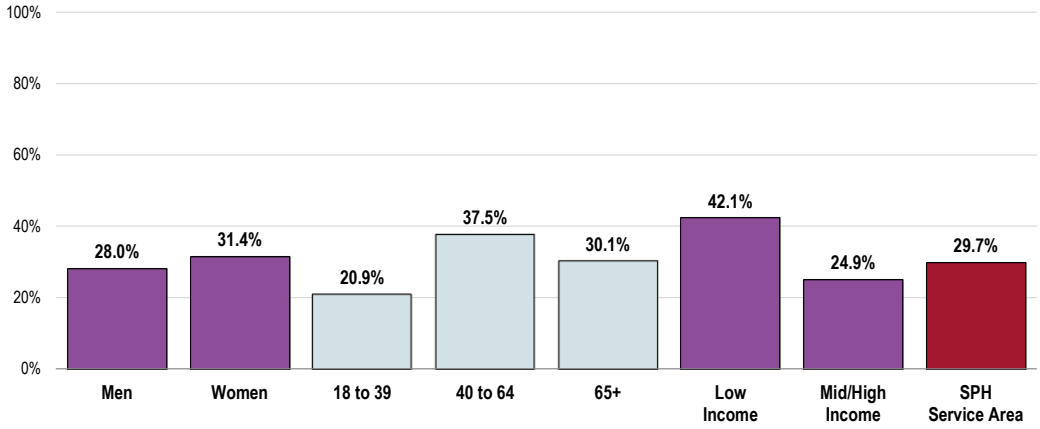
Obesity is notably more prevalent among:

- Respondents age 40 or older
- Residents with lower incomes.

Prevalence of Obesity

(Percent of Adults With a BMI of 30.0 or Higher; SPH Service Area, 2018)

Healthy People 2020 Target = 30.5% or Lower



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 154]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

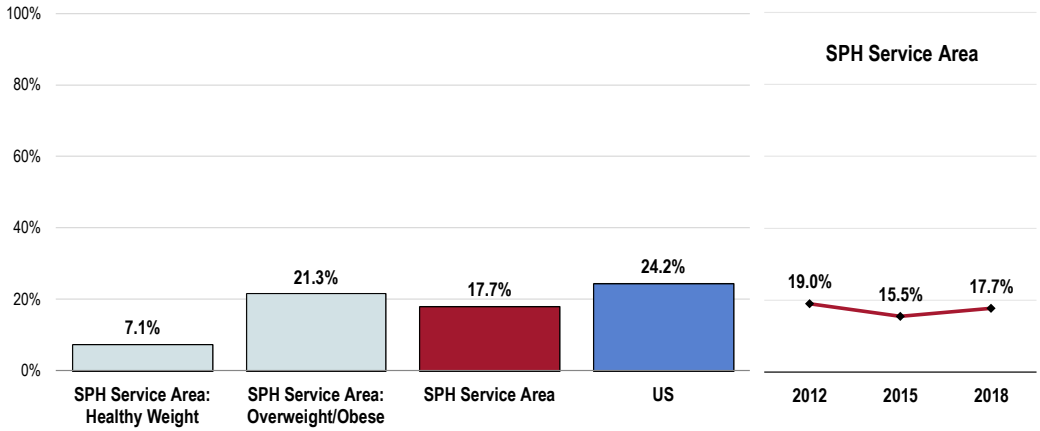
Health Advice

A total of 17.7% of adults have been given advice about their weight by a doctor, nurse, or other health professional in the past year.

- Lower than national findings.
- TREND: Statistically unchanged from prior years.
- Note that 21.3% of overweight/obese adults have been given advice about their weight by a health professional in the past year (while four in five have not).

Have Received Advice About Weight in the Past Year From a Physician, Nurse, or Other Health Professional

(By Weight Classification)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 98, 156-157]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Relationship of Overweight With Other Health Issues

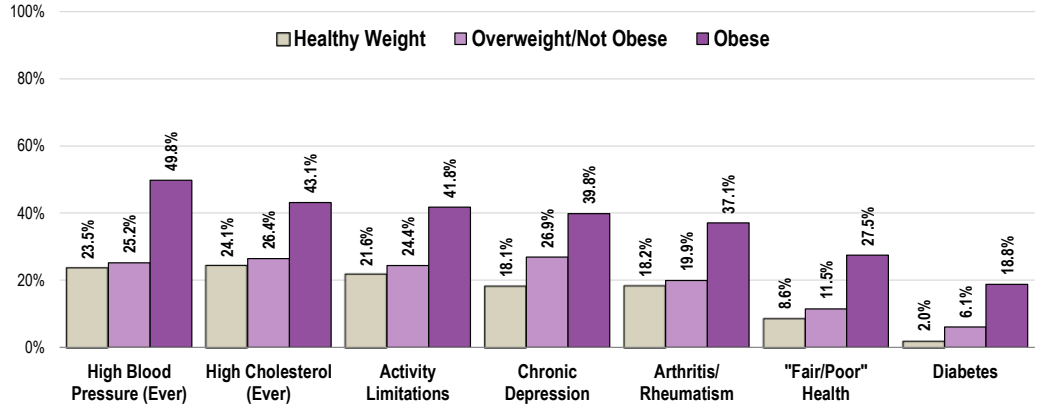
The correlation between overweight and various health issues cannot be disputed.

Overweight and obese adults are more likely to report a number of adverse health conditions. Among these are:

- High blood pressure.
- High cholesterol.
- Activity limitations.
- Chronic depression.
- Arthritis/rheumatism.
- “Fair” or “poor” physical health.
- Diabetes.

Relationship of Overweight With Other Health Issues

(By Weight Classification; SPH Service Area, 2018)



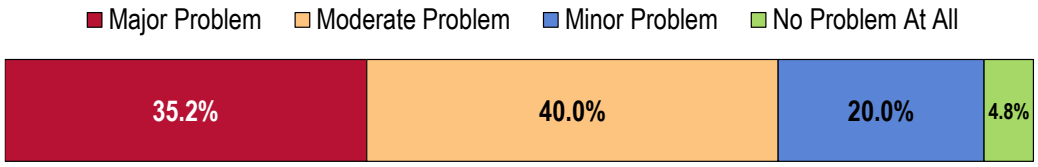
Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 5, 25, 39, 100, 109, 130, 140]
Notes: ● Based on reported heights and weights, asked of all respondents.

Key Informant Input: Nutrition, Physical Activity, & Weight

Key informants taking part in an online survey most often 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, 2018)



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

Top Concerns

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

Diet/Nutrition

> *The easy choice is fast food or high fat. – Other Health Provider*
>
> *Poor understanding of nutritional needs and consequences of bad diets. Increasing prevalence of packaged, low nutrition foods, corporate marketing of bad choices. Sports energy drinks, sodas, alcohol, fast foods, "giant" servings. – Community Leader*
>
> *In general, I feel as though healthy diet is not culturally the norm here. I would guess we have a larger percentage than normal of overweight people. – Physician*
>
> *There is a proliferation of quick, unhealthy, cheap food in our community, from restaurants to what is available at the nearest gas station. It seems that access to supermarkets has improved in the last few years. – Other Health Provider*
>
> *We need to provide good nutrition to our aging community and our youngest community members.*

Nobody should go hungry or eat unhealthy food to survive. Also, taking the candy and soda out of schools doesn't help. Children will find a way to get candy. – Social Services Provider

In Helena, specifically, we need to do a better job with our school lunches. Fewer options, especially for elementary students, scratch cooking, and local foods. Walkability, sidewalks in town are not complete, snow removal is ill-enforced. – Public Health Representative

School lunches are horrible, little nutritional value. If a child had a gluten intolerance they would starve. Kids that do try to eat a healthier diet, or are vegan, have to have a note from their doctor in order to receive food from the school lunch. – Social Services Provider

Access to Healthy Food

Access to healthy foods, limits on unhealthy foods, and social structures to support regular physical activity. – Social Services Provider

Impaired motivation, limited healthy food options, too much fast food. – Physician

I think diet is the biggest challenge locally. Access to healthy food and knowledge about healthy food preparation is lacking. People with limited self-care and low incomes are particularly challenged. Eating healthy in area restaurants is very limited. – Social Services Provider

Affordable access to healthy foods rather than inexpensive, good-tasting fast foods. – Public Health Representative

I think the biggest problem is that the healthy foods are more expensive than the problematic foods. – Community Leader

Built Environment

Our community is fortunate to have lots of access to outdoor opportunities for physical activity. Not all individuals are able to access these opportunities. I believe we need policy change to enhance access, especially for those with low incomes. – Public Health Representative

Lack of pedestrian walkways. – Community Leader

Have to change norms and make doing the right thing easy. Helena isn't very walkable. Schools are still not doing a great job with prevention and people with low socioeconomic status are at a disadvantage in terms of purchasing healthy food. – Public Health Representative

Food insecurity. Children too sedentary, need more accessible sidewalks and complete network for pedestrians and bicyclists. Fewer variances given to wealthy property owners who could afford to put in sidewalks in front of their million-dollar homes. – Public Health Representative

There is not a connected network of sidewalks or bicycle routes, prohibiting many people from being able to walk or bicycle. Sidewalks are not cleared in the winter, making it nearly impossible to walk. In addition, wide roads and fast speed limits. – Other Health Provider

Health Awareness/Education

Education, funds, places and ways to be active. Even in the cold and snow, access to affordable fresh foods. – Other Health Provider

We need to do more to promote better nutrition and encourage people to be more active. – Social Services Provider

Education, the ability to alter habits, reformation of attitudes and beliefs about nutrition. – Other Health Provider

I think that while we do a great job of appealing to those who already are physically fit and active, we still need education and programs that help encourage and incentivize those who need that little push to get and stay motivated. – Community Leader

There is a lack of awareness, diversity and ease of use for weight loss programs and support throughout the community. – Physician

Lifestyle

Busy lifestyles, low income. Perception that eating healthier is more expensive. Lots of fast food chains. – Other Health Provider

Maintaining a healthy weight and lifestyle. – Public Health Representative

Today's society, fast food convenience, Town Pumps. Physically as a society we are getting lazy, overweight, and living unhealthily. Social media and electronic entertainment contribute greatly to unhealthy lifestyles and overweight issues. – Public Health Representative

Lifestyle issues are a significant contributor to most chronic medical problems, like heart disease and diabetes. – Physician

> *Our community is not always conducive to exercise and being active. For example, winter in Montana is about half the year, and because we don't invest as much money into snow plowing in Helena as we do in other communities, it is difficult to exercise. – Social Services Provider*

Obesity

> *The obesity epidemic is a serious medical problem throughout the country. – Physician*
>
> *Financial and education related drivers for obesity. Lack of access to local/fresh/low cost produce. – Social Services Provider*
>
> *Obesity among the poor is a serious problem, maybe it was listed earlier, and I missed it but it limits many people's abilities to be active and causes other problems like diabetes, joint problems, heart disease. – Community Leader*

Access to Care/Services

> *Access to programs. – Community Leader*

Environmental Contributors

> *Air quality is very poor, so much gravel is placed on the road in the winter in the spring, it is very dusty. Not enough bike paths and quality sidewalks. Not enough healthy restaurants. Need more community gardens. More exercise classes. – Physician*

Prevalence/Incidence

> *Basic population problem. – 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)

Age-Adjusted Cirrhosis/Liver Disease Deaths

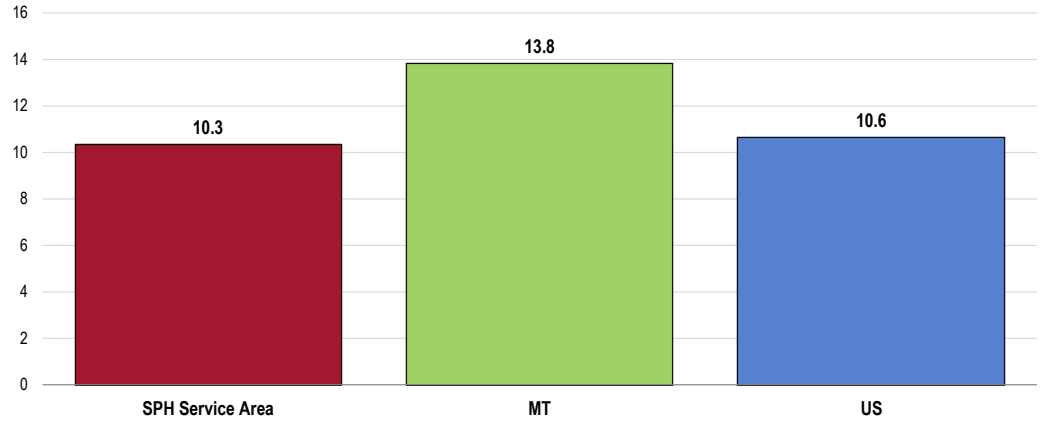
Between 2014 and 2016, the SPH Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 10.3 deaths per 100,000 population.

- Below the statewide rate.
- Comparable to the national rate.
- Fails to satisfy the Healthy People 2020 target (8.2 or lower).

Cirrhosis/Liver Disease: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 8.2 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

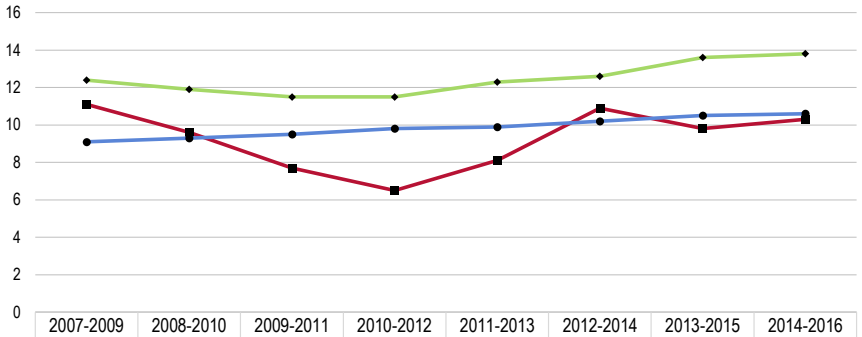
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: The mortality rate has fluctuated widely in the region, showing no clear trend. Statewide and nationwide, rates have increased slightly.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 8.2 or Lower



	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
SPH Service Area	11.1	9.6	7.7	6.5	8.1	10.9	9.8	10.3
MT	12.4	11.9	11.5	11.5	12.3	12.6	13.6	13.8
US	9.1	9.3	9.5	9.8	9.9	10.2	10.5	10.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

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

Alcohol Use

Excessive Drinking

"**Excessive drinking**" includes heavy **and/or** binge drinkers:

- **Heavy drinkers** include men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- **Binge drinkers** include men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

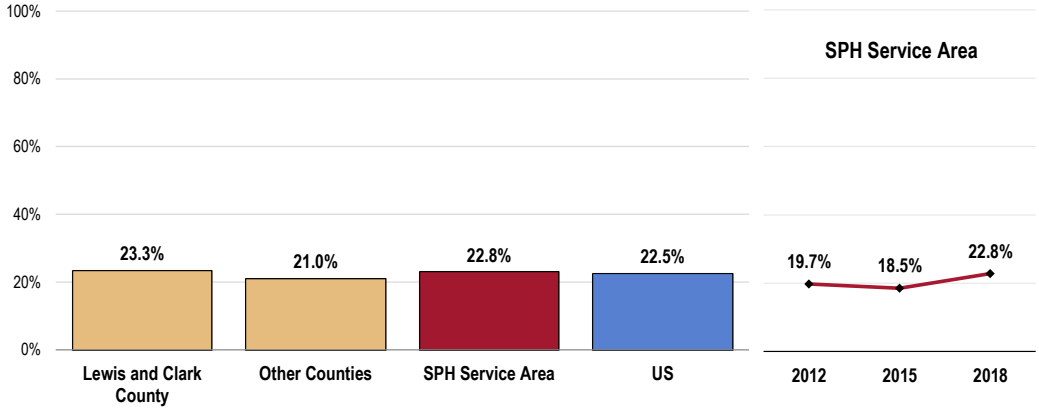
RELATED ISSUE:
See also *Mental Health: Stress* in the **General Health Status** section of this report.

A total of 22.8% of area adults are excessive drinkers (heavy and/or binge drinkers).

- Almost identical to the national proportion.
- Similar to the Healthy People 2020 target (25.4% or lower).
- Comparable by county area.
- TREND: Statistically unchanged since 2012.

Excessive Drinkers

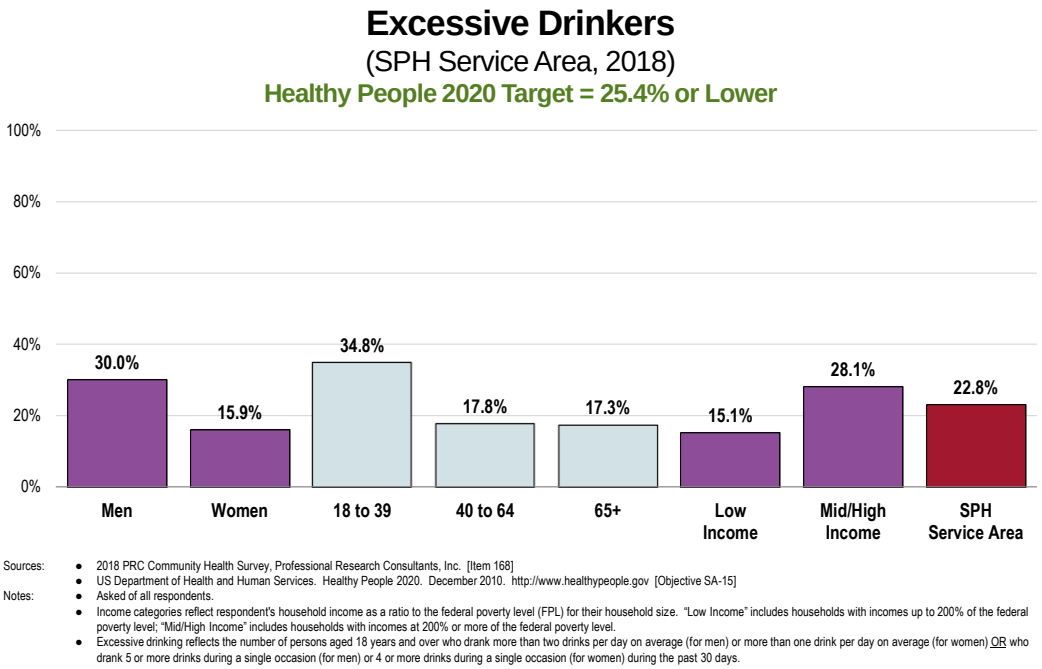
Healthy People 2020 Target = 25.4% or Lower



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Excessive drinking is more prevalent among men, young adults (under age 40), and those with higher incomes.



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

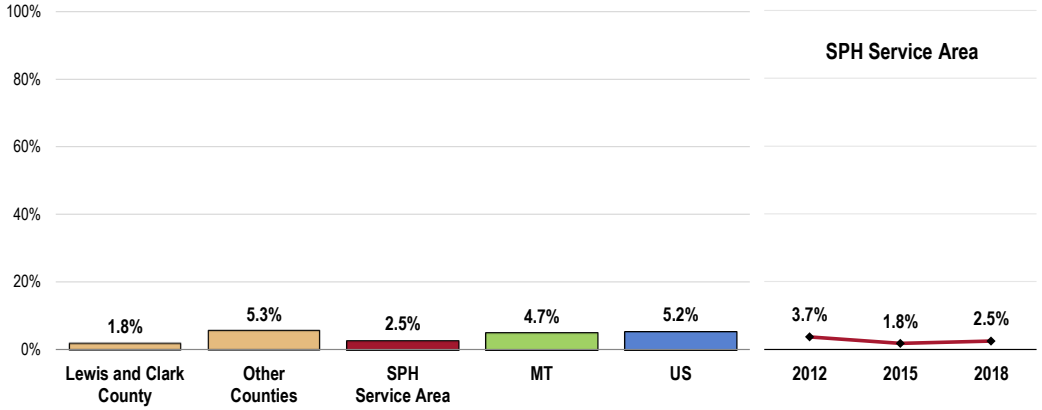
Drinking & Driving

A total of 2.5% of SPH Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

- Lower than national findings.
- Similar to Montana findings.
- Statistically similar by community.
- TREND: The drinking and driving prevalence has not changed significantly since 2012.

Have Driven in the Past Month After Perhaps Having Too Much to Drink



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Age-Adjusted Unintentional Drug-Related Deaths

Between 2014 and 2016, there was an annual average age-adjusted unintentional drug-related mortality rate of 8.3 deaths per 100,000 population in SPH Service Area.

- Much lower than the national rate.
- Similar to the statewide rate.
- Satisfies the Healthy People 2020 target (11.3 or lower).

Unintentional Drug-Related Deaths: Age-Adjusted Mortality

(2014-2016 Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 11.3 or Lower

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

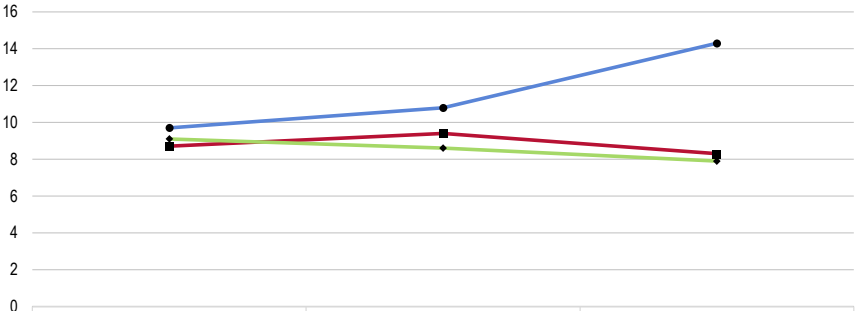
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

- TREND: After increasing slightly in the late 2000s/early 2010s, the mortality rate in the SPH Service Area has since decreased slightly. Over this same time period, rates have decreased across the state while increasing nationally.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 Target = 11.3 or Lower



	2008-2010	2011-2013	2014-2016
SPH Service Area	8.7	9.4	8.3
MT	9.1	8.6	7.9
US	9.7	10.8	14.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2018.
- UD Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12].

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

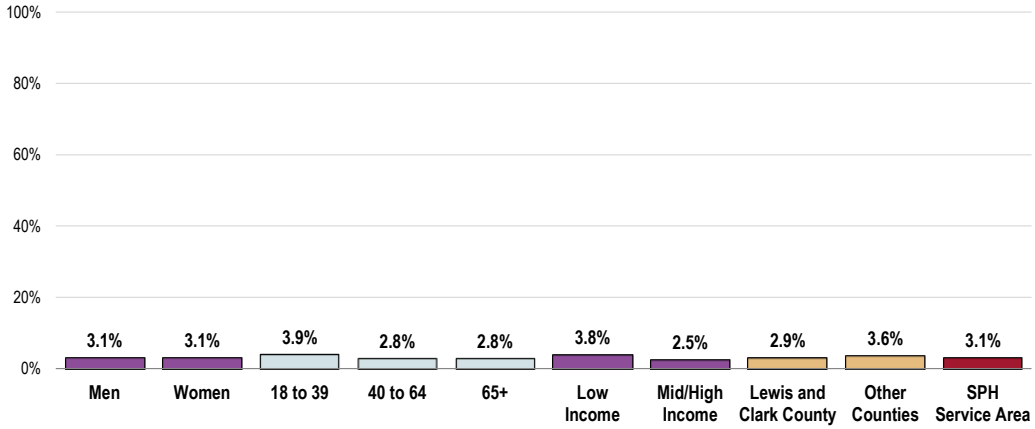
Prescription Drug Use

Responding about the past year, 3.1% of SPH Service Area adults report using a prescription drug "on their own" (without a prescription, more than prescribed, and/or longer than prescribed).

- Similar by community.
- No significant differences by demographics.

Took Prescription Drugs On Own in the Past Year

(Without Rx or More/Longer Than Prescribed; SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 314]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Illicit Drug Use

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

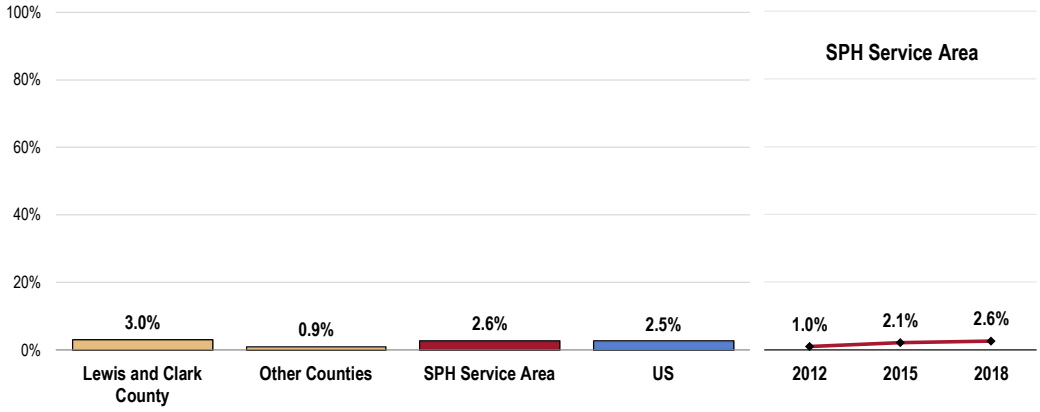
Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

A total of 2.6% of SPH Service Area adults acknowledge using an illicit drug in the past month.

- Almost identical to the proportion found nationally.
- Satisfies the Healthy People 2020 target of 7.1% or lower.
- Statistically similar by county area.
- TREND: The increase since 2012 is not statistically significant.

Illicit Drug Use in the Past Month

Healthy People 2020 Target = 7.1% or Lower



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

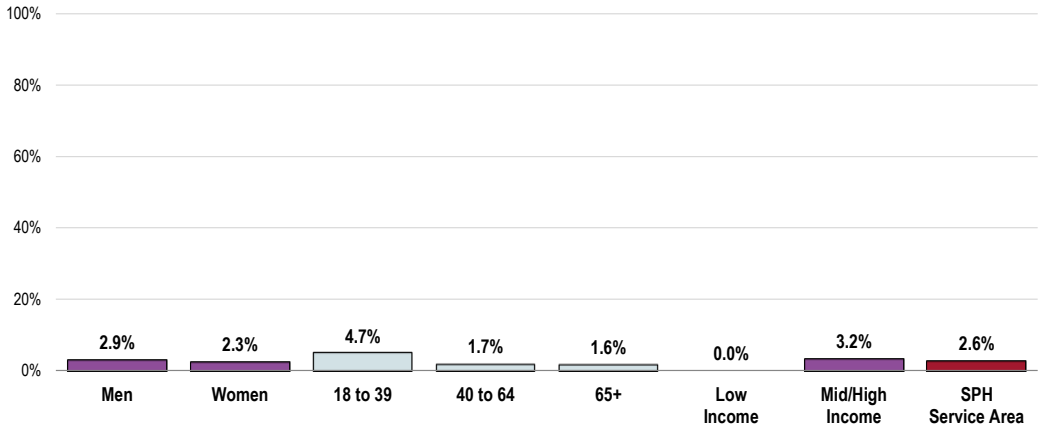
Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- No significant differences in illicit drug use when viewed by demographics.

Illicit Drug Use in the Past Month

(SPH Service Area, 2018)

Healthy People 2020 Target = 7.1% or Lower



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 59]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

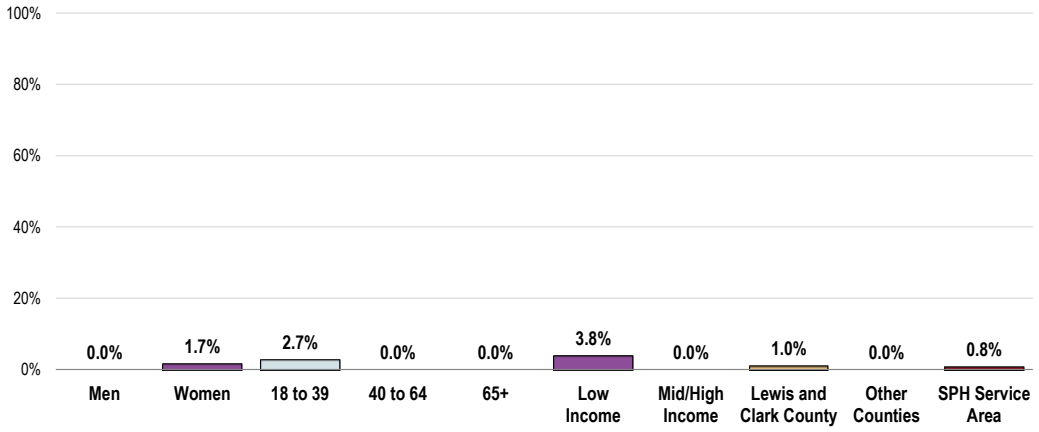
Alcohol & Drug Treatment

A total of 0.8% of SPH Service Area adults report that they have experienced trouble finding professional help for an alcohol- or drug-related problem in the past year.

- Similar by community.
- By demographics, women are more likely to have experienced this difficulty.

Difficulty Finding Professional Help for an Alcohol/Drug-Related Problem in the Past 12 Months

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 315]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

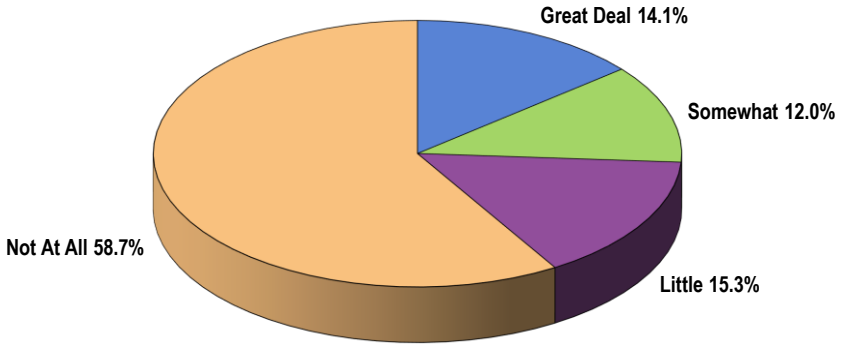
Negative Effects of Substance Abuse

Area adults were also asked to what degree their lives have been negatively affected by substance abuse (whether their own abuse or that of another).

In all, most respondents have not been negatively affected (58.7% "not at all" responses).

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)

(SPH Service Area, 2018)

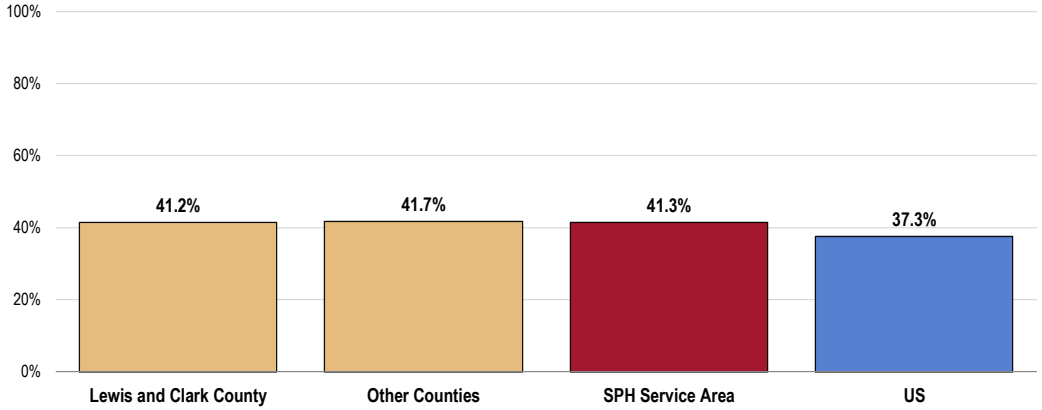


Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]
Notes: • Asked of all respondents.

In contrast, four in ten (41.3%) of survey respondents indicate that their lives have been negatively affected by substance abuse, including 14.1% who report having been affected "a great deal."

- Similar to the US figure.
- Nearly identical by community.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

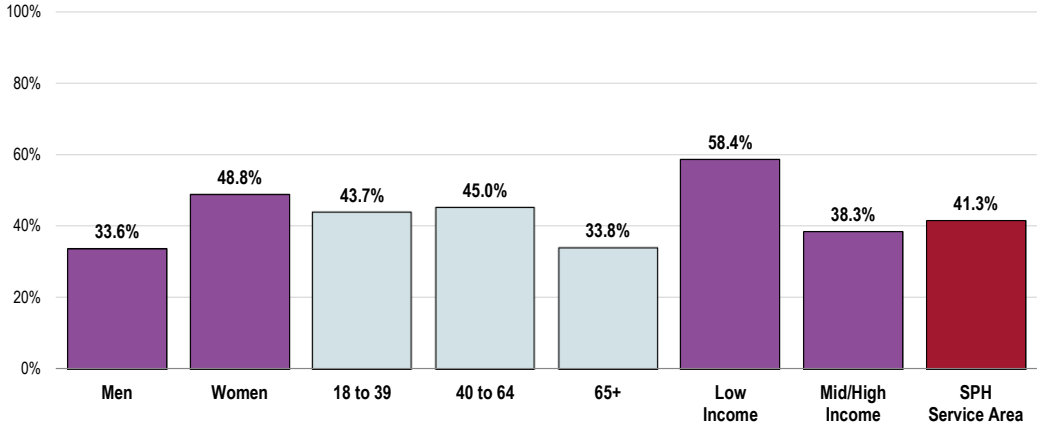
Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

The prevalence of survey respondents whose lives have been negatively impacted by substance abuse, whether their own abuse or that of another, is higher among the following:

- Women.
- Adults under age 65.
- Lower-income residents.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 61]

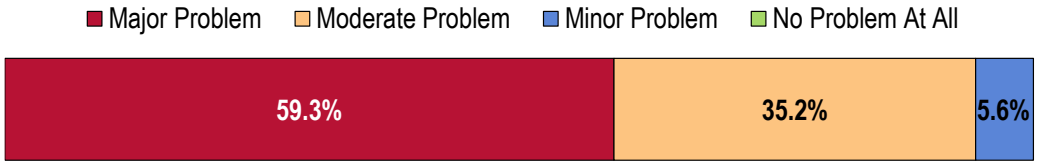
Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Substance Abuse

Six in 10 key informants taking part in an online survey characterized *Substance Abuse* as a "major problem" in the community.

Perceptions of Substance Abuse as a Problem in the Community

(Key Informants, 2018)



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

Top Concerns

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

Access to Care/Services

No inpatient treatment facilities, limited outpatient resources, and inability to detox. – Physician

Lack of substance abuse treatment. – Public Health Representative

Not enough treatment centers available. Also, patients with addiction problems often don't have insurance or means to pay for detox and treatment. – Physician

No programs to help people stop using drugs. – Physician

Limited treatment services. – Public Health Representative

I think the greatest barriers to substance abuse treatment are the limited number of treatment providers, the stigma attached to substance abuse, and, perhaps most of all, the inherent Montana "culture" of drinking and using tobacco. – Public Health Representative

No nearby treatment facilities. – Public Health Representative

Access, availability, insurance coverage/cost. When these people present and are at "rock bottom" and in need of immediate assistance and ready to enter treatment program, there is nowhere to send them. Frequently programs have a waiting list. – Physician

Choice and adequacy of service provisions. – Community Leader

Access to effective treatment and affordability. – Social Services Provider

Lack of available treatment beds and services for when people are ready to use them. Easy availability of addictive substances like meth, alcohol, and opioids. – Community Leader

I think we have a serious problem in this community, and that there are not enough resources to address the direct problem and all of the indirect problems that are either symptoms or direct results of substance abuse. – Community Leader

Access and funding for treatment programs. – Physician

Minimal programs available. – Physician

Not enough inpatient services. MCDC is the only option for some and it is very hard to get into in a timely manner. Not enough outpatient LAC's. – Physician

Substance abuse is a huge issue in the community. Greatest barrier is getting them into a treatment center that they can afford and then getting them to stay for the duration. The court system in Helena also needs to offer treatment as an option. – Public Health Representative

The demand and need for services far outweigh the resources we have in the community. – Public Health Representative

Quality treatment and funding. – Social Services Provider

Minimal treatment available and huge financial barriers for getting that treatment. – Physician

Minimal resources dedicated/available is primary barrier. Stigma associated with utilizing these services remains. – Community Leader

People with serious substance abuse needs lack immediate access to treatment when they may be open to intervention. The supply of intensive long-term treatment resources is greatly inadequate. Many treatment options simply. – Social Services Provider

Close treatment options and affordability. From my experience, people have to leave the county to attend inpatient treatment. Even when they are willing to do that there are limited "low cost" beds available so they have to be on a waiting list. – Public Health Representative

I am not aware of any type of rehab center in Lewis and Clark County. Individuals seeking treatment and/or counseling are also on a wait list, so if someone does detox the follow up is lacking. – Other Health Provider

Lack of chronic pain and Suboxone access. – Physician

Lack of services for pregnant women, more services needed for teens and our service members/veterans and their families. – Public Health Representative

Everything revolves around alcohol. Too many people are binge drinking and they don't have access to treatment centers. We need a detox facility for drugs and alcohol. You shouldn't have to leave your family to get the help you need in Missoula. – Social Services Provider

Prevalence/Incidence

Have a drinking culture. It is extremely difficult and takes a ton of will power for someone to remove themselves from the drinking and still participate in social events. In terms of illegal drug use, I would not know who to contact if I had a problem. – Other Health Provider

Meth is a huge problem in our community and it affects all ages. We do not have an inpatient treatment centers and we do not have enough support or education. – Physician

This is a major issue in our county at this time and is a major issue for our people. – Social Services Provider

We have a very scary usage rate of alcohol, marijuana, meth and heroin use in our community. Despite campaigns and education in schools, the rates continue to be alarmingly high. Recognition of the problem, willingness to get help, wanting to quit. – Other Health Provider

It's not barriers, it's society. Multiple repeated convictions and still on the streets. Penalties are not deterrent enough evidently. – Public Health Representative

The overall acceptance of alcohol use, lack of laws that punish unlawful behavior, and no one really wants to do anything about it. – Community Leader

The overwhelming number of individuals suffering from substance abuse disorders is overwhelming and probably underestimated. A lack of qualified addictive specialists. – Other Health Provider

Lack of Providers

No providers. – Physician

Not enough providers or medical coverage. – Social Services Provider

Not enough providers, cost of treatment, no place to detox. The one provider in town does not use the most client-centered approach and clients are stuck with them. – Social Services Provider

Not enough providers for low income individuals, and also the fear of getting treated in a "small" town where everybody knows what everybody is doing. – Community Leader

Not enough choices for professional intervention. – Social Services Provider

There are a limited number of skilled trained professionals who are providing these addiction related services. Those that do practice may face heavy caseloads resulting in delays in getting patients into services. – Public Health Representative

Affordable Care/Services

Affordability and just having enough high-quality programs to meet the needs of everyone that has challenges with substance abuse, instead of people having to be on waiting lists. Having high quality programs that have excellent overall clients. – Social Services Provider

Finances. – Community Leader

I think barriers are risks of being arrested and no money for health care. – Social Services Provider
The cost it takes to treat someone, especially those who can't afford treatment. Incarceration seems to be the final access they have to treatment. – Other Health Provider

Denial/Stigma

Stigma. – Community Leader

Addiction, stigma, resources, boredom, mental illness, poverty, family support and education. – Physician

Focus on incarceration rather than treatment, stigma around this population. – Community Leader

The abuser willing to admit that they need help. – Community Leader

Contributing Factors

Housing is a huge problem, outreach for addiction, and stigma. – Social Services Provider

Mental health, poverty, and employment. – Physician

Reliable after hours public transportation such as taxis or Uber. There are occasionally Ubers running after hours, but not reliably. This is a problem for several reasons. Cabs generally stop running before bars close pushing more drunk driving. – Physician

Lack of Funding

Funding to address opioid and meth addiction. Consequently, crime is epidemic. – Community Leader

Money, public understanding of the issue, public attitude toward alcohol use, medical marijuana, fear of going to jail or losing a job. – Other Health Provider

Funding and the public recognition of treatment needs. – Community Leader

Diagnosis/Treatment

Most important is identifying those who need it. The schools offer an opt-in screening of high school students for mental health and substance use rather than an opt-out. When kids are identified they can get help. – Social Services Provider

Education, prevention, treatment, and affordability of education, prevention and treatment. – Other Health Provider

Parental Influence

Parents, they enable children with alcohol, leave pills around and afraid to discipline. – Other Health Provider

Stress

Putting your brain on hold as a stress reliever is not a long-term help. Postpones the agony suffered after each life is permanently altered. We still do not identify drug free places for community activities, stress free tools. – Other Health Provider

Most Problematic Substances

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

Problematic Substances as Identified by Key Informants	
	Total Mentions
Alcohol	**57**
Methamphetamines or Other Amphetamines	**44**
Heroin or Other Opioids	**34**
Prescription Medications	**21**
Marijuana	**11**
Cocaine or Crack	**4**
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	**1**

Tobacco Use

About Tobacco Use

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

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- 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.

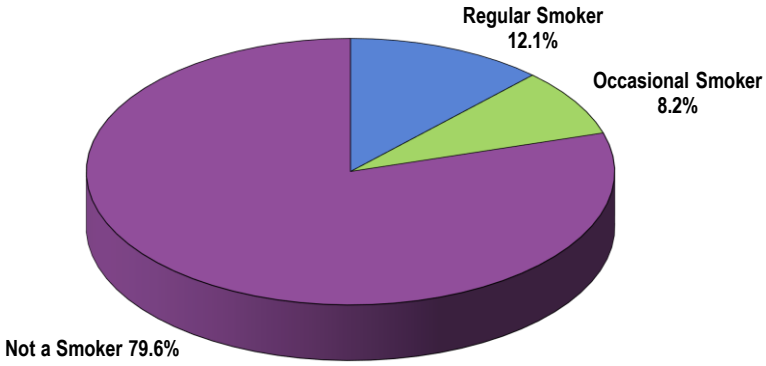
- Healthy People 2020 (www.healthypeople.gov)

Cigarette/Cigar/Pipe Smoking Prevalence

A total of 20.3% of SPH Service Area adults currently smoke cigarettes, cigars, and/or pipes, either regularly (12.1% every day) or occasionally (8.2% on some days).

Cigarette/Cigar/Pipe Smoking Prevalence

(SPH Service Area, 2018)



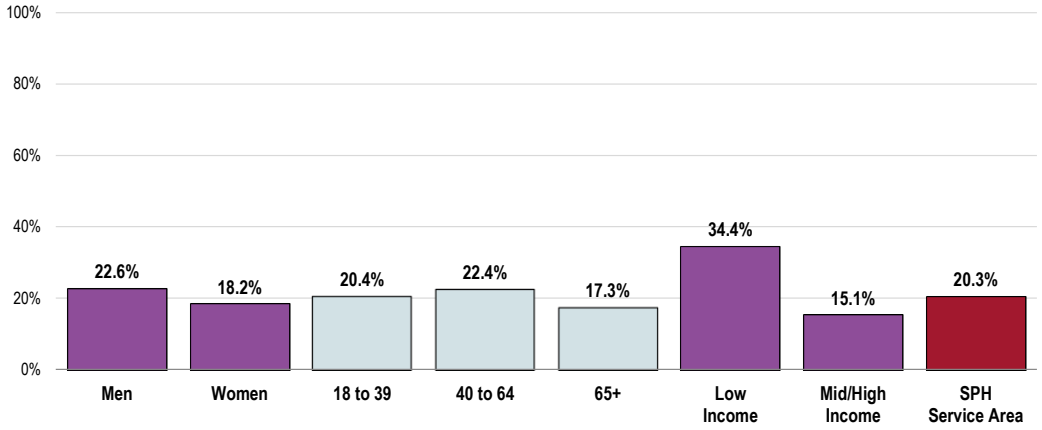
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 313]

Notes:
- Includes cigarettes, cigars, and/or pipes.

:
- Asked of all respondents.

- Smoking is more prevalent among lower-income residents.

Current Cigarette/Cigar/Pipe Smokers
(SPH Service Area, 2018)



Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 313]
Notes: ● Asked of all respondents.
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
● Includes regular and occasional smokers (every day and some days) of cigarettes, cigars, and/or pipes.

Environmental Tobacco Smoke

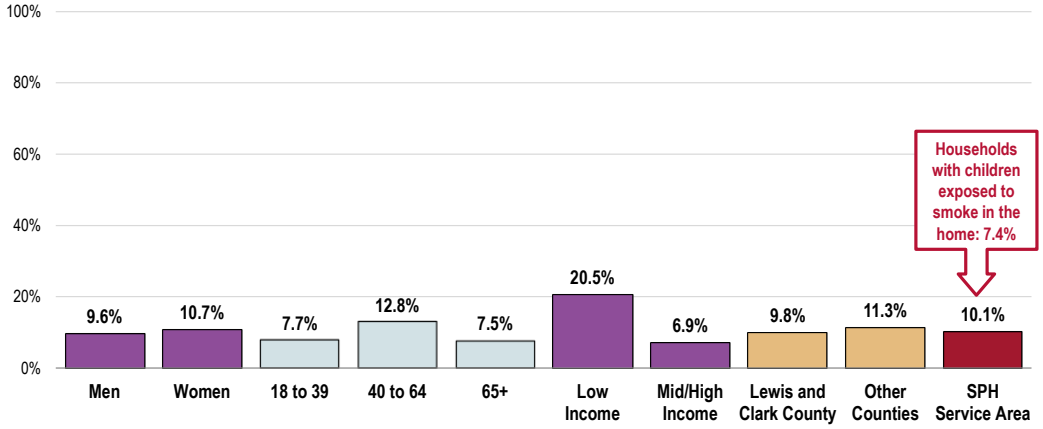
One in 10 SPH Service Area adults (10.1%, including smokers and nonsmokers) report that a member of their household has smoked cigarettes, cigars, or a pipe in the home an average of 4+ times per week over the past month.

- Similar by county area.
- Notably higher in low-income households.

Note that 7.4% of SPH Service Area children are exposed to cigarette, cigar, or pipe smoke at home.

Member of Household Smokes At Home

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 52, 162]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Smoking Cessation

About Reducing Tobacco Use

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

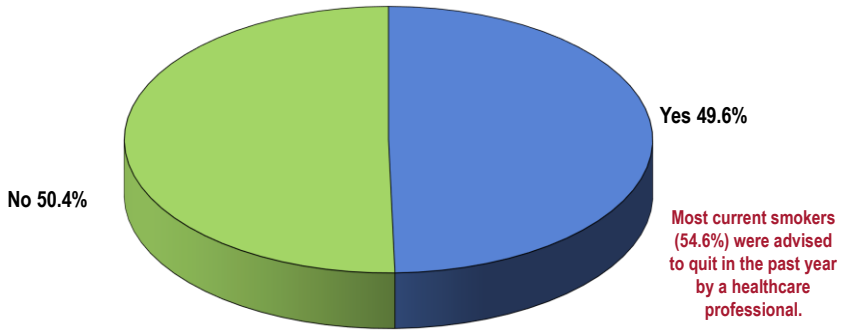
- Healthy People 2020 (www.healthypeople.gov)

One-half of regular smokers (49.6%) went without smoking for one day or longer in the past year because they were trying to quit smoking (including cigarettes, cigars, and pipes).

Over half of current smokers (54.6%) have been advised by a healthcare professional in the past year to quit smoking.

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking

(Among Everyday Smokers, SPH Service Area, 2018)



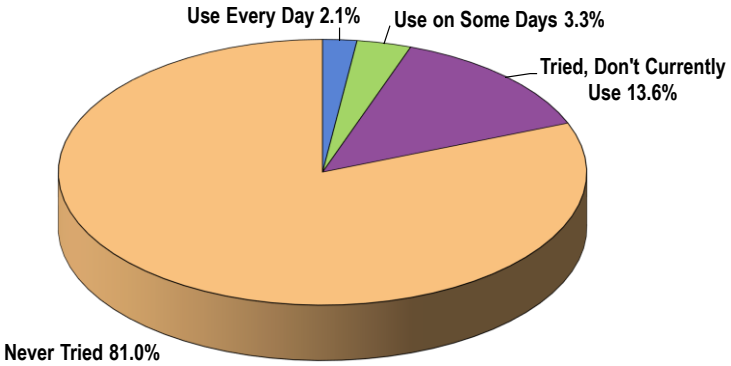
Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 50-51]
Notes: • Asked of respondents who smoke cigarettes, cigars, and/or pipes every day.

Use of Vaping Products

A total of 5.4% of SPH Service Area adults currently use electronic cigarettes (e-cigarettes) or other electronic vaping products either regularly (2.1% every day) or occasionally (3.3% on some days).

Use of Vaping Products

(SPH Service Area, 2018)

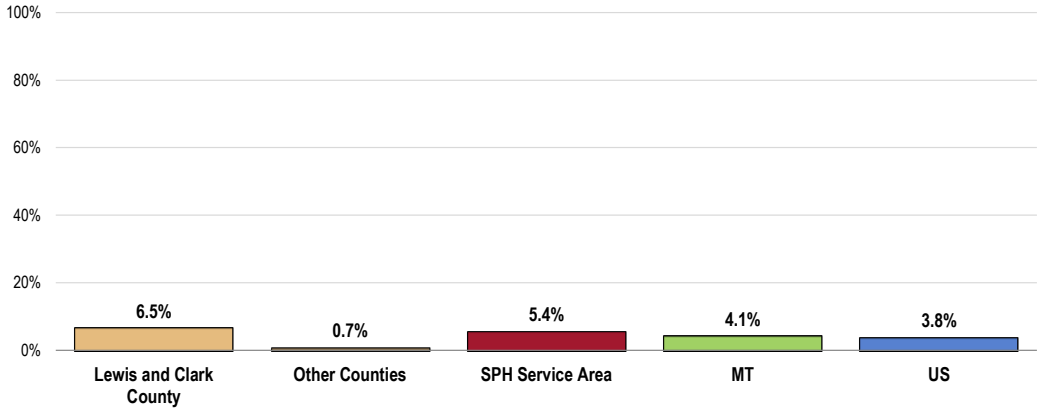


Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 163]
Notes: • Asked of all respondents.

- Similar to state and national findings.
- Least favorable in Lewis and Clark County.

Currently Use Vaping Products

(Every Day or on Some Days)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 163]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.

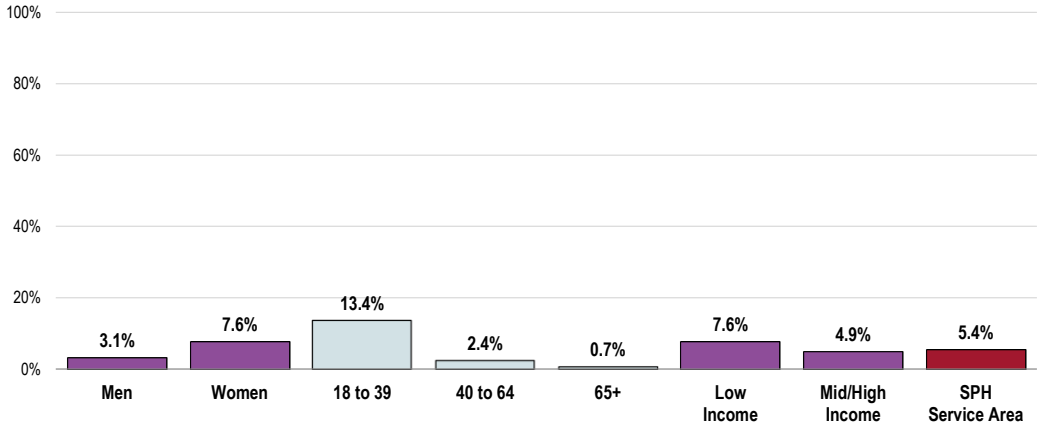
Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Electronic cigarette/other vaping product use is more prevalent among:

- Women.
- Adults under age 40 (negative correlation with age).

Currently Use Vaping Products

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 163]

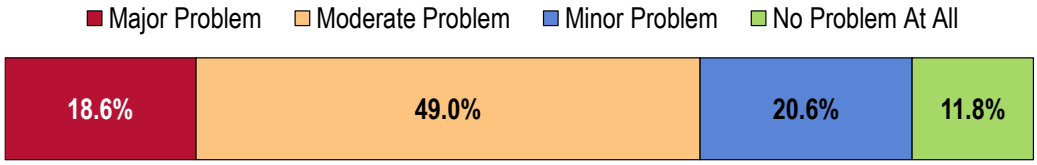
Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

Half 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, 2018)



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

Top Concerns

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

Prevalence/Incidence

Historically we have a high rate of tobacco use. Unfortunately, we are seeing young people continuing to start early still despite campaigns against tobacco. Products are made to be appealing to young adults. I am concerned about vaping in teens. – Other Health Provider

Still a major problem for public at large and particularly youth addiction. High rate of tobacco use in our area and in Montana. Extreme public health costs of treating with tobacco-related diseases. – Community Leader

Higher than average rate of smokers, fewer people desiring to quit. Still more culturally normal than in other parts of the country I have been. – Physician

Higher than average rate of smokers, fewer people desiring to quit. Still more culturally normal than in other parts of the country I have been. – Physician

Rates of use are high locally and its impact on health is huge. – Physician

Smoking is seen or smelled everywhere. – Community Leader

I see so many people, young and old, smoking. – Social Services Provider

Lots of people still smoke. – Physician

High smoking rates in the community with little to no interest in quitting. – Physician

Major problem everywhere. – Other Health Provider

Vaping Products

Too many youths are using the new vapes. My daughter says they are using them in class, and teachers don't know who it is. These things need to be taxed at a higher rate. Also, how are they getting it? – Social Services Provider

Rampant nicotine use and increasing use among teenagers with the introduction of E-cigarettes and vaping. Numerous health problems associated. – Physician

It still is in many places. Kids and young people have moved from cigarettes to E-cigs. The industry is still peddling the stuff to kids hard. Many products are just for this audience. – Public Health Representative

The fake cigarettes have become very popular. – Community Leader

Comorbidities

The consequences of chronic use translate into multiple life-threatening health problems later. The financial drain both to smokers and the health care system is enormous. – Physician

> *Causes health conditions and generally those with less means smoke and a pack of cigarettes is over 7 dollars. This can feed a person for a day, or a day of energy for their house. – Community Leader*
>
> *Major contributor to multiple health problems. Prevention of tobacco use should be a goal. – Public Health Representative*

Access to Health Services

Professional Research Consultants, Inc.

Health Insurance Coverage

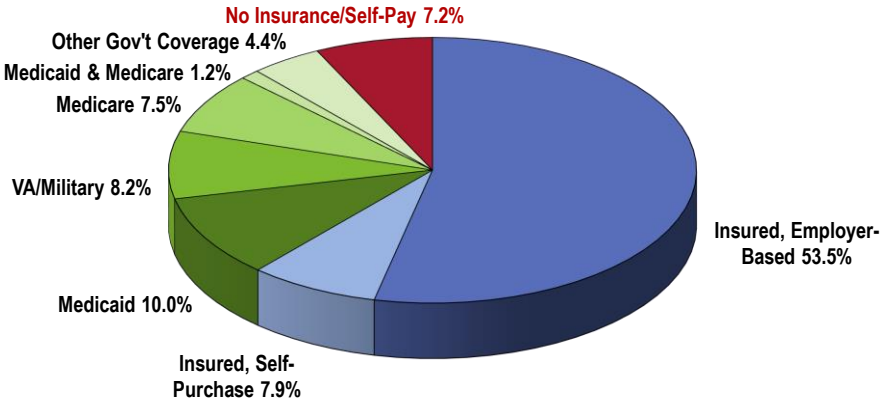
Type of Healthcare Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

Six in 10 SPH Service Area adults age 18 to 64 (61.4%) report having healthcare coverage through private insurance. Another 31.4% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage

(Among Adults Age 18-64; SPH Service Area, 2018)



Sources: • 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

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

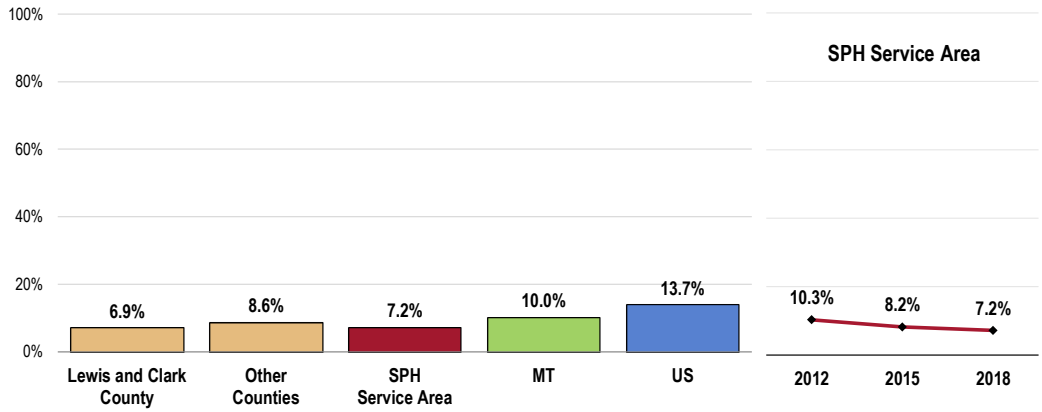
Among adults age 18 to 64, 7.2% report having no insurance coverage for healthcare expenses.

- Similar to the state finding.
- More favorable than the national finding.
- The Healthy People 2020 target is universal coverage (0% uninsured).
- Comparable by community.
- TREND: Statistically similar to 2012 findings.

Lack of Healthcare Insurance Coverage

(Among Adults Age 18-64)

Healthy People 2020 Target = 0.0% (Universal Coverage)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 169]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- No significant differences by demographics (not shown).

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)

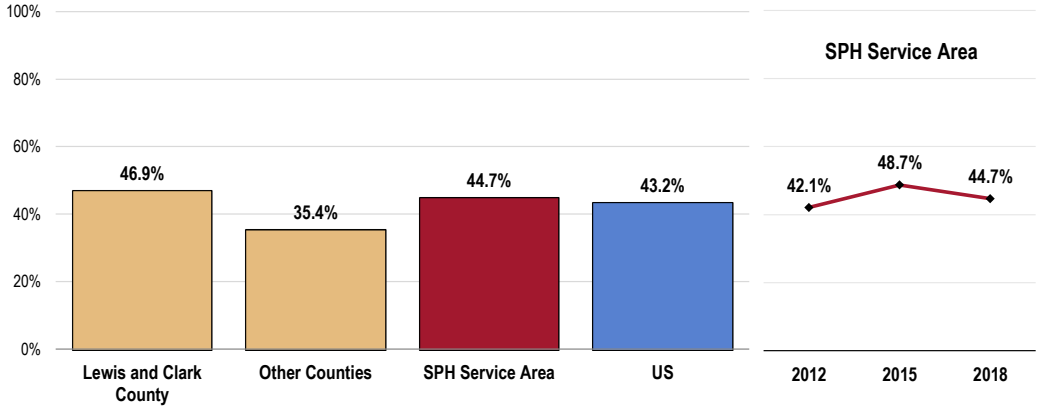
Difficulties Accessing Services

This indicator reflects the percentage of the total population experiencing problems accessing healthcare in the past year, regardless of whether they needed or sought care.

A total of 44.7% of SPH Service Area adults report some type of difficulty or delay in obtaining healthcare services in the past year.

- Comparable to US data.
- Access difficulties are highest in Lewis and Clark County.
- TREND: Statistically similar to prior data.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year

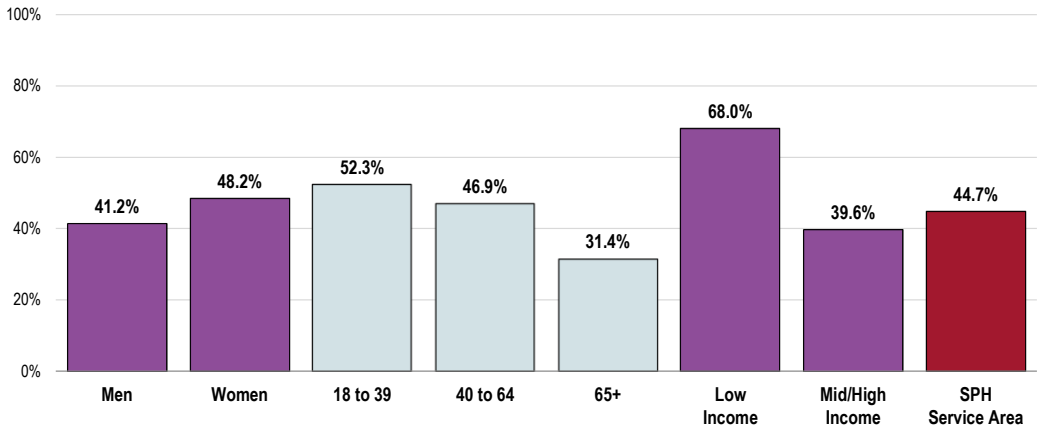


Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 171]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Note the correlation of access difficulties with both income and age.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 171]

Notes:
- Asked of all respondents.
- Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Barriers to Healthcare Access

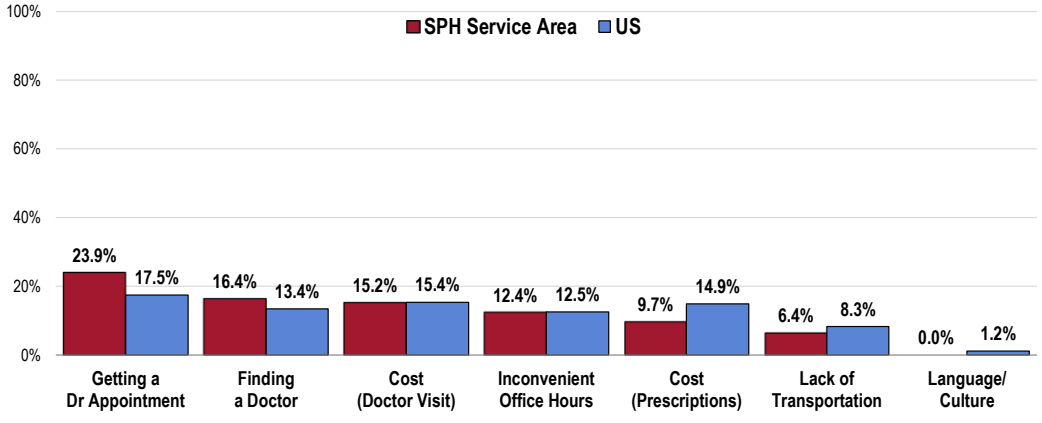
To better understand healthcare access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Of the tested barriers, difficulty getting an appointment impacted the greatest share of SPH Service Area adults (23.9%).

- The proportion of impacted SPH Service Area adults is statistically comparable to or better than that found nationwide for each of the tested barriers, with the exception of difficulty getting an appointment.

Barriers to Access Have Prevented Medical Care in the Past Year



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-13]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

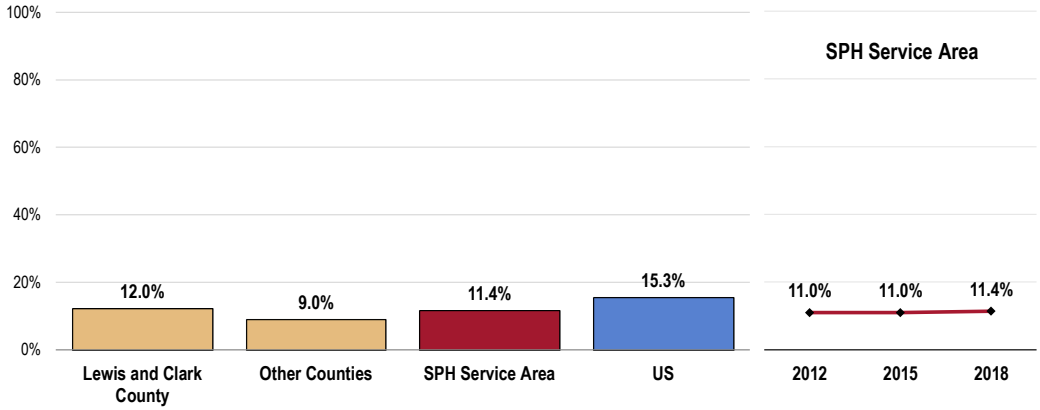
Notes:
- Asked of all respondents.

Prescriptions

Among all SPH Service Area adults, 11.4% skipped or reduced medication doses in the past year in order to stretch a prescription and save money.

- More favorable than national findings.
- Similar by county area.
- TREND: Statistically similar to prior findings.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

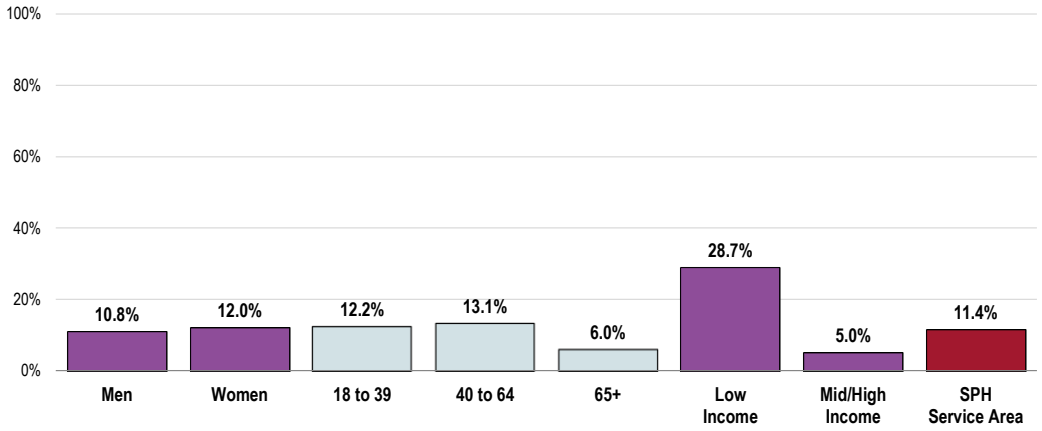
Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Adults more likely to have skipped or reduced their prescription doses include:

- Adults age 40 to 64.
- Respondents with lower incomes.

Skipped or Reduced Prescription Doses in Order to Stretch Prescriptions and Save Money

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 14]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Accessing Healthcare for Children

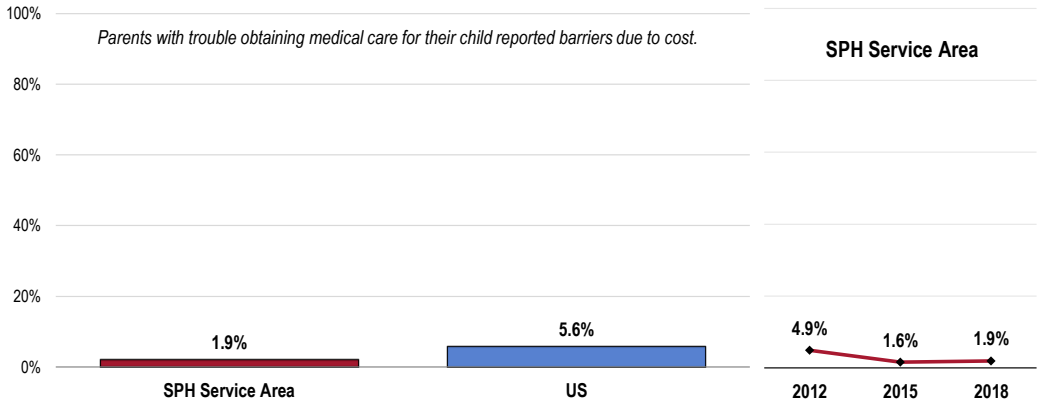
A total of 1.9% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

- Statistically similar to what is reported nationwide.
- TREND: Statistically unchanged since 2012.

Had Trouble Obtaining Medical Care for Child in the Past Year

(Among Parents of Children 0-17)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 118-119]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

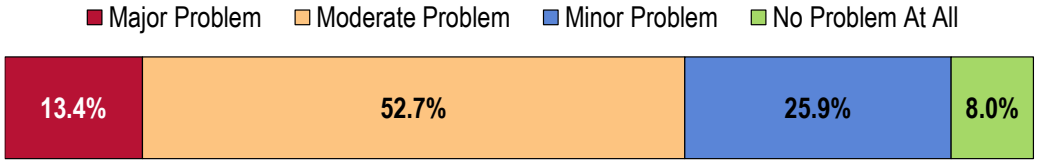
Those parents experiencing difficulties cited **cost** as the primary reason.

Key Informant Input: Access to Healthcare Services

Over half of the key informants taking part in an online survey most often characterized *Access to Healthcare Services* as a "moderate problem" in the community.

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

(Key Informants, 2018)



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

Top Concerns

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

Access to Care/Services

Montana in general, and also Helena is lacking in high quality health care services. Often times, people have to travel to Seattle or elsewhere for major surgeries and more serious or unique medical conditions. – Social Services Provider

Making and ordering referrals. Patients have a difficult time getting to appointments. Patients have a difficult time scheduling appointments within a reasonable time frame. – Physician

Health system availability, it is very difficult to make appointments anywhere, mostly a phone system problem. – Physician

Ability to pay, choice of available health care providers. Education in community of what sources are available lack of choice in some fields of medicine. – Community Leader

Financial, lack of providers, providers having to answer to insurance companies, not enough time with patients due to policy. – Social Services Provider

Affordable healthcare. Availability of healthcare, especially on weekends or after hours. – Public Health Representative

Limited access to primary care. – Other Health Provider

Senior access to physicians. – Community Leader

Access to Providers Accepting Medicaid/Medicare

Lack of choices for Medicare patients. St. Peters is the only choice available for general practitioners or family physicians due to low Medicare payments, because St. Peters has purchased practices or hired these doctors and added them to the hospital. – Community Leader

Providers for adults who will take Medicaid and Medicare services for drug and alcohol treatment. – Physician

Limited choices for general practitioner/primary care doctors for Medicare patients. We have retained our primary care physician in another city and go there for regular exams and can call for advice and responses to issues if needed. – Community Leader

Affordable Health Insurance

Biggest challenges include access to affordable health insurance. Even with the ACA, many people are under or over insured, making accessing health care services difficult and expensive. Particularly for emergency care. – Public Health Representative

> *Insurance coverage or financial availability for all. – Social Services Provider*
>
> *Cost of service. – Community Leader*

Lack of Specialists

> *We seem to be very short on higher level sub specialists which should be very prevalent in a community our size. I see patients on a regular basis that I have to send over one hour away for what should be an easy to fix problem. Urology, GI, Spinal ortho. – Physician*
>
> *Neurosurgical/spine surgeons recruitment would cover both spine surgery and neurosurgical backup for development of interventional stroke and trauma treatment. – Physician*

Transportation

> *No real public transportation. – Other Health Provider*

Type of Care Most Difficult to Access

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

Medical Care Difficult to Access as Identified by Key Informants

	Total Mentions
Mental Health Care	**9**
Substance Abuse Treatment	**9**
Specialty Care	**4**
Chronic Disease Care	**3**
Pain Management	**3**
Elder Care	**2**
Hospice Care	**1**
Spinal Orthopedics/Neurosurgery	**1**
Gastroenterology	**1**
Case Management	**1**
Urology	**1**
Primary Care	**1**

Primary Care Services

About Primary Care

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

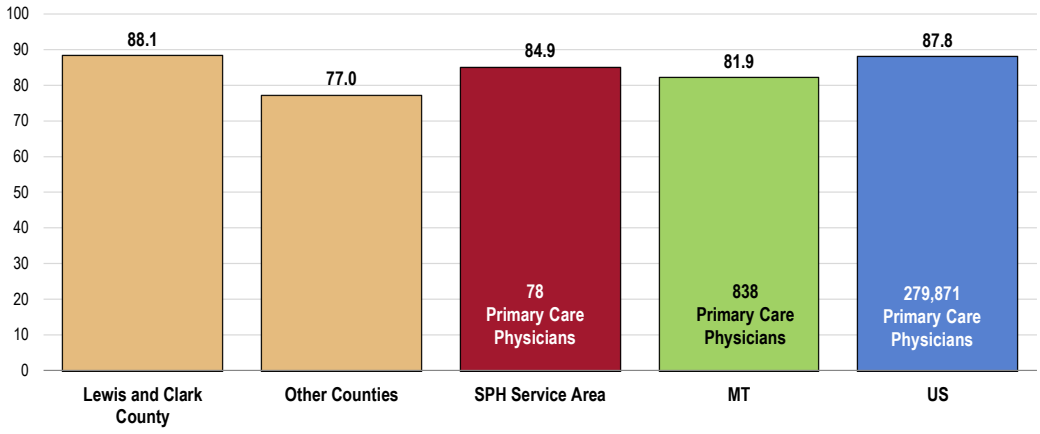
Access to Primary Care

In SPH Service Area in 2014, there were 78 primary care physicians, translating to a rate of 84.9 primary care physicians per 100,000 population.

- Comparable to state and national findings.
- Similar by county area.

Access to Primary Care

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

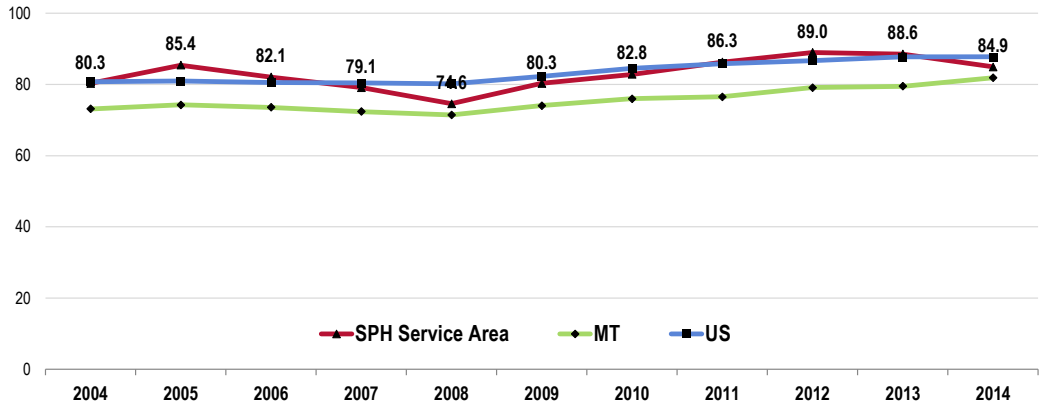


Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- TREND: Access to primary care (in terms of the rate of primary care physicians to population) has not changed greatly over the past decade in SPH Service Area.

Trends in Access to Primary Care
(Number of Primary Care Physicians per 100,000 Population)



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Retrieved April 2018 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.
- These figures represent all primary care physicians practicing patient care, including hospital residents. In counties with teaching hospitals, this figure may differ from the rate reported in the previous chart.

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

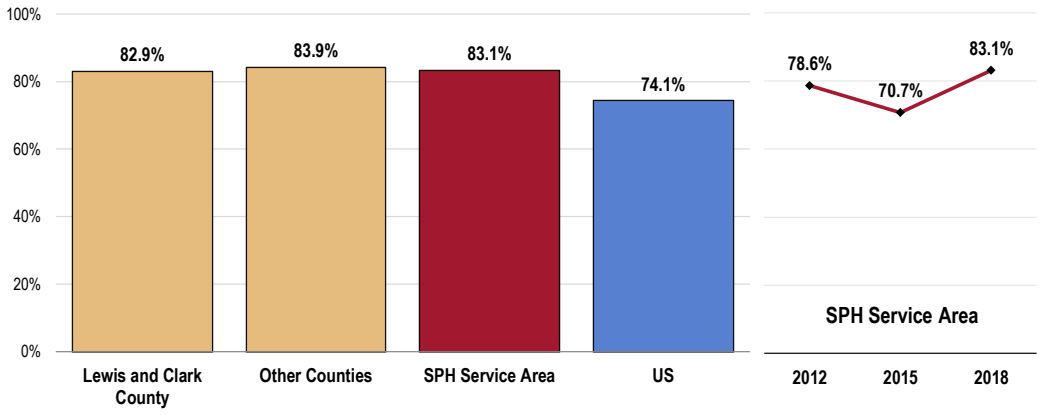
Specific Source of Ongoing Care

A total of 83.1% of SPH Service Area adults have a specific source of ongoing medical care.

- Above national findings.
- Fails to satisfy the Healthy People 2020 objective (95% or higher).
- Similar by community.
- TREND: Marks an increase since 2015, though statistically similar to 2012 findings.

Have a Specific Source of Ongoing Medical Care

Healthy People 2020 Target = 95.0% or Higher



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 170]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

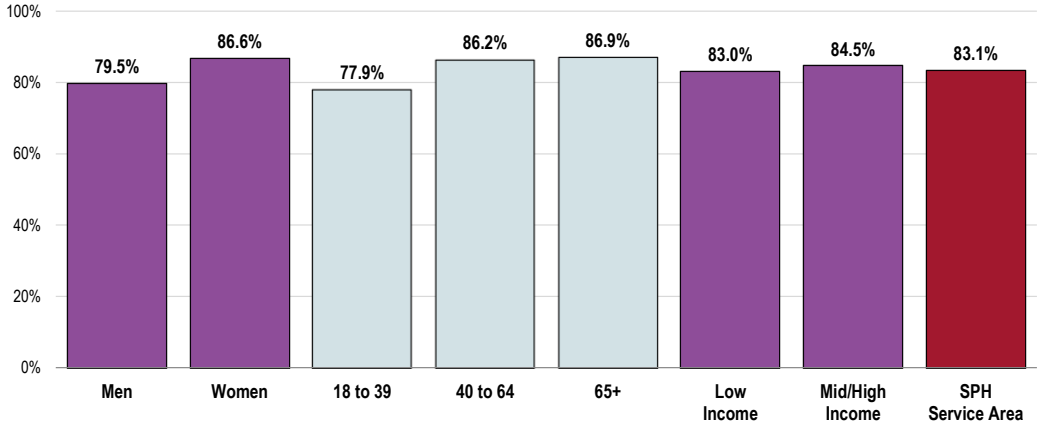
Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- No significant differences when viewed by demographics.

Have a Specific Source of Ongoing Medical Care

(SPH Service Area, 2018)

Healthy People 2020 Target = 95.0% or Higher



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 170]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

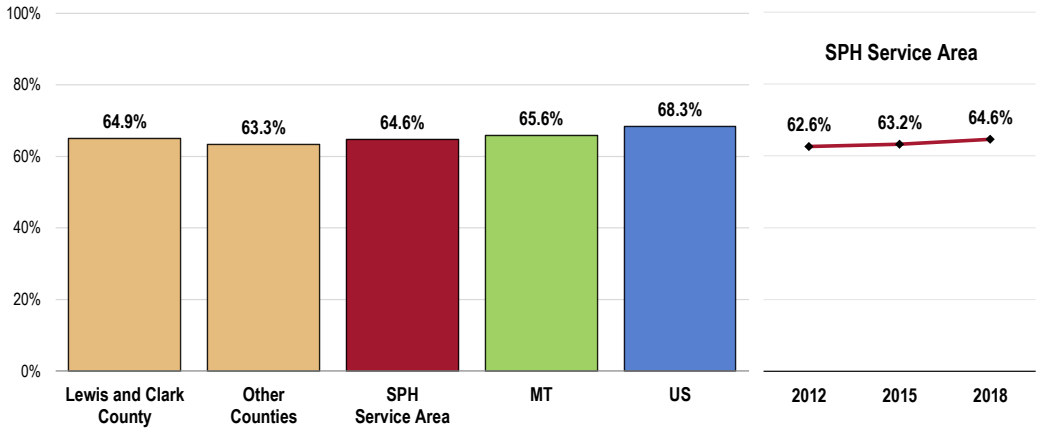
Utilization of Primary Care Services

Adults

Just under two-thirds of adults (64.6%) visited a physician for a routine checkup in the past year.

- Comparable to state and national findings.
- Comparable by community.
- TREND: No significant change since 2012 findings.

Have Visited a Physician for a Checkup in the Past Year



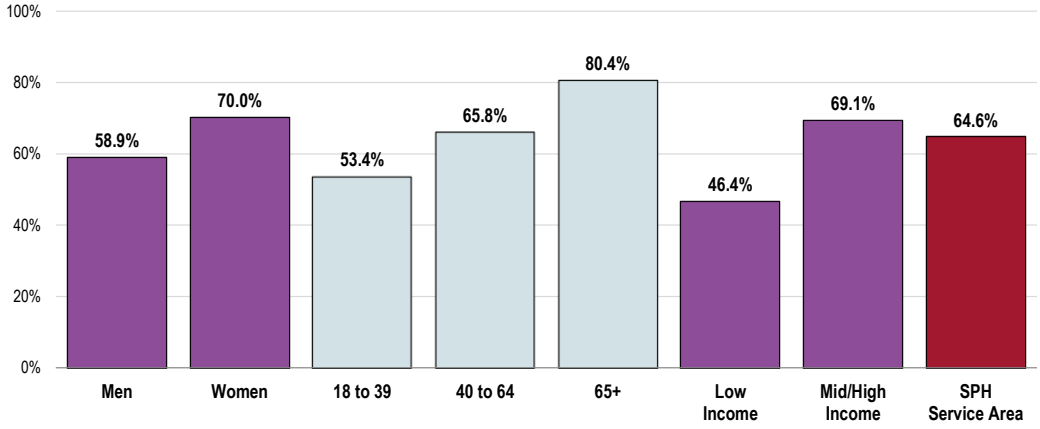
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Adults under age 40 are less likely to have received routine care in the past year (note the strong positive correlation with age), as well as men and those with lower incomes.

Have Visited a Physician for a Checkup in the Past Year

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

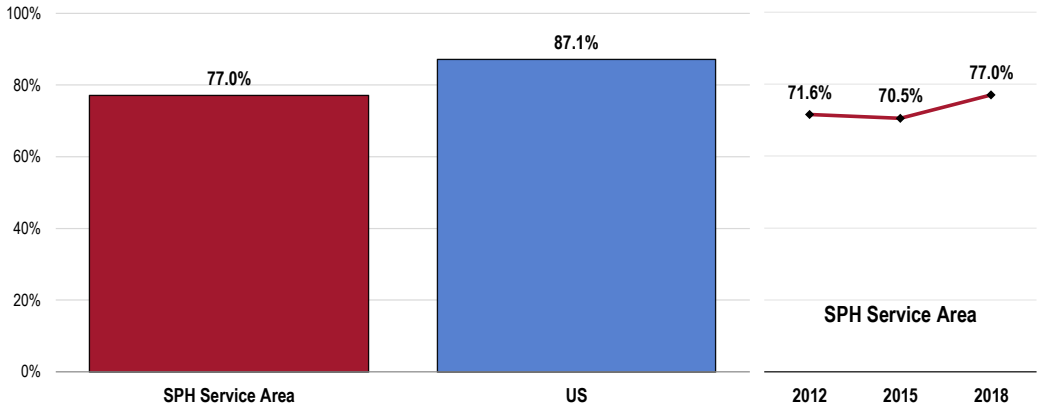
Children

Among surveyed parents, 77.0% report that their child has had a routine checkup in the past year.

- Statistically similar to national findings.
- TREND: Statistically similar to 2012 findings.

Child Has Visited a Physician for a Routine Checkup in the Past Year

(Among Parents of Children 0-17)



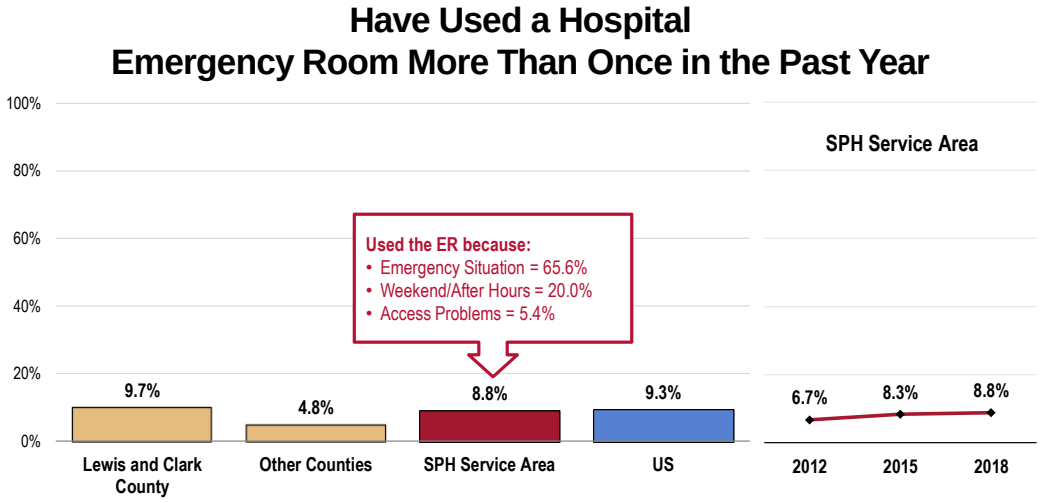
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 120]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

A total of 8.8% of SPH Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

- Similar to national findings.
- Differences by community are not statistically significant.
- TREND: Statistically unchanged over time.



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

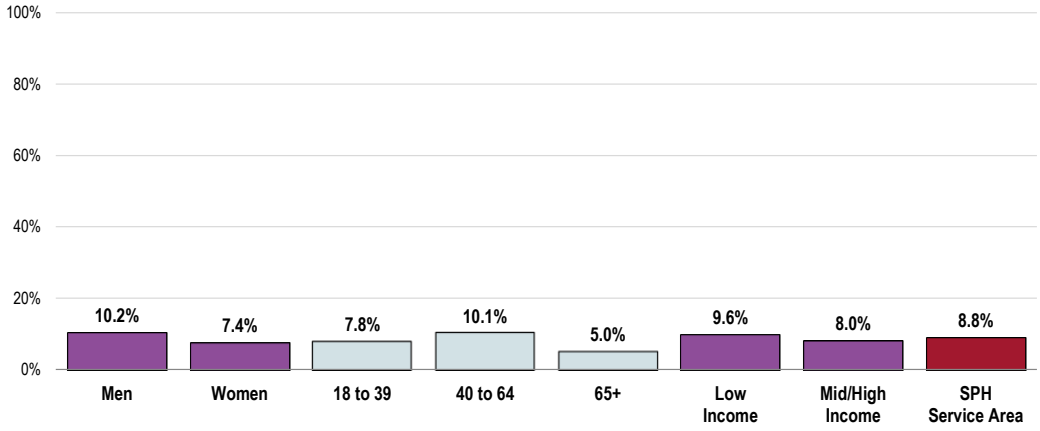
Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Of those using a hospital ER, two-thirds (65.6%) say this was due to an **emergency or life-threatening situation**, while 20.0% indicated that the visit was during **after-hours or on the weekend**. A total of 5.4% cited **difficulties accessing primary care** for various reasons.

- Differences by demographics are not statistically significant.

Have Used a Hospital Emergency Room More Than Once in the Past Year

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 22]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

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.

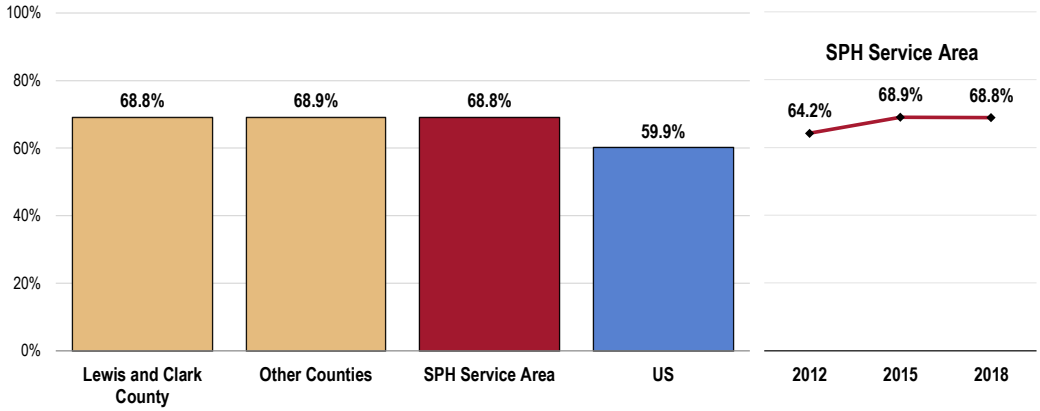
- Healthy People 2020 (www.healthypeople.gov)

Dental Insurance

Over two-thirds of SPH Service Area adults (68.8%) have dental insurance that covers all or part of their dental care costs.

- Much higher than the national finding.
- Almost identical by community.
- TREND: Statistically unchanged since 2012.

Have Insurance Coverage That Pays All or Part of Dental Care Costs



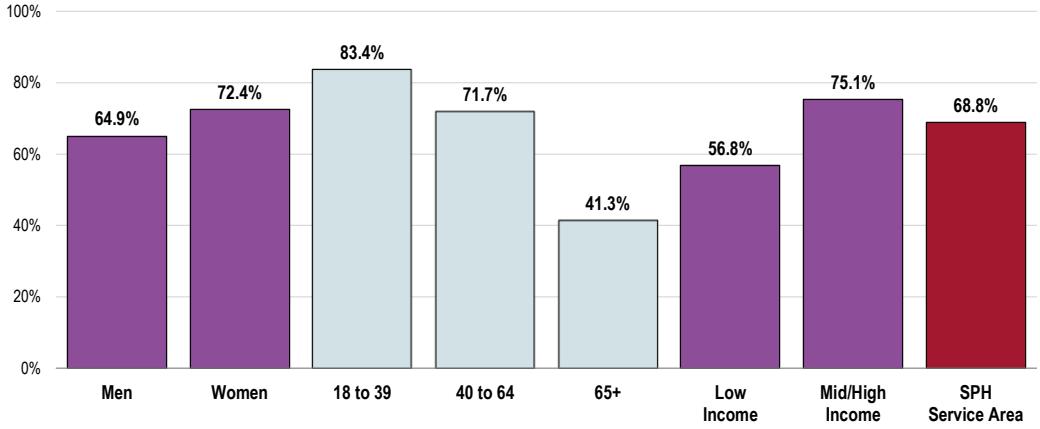
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Note the strong correlation between dental insurance and age and income level.

Have Insurance Coverage That Pays All or Part of Dental Care Costs

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Dental Care

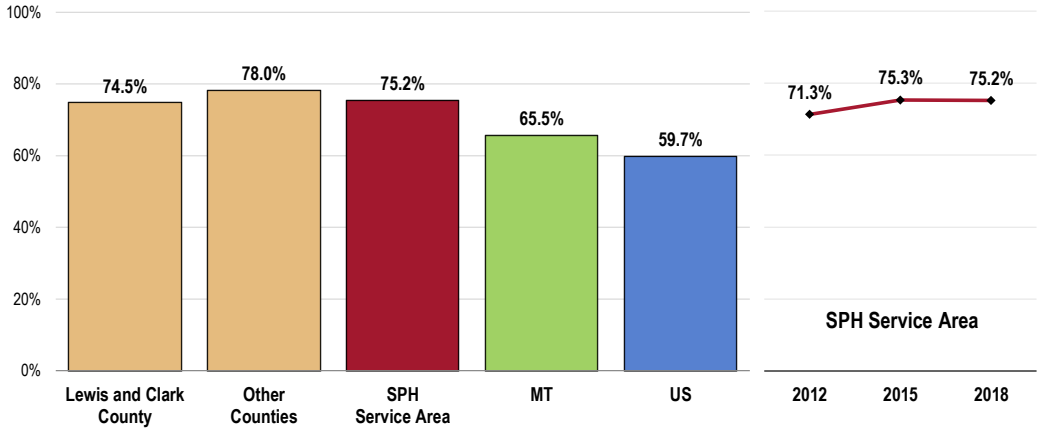
Adults

Three-quarters (75.2%) of SPH Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

- Much higher than both statewide and national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- Comparable by county area.
- TREND: Statistically unchanged since 2012.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2020 Target = 49.0% or Higher



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 Montana data.
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

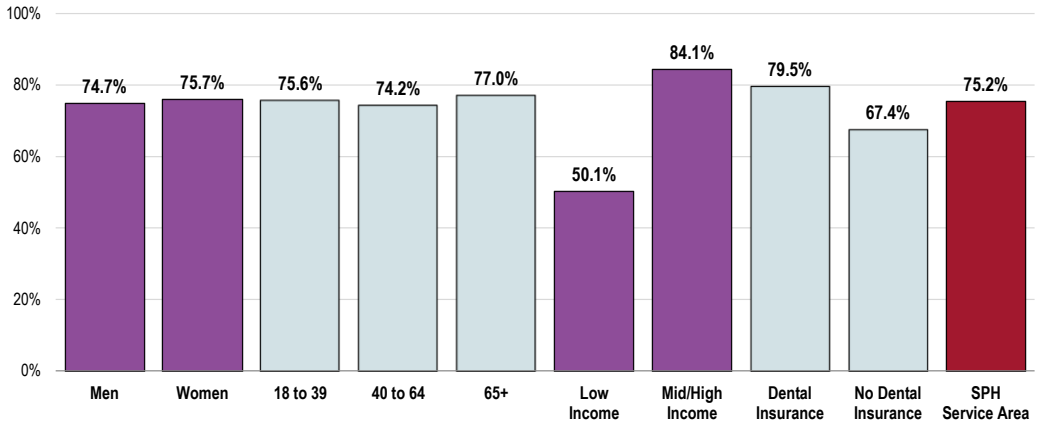
Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

- Note that only half of low-income adults have visited a dentist or dental clinic in the past year, compared to 84.1% of those with higher incomes.
- As might be expected, those without dental insurance report much lower utilization of oral health services than those with coverage.

Have Visited a Dentist or Dental Clinic Within the Past Year

(SPH Service Area, 2018)

Healthy People 2020 Target = 49.0% or Higher



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Children

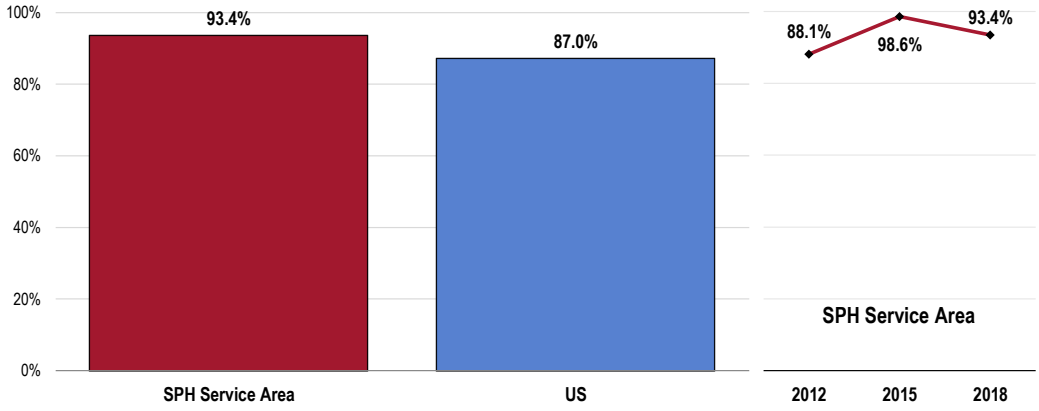
A total of 93.4% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

- Comparable to national findings.
- Satisfies the Healthy People 2020 target (49% or higher).
- TREND: No significant change in children's dental care since 2012.

Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Among Parents of Children Age 2-17)

Healthy People 2020 Target = 49.0% or Higher



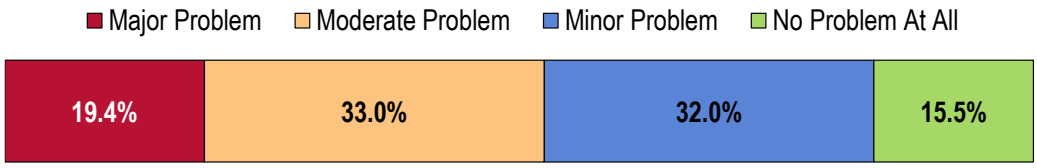
Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 123]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Notes:
- Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

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

Perceptions of Oral Health as a Problem in the Community
(Key Informants, 2018)



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

Top Concerns

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

Affordable Care

Oral/dental health is expensive and difficult for many people to access. Without insurance, many people wait for dental pain before seeking care. – Social Services Provider

Challenges include lack of access to dental health providers for those who are underinsured. Patients have difficulty prioritizing dental care amount other health crises and basic needs for living. – Public Health Representative

I see many seniors at RMDC's Senior Center with few or no teeth. The expense is huge especially for those without insurance. Poor dental health can have significant impact on overall health. – Social Services Provider

Helena is similar to many other communities, in that dental care is the last type of healthcare to be accessible for low-income families. Many insurance plans either do not cover dental, or they require a high copayment/deductible. – Social Services Provider

Oral health and dental care are not covered by traditional health insurance. This keeps many people away from dental care until problems become severe. – Public Health Representative

Access to Care/Services

Very little emergency coverage. – Physician

Oral/dental health can often be neglected when there are not enough resources to go around until such time when it may be too late to provide preventative care. – Community Leader

Access to dental hygienists is a challenge. It takes a year to get an appointment with one. It is also difficult to afford good dental care. There is also a low capacity for Oral Health program funding and staff in Helena. – Public Health Representative

Access and cost of services. The cost is outrageous for those with dental issues. How do we reduce the burden since oral health can make the rest of your body ill? – Social Services Provider

Medicare/Medicaid

It is across the state. No insurance co-state for it. Many dentists don't take Medicaid. – Public Health Representative

Medicaid provides inadequate oral health care, often just pulling people's teeth instead of helping them save teeth or getting dentures. Even children in Helena, poor kids, have terrible teeth. I see this through my volunteering at Helena Food Share. – Community Leader

Again, resources are very limited for income limited populations and Medicaid patients. Have had several instances of delay of care due to wait times. – Physician

Impact on Overall Health

> *If people are unable to eat due to pain, then they drop weight, lose sleep, cannot function to carry a conversation. Increase other underlying issues. – Social Services Provider*
>
> *The so called oral systemic link has been studied extensively over the past few years and there are both conclusive and suspected relationships between an individual's oral health and systemic health. – Other Health Provider*

Contributing Factors

> *I think the problems are related to the rampant drug abuse problems in the community. – Community Leader*
>
> *Large percentage of the population in Helena lack access to dental care primarily due to low incomes. Poor diet, especially high sugar drink intake is an issue among young and old. The meth epidemic. – Social Services Provider*

Vision Care

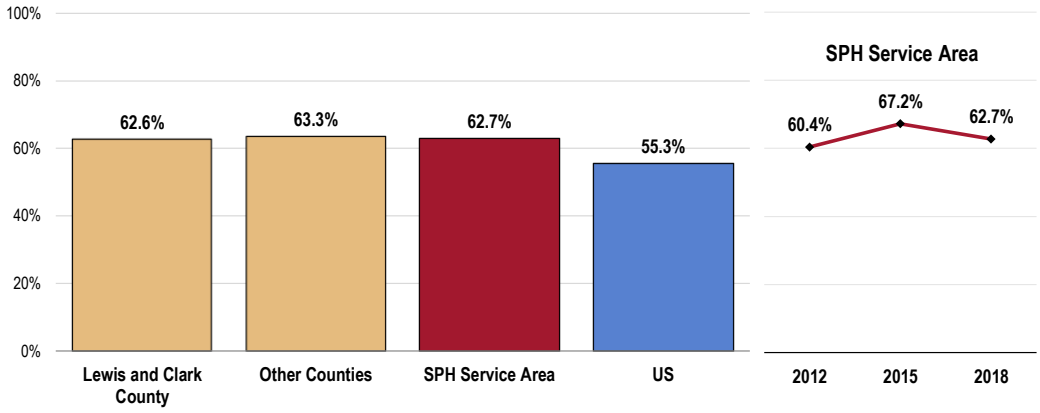
RELATED ISSUE:

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

A total of 62.7% of SPH Service Area residents had an eye exam in the past two years during which their pupils were dilated.

- Higher than national findings.
- Similar by community.
- TREND: No significant difference from previous years' findings.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]
- 2017 PRC National Health Survey, Professional Research Consultants, Inc.

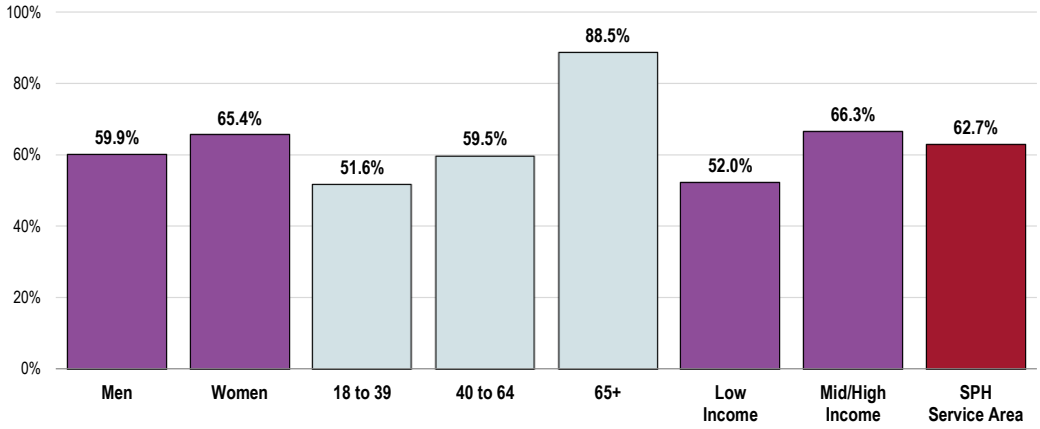
Notes:
- Asked of all respondents.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Recent vision care in the SPH Service Area is more often reported among:

- Adults age 65+ (positive correlation with age).
- Residents with higher incomes.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Local Resources

Professional Research Consultants, Inc.

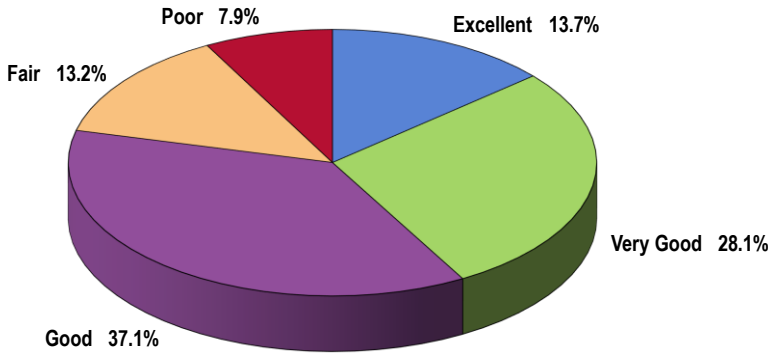
Perceptions of Local Healthcare Services

Four in 10 SPH Service Area adults (41.8%) rate the overall healthcare services available in their community as "excellent" or "very good."

- Another 37.1% gave "good" ratings.

Rating of Overall Healthcare Services Available in the Community

(SPH Service Area, 2018)

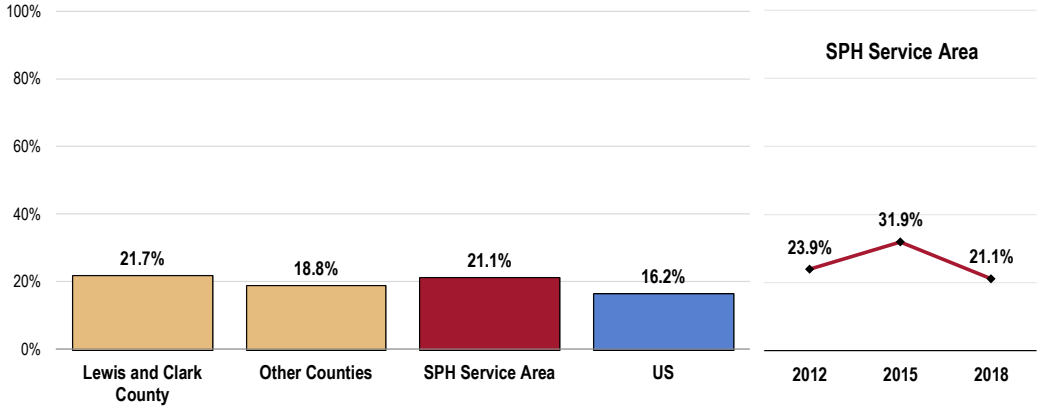


Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
Notes: ● Asked of all respondents.

However, 21.1% of residents characterize local healthcare services as "fair" or "poor."

- Less favorable than reported nationally.
- Similar by community.
- TREND: Marks a statistically significant improvement in ratings since 2015, though not significantly different from 2012 findings.

Perceive Local Healthcare Services as "Fair/Poor"

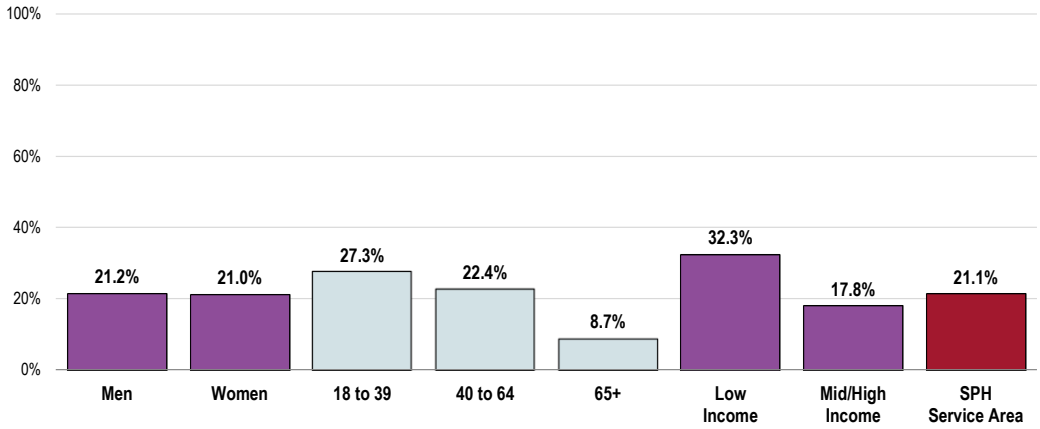


Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
● 2017 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

The following residents are more critical of local healthcare services:

- Residents with lower incomes.
- Adults under age 65 (negative correlation with age).

Perceive Local Healthcare Services as "Fair/Poor"
(SPH Service Area, 2018)



Sources:
- 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]

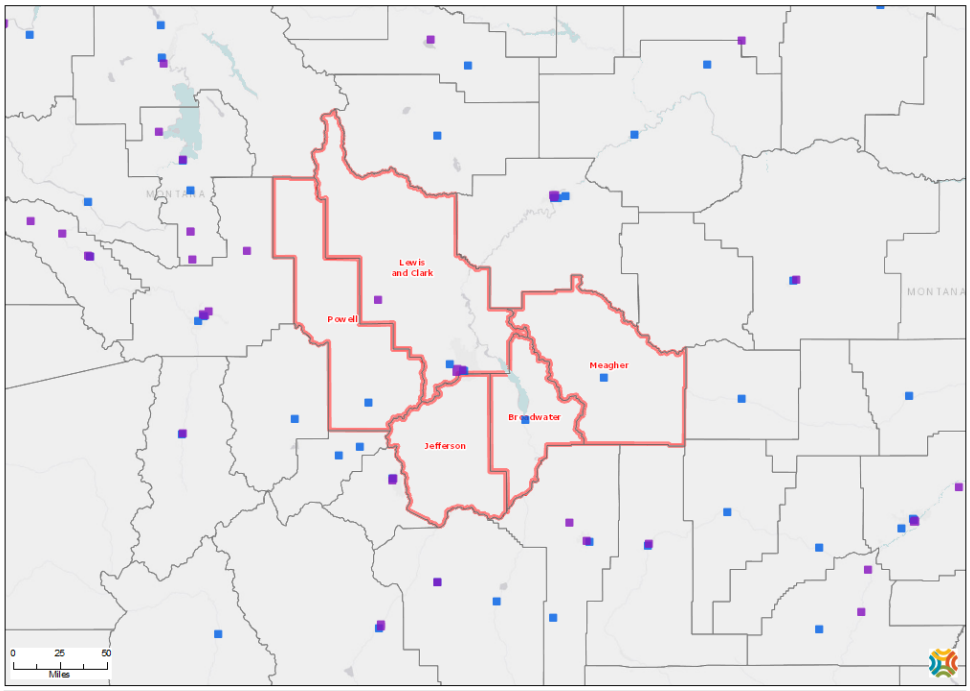
Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Healthcare Resources & Facilities

Hospitals & Federally Qualified Health Centers (FQHCs)

The following map details the hospitals and Federally Qualified Health Centers (FQHCs) within the SPH Service Area as of March 2018.

Hospitals and Federally Qualified Health Centers, POS March 2018



Map Legend

Federally Qualified Health Centers, POS March 2018

All Hospitals, POS March 2018

SPH Service Area

Community Commons, 5/9/2018

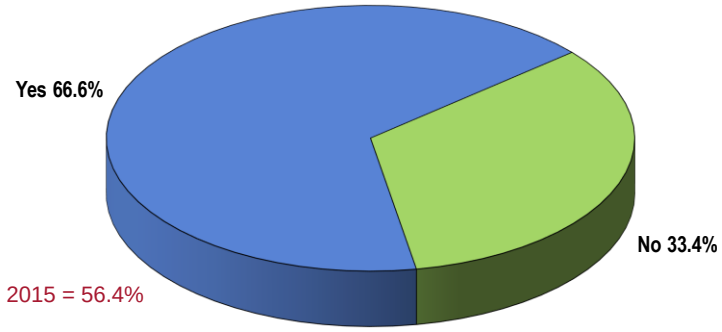
A Workplace Wellness Program/Event

Among employed survey respondents, two-thirds (66.6%) report that their employer offers a workplace wellness program.

- TREND: The increase from 2015 is not statistically significant.

Employer Offers a Workplace Wellness Program

(SPH Service Area Employed Residents, 2018)



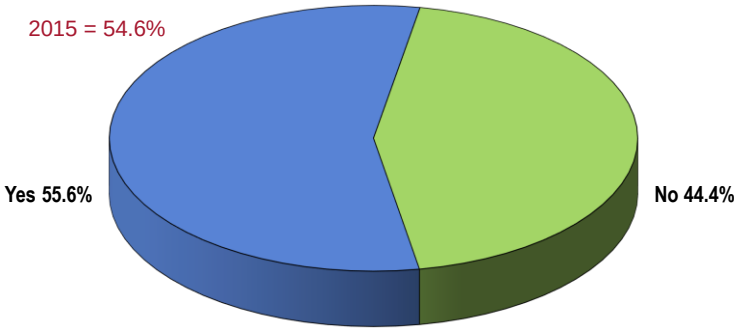
Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 323]
Notes: ● Asked of all employed respondents.

Of those employed respondents whose employer offers a workplace wellness program, just over half (55.6%) participated in such an event at least once in the past year

- TREND: No significant change when compared to 2015 findings.

Participated in a Workplace Wellness Program in the Past Year

(SPH Service Area Employees Whose Employer Offers a Wellness Program, 2018)



Sources: ● 2018 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 324]
Notes: ● Asked of all employed respondents whose employer offers a wellness event.

Resources Available to Address the Significant Health Needs

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

Access to Healthcare Services

- *Bus*
- *CareHere*
- *Doctor's Offices*
- *Healthy Mothers Healthy Babies*
- *Helena Indian Alliance*
- *Hospitals*
- *Indian Health Services*
- *Lewis and Clark Public Health*
- *Montana Health Co-Op*
- *Office of Public Assistance*
- *Planned Parenthood*
- *PureView Health Center*
- *Referrals to Surrounding Towns*
- *St. Peter's Health*
- *St. Peter's Medical Group*

Arthritis, Osteoporosis, & Chronic Back Conditions

- *Capital City Health Club*
- *Doctor's Offices*
- *Fitness Centers/Gyms*
- *Helena College*
- *Leo Pocha Memorial Clinic*
- *Parks and Recreation*
- *Physical Therapy*
- *PureView Health Center*
- *St. Peter's Health*

Cancer

- *1-800-Montana Quits*
- *Associated Dermatology and Skin Cancer Clinic*
- *Cancer Center*
- *Cancer Screenings*
- *CareHere*
- *Doctor's Offices*
- *Fitness Centers/Gyms*
- *Hospitals*
- *Montana Cancer Coalition*
- *Montana Cancer Screening Program*
- *Montana Department of Public Health and Human Services*
- *Nurse Navigators*
- *PureView Health Center*
- *St. Peter's Health*
- *St. Peter's Medical Group*
- *Survivorship Program*

Dementias, Including Alzheimer's Disease

- *Alzheimer's Support Group*
- *Area IV Agency on Aging*
- *Assisted Living Facilities*
- *Care Facilities*
- *Community Resources for Family Members*
- *Cooney Health Care*
- *Doctor's Offices*
- *Edgewood*
- *Frontier Health*
- *Home Instead Senior Care*
- *Home Sweet Home Health Care*
- *Hospice of St. Peter's*
- *Long-Term Care Facilities*
- *Melodee House*
- *Mental Health Services*
- *Montana Alzheimer's and Dementia State Plan*
- *Montana Alzheimer's Association*
- *Montana Area Agencies on Aging*
- *Montana Department of Public Health and Human Services*
- *Montana Gerontology Society*
- *Nursing Homes*
- *Respite Care*
- *Skilled Nursing Facilities*

- *St. Peter's Behavioral Health Unit*
- *St. Peter's Health*
- *Support Groups*

Diabetes

- *American Diabetes Association*
- *CareHere*
- *Community Health Center*
- *Dentist's Offices*
- *Department of Public Health and Human Services*
- *Diabetic Services*
- *Doctor's Offices*
- *Health Center*
- *Health Department*
- *Helena Indian Alliance*
- *Hospitals*
- *Inch by Inch Program*
- *Indian Health Alliance*
- *Leo Pocha Memorial Clinic*
- *Lewis and Clark Health Department*
- *Montana Department of Public Health and Human Services*
- *Montana Diabetes Prevention Program*
- *Mountain Pacific Quality Health*
- *Nutrition Services*
- *Pharmacists*
- *PureView Health Center*
- *Quality Diabetes Education Initiative*
- *Safeway Pharmacy*
- *School Systems*
- *St. Peter's Health*
- *St. Peter's Medical Group*

Family Planning

- *Doctor's Offices*
- *Indian Health Alliance*
- *Planned Parenthood*

Heart Disease & Stroke

- *AARP*
- *American Heart Association*
- *American Red Cross*
- *Cardiovascular Health Program for State Employees*
- *CareHere*
- *Community Health Center*
- *Department of Public Health and Human Services*
- *Doctor's Offices*
- *Fitness Centers/Gyms*
- *Health Department*
- *Home Health Care*
- *Hospitals*
- *Internet*
- *Leo Pocha Memorial Clinic*
- *Lewis and Clark Health Department*
- *Montana Cardiovascular Disease and Diabetes Program*
- *Physical Therapy*
- *Prevention/Policy Work*
- *PureView Health Center*
- *School Systems*
- *St. Peter's Health*
- *St. Peter's Medical Group*
- *Strong Women – Healthy Hearts Program*

HIV/AIDS

- *Doctor's Offices*

Immunization & Infectious Diseases

- *Doctor's Offices*
- *Flu Vaccine Clinics*
- *Helena Indian Alliance*
- *Lewis and Clark Public Health*
- *PureView Health Center*
- *School Systems*
- *St. Peter's Health*

Infant & Child Health

- *AWARE*
- *CareHere*
- *Childcare Connections*
- *Children's Health Insurance Program (CHIP)*
- *Department of Public Health and Human Services*
- *Doctor's Offices*
- *Florence Crittenton*
- *Healthy Montana Kids*
- *Home Health Care*
- *Intermountain*
- *Leo Pocha Memorial Clinic*
- *Lewis and Clark Health Department*
- *Partners in Pediatrics*
- *PureView Health Center*
- *Rocky Mountain Development Council*
- *School Systems*
- *Shodair Children's Hospital*
- *St. Peter's Health*
- *St. Peter's Medical Group*
- *WIC*

Injury & Violence

- *AA/NA*
- *Boyd Andrew Community Services*
- *Center for Mental Health*
- *County and City Commissioners*
- *Family Outreach*
- *Foster Care System*
- *Friendship Center*
- *Helena City Police*
- *Helena Indian Alliance*
- *Hospitals*
- *Jail*
- *Law Enforcement*
- *Lewis and Clark County Sheriff's Office*
- *Medivac Air Services*
- *Non-Profit Organizations*
- *PureView Health Center*
- *School Systems*
- *St. Peter's Health*
- *St. Peter's Medical Group*
- *Treatment Court*

Kidney Disease

- *Leo Pocha Memorial Clinic*
- *Medical Staff Recruiting*
- *PureView Health Center*

Mental Health

- *AA/NA*
- *Addictive and Mental Disorders Division*
- *Adult Protective Services (APS)*
- *Advisory Council on Mental Health*
- *AWARE*
- *Boyd Andrew Community Services*
- *CareHere*
- *Center for Mental Health*
- *Child Protective Services (CPS)*
- *County Detention Center*
- *Crisis Response Team*
- *Doctor's Office*
- *Drop-In Center*
- *Drug Courts*
- *Employee Assistance Programs*
- *Florence Crittenton*
- *Fort Harrison*
- *God's Love*
- *Helena Indian Alliance*
- *Helena Industries*
- *Helena School District*
- *Hospitals*
- *Indian Health Alliance*
- *Intermountain*
- *Jail*
- *Journey Home*
- *Local Advisory Council & Central Service Area Authority (LAC/CSAA)*
- *Law Enforcement*
- *Leo Pocha Memorial Clinic*
- *Lewis and Clark Mental Health Advisory Council*
- *Lewis and Clark Public Health*
- *Lewis and Clark Suicide Prevention Group*
- *Lewis and Clark Contracted Jails*
- *Mental Health Center*
- *Mental Health Services*
- *Montana Telepsychiatry*
- *National Alliance on Mental Illness (NAMI)*
- *Our Place*
- *Program for Assertive Community Treatment (PACT)*
- *PureView Health Center*
- *Reliant Behavioral Health*
- *Rocky Mountain Development Council*
- *Shodair Children's Hospital*
- *St. Peter's Behavioral Health Unit*
- *St. Peter's Health*
- *St. Peter's Medical Group*
- *Suicide Coalition*
- *Suicide Hotline*
- *Veterans Administration*
- *Warm Springs*
- *Western Montana Mental Health*
- *Youth Connections*

Nutrition, Physical Activity, & Weight

- *Bike Helena*
- *Bike Walk Montana*
- *Capital City Health Club*
- *CareHere*
- *Centennial Trail and Park*
- *Churches*
- *Community Health Center*
- *County Extension*
- *Crossroads*
- *Department of Public Health and Human Services*
- *Doctor's Offices*
- *Employer Wellness Programs*

- *Fitness Centers/Gyms*
- *Helena Food Share*
- *Helena Parks and Recreation Department*
- *Helena Public Schools*
- *Inch by Inch Program*
- *Just Tapped*
- *Lewis and Clark Health Department*
- *Lewis and Clark Public Health*
- *Montana No Kid Hungry*
- *MSU Extension Services Nutrition Programs*
- *Natural Grocery Stores*
- *Nutrition Services*
- *Obesity Action Coalition*
- *Office of Public Assistance*
- *Parent Groups*
- *Parks and Recreation*
- *Physical Therapy*
- *Prickly Pear Land Trust*
- *Public Health*
- *PureView Health Center*
- *Real Food Store*
- *Safeway Pharmacy*
- *SNAP*
- *Sodexo Summer Feed Program*
- *St. Peter's Health*
- *Street Sweeping*
- *Supplemental Nursing Assistance Program*
- *Trails Rx Program*
- *Weight Watchers*
- *WIC*
- *YMCA*
- *Youth Connections*

Oral Health

- *Associated Dental Care*
- *CareHere*
- *Dentist's Offices*
- *Department of Public Health and Human Services*
- *Doctor's Offices*
- *Donated Dental Care*
- *Healthy Montana Kids*
- *Hospitals*
- *Medicaid*
- *Montana Dental Assistance*
- *Montana Dental Association*
- *PureView Health Center*
- *Rocky Mountain Development Council*
- *School Systems*
- *St. Peter's Health*

Respiratory Diseases

- *1-800-Montana Quits*
- *Air Quality Bureau*
- *Allergy/Immunology*
- *American Lung Association*
- *Board of Health*
- *Cardiopulmonary Rehab*
- *CareHere*
- *Doctor's Offices*
- *Environmental Quality Department*
- *Helena Street Maintenance*
- *Lewis and Clark Health Department*
- *Montana Clean Indoor Air Act*
- *Montana Department of Environmental Quality*
- *Montana Lung Association*
- *PureView Health Center*
- *Respiratory Therapy*
- *Sleep Labs*
- *St. Peter's Health*

Sexually Transmitted Diseases

- *Doctor's Offices*
- *Friendship Center*
- *Helena Public Schools*
- *Lewis and Clark Health Department*
- *Montana Personal Responsibility Education Program*
- *Planned Parenthood*
- *PureView Health Center*
- *St. Peter's Health*
- *St. Peter's Medical Group*

Substance Abuse

- *AA/NA*
- *Abuse Hotlines*
- *Addiction Recovery Centers*
- *AWARE*
- *Boyd Andrew Community Services*
- *CareHere*
- *Center for Mental Health*
- *Churches*
- *Doctor's Offices*
- *Drug Abuse Treatment Center*
- *Drug Courts*
- *Health Department*

Helena Indian Alliance
Indian Health Alliance
Intermountain
Law Enforcement
Leo Pocha Memorial Clinic
Lewis and Clark County DUI Task Force
Lewis and Clark Health Department
Licensed Addiction Counselors
Mental Health Services
Missouri River Drug Task Force
Montana Chemical Dependency Center
PureView Health Center
Restorative Justice
School Systems
Shodair Children's Hospital
Sober Homes
St. Peter's Behavioral Health Unit
St. Peter's Health
Support Groups
Veterans Administration

Tobacco Use

1-800-Montana Quits
1-800-Quit Lines
CareHere
County Tobacco Prevention Program
Department of Public Health and Human Services
Doctor's Offices
Helena Indian Alliance
Lewis and Clark Public Health
Mental Health Services
Montana Tobacco Use Prevention Program
PureView Health Center
School Systems
St. Peter's Health
St. Peter's Medical Group
Support Groups
The Man Store

Appendices

Professional Research Consultants, Inc.

Appendix I: Evaluation of Past Activities

On May 15, 2017, members of the Lewis and Clark County Community Health Improvement Planning (CHIP) Task Force met to review progress toward the public health goals and objectives. Forty-eight representatives of a wide cross-section of the community participated in the meeting, which was facilitated by Lewis and Clark Public Health and St. Peter's Hospital. (*See appendix for a full list of participants*.)

Methodology

Task force members broke into seven small groups based on the CHIP priorities:

- Access to Health Care
- Chronic Disease
- Communicable Disease
- Environmental Health and Injury
- Maternal and Child Health
- Mental Health
- Substance Abuse

Each group was tasked with discussing the following questions:

1. Do we have/can we collect the data we need to assess our progress on specific goals and objectives in the 2016 Community Health Improvement Plan (CHIP)? Do we want to collect data on fewer, more, or different health indicators? Use other data sources?

2. What progress have we and/or community partners made on each of the strategies? Include specific achievements and how and by whom they were accomplished.

3. Do we want or need to revise any of our strategies, either because
   - our objective has been achieved;
   - there is an emerging health issue that we want to address;
   - there has been a change in available resources; or
   - there has been a change in responsibilities.

4. Are there any social determinants of health or health inequities that impact our ability to address our goals?
   Social determinants *of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. For example, education, economic status, employment, physical environment, access to health care.*

   Health inequities *are differences or disparities in health outcomes that are systematic, avoidable, and unjust. These may be caused by social determinants of health.*

5. Have there been other achievements/actions taken that could impact our goals, unrelated to the strategies we identified?

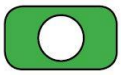
6. What barriers to progress have we identified?

Format

The information captured during these small-group discussions formed the basis for the following progress report. The report also includes data updates, where available, to priority health indicators from the CHIP plan.

Strikeouts and underlining have been used to indicate changes to the original CHIP plan.

For ease of use, progress has been summarized in this report using the following at-a-glance format:

Goal Achieved/Being Met 

In Progress 

Not Started/Behind Target 

Data

We attempted to get up-to-date data for all health indicators in this report but were unsuccessful in many cases. The 2017 Youth Risk Behavior Survey was released just prior to our May 15 meeting, and its findings are represented here. Data from the Behavioral Risk Factor Surveillance System and Montana Vital Statistics were not available. The Montana Department of Public Health and Human Services, which collects those data, is in the process of revamping the online platform it uses to provide it, and DPHHS staff were unable to meet requests for data at the time.

MENTAL HEALTH

Goal 1: Reduce suicide rate.

Health indicator	2008-2010	2011-2013	2014-2016	CHIP 2019 Goal	HP 2020 Target
Suicide rate per 100,000 adults	15.8	19.3	unavailable	17.7	10.2

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
Attempted suicide in high school youth	14.9%	13.4%	15.8%	13.6%	1.7%

Objective	Strategy	Lead	Progress	Status
1.1.1 By 2019, decrease the adult suicide rate to 17.7 per 100,000. (Source: Montana Vital Statistics)	Increase access to and capacity for community education about suicide. Support interventions and policies related to gun safety.	DPHHS, NAMI, Youth Connections St. Peter's Hospital, medical providers	City of East Helena held "Out of the Darkness" suicide prevention walk. 24 local law enforcement officers received crisis training through Local Mental Health Advisory Committee (LAC) crisis intervention program. LAC formed Suicide Prevention Committee, which meets monthly. It has completed a gap analysis. County jail using screening tools for inmates who are potentially suicidal.	
1.1.2 By 2019, reduce the percentage of high school students who report attempting suicide to 13.6%. (Source: Youth Risk Behavior Survey)			Shodair is partnering with state Office of Public Instruction, Montana Pacific Quality Foundation, Montana Hospital Association, Helena and East Helena schools to offer mental health training and mentorship and leadership training. Students at Capital and Helena High Schools are receiving Youth Aware of Mental Health (YAM) training. Free gun locks are available in Helena	

Other achievements/actions taken to reduce suicide:

- 2017 Montana Legislature passed HB 118, providing additional funding for a state suicide prevention program, and HB 381, requiring school districts to address suicide prevention and response. Several other suicide-prevention bills were killed.

Data issues: None identified.

Barriers to progress: The group identified the following barriers:

- How can use of screening tools be improved for individuals being admitted to jail?
- Need to target root causes of suicide among different age groups. For example, senior citizens are more likely to commit suicide due to chronic pain or other health conditions. Middle-aged people are more likely to commit suicide due to financial strife.
- Access to mental health professionals is limited, especially in rural areas.
- Montana has a culture that encourages "pulling yourself up by the bootstraps." This creates a stigma that discourages people from seeking mental health treatment.

Revisions to original goals, objectives: None identified.

Social determinants/health inequities related to suicide: The World Health Organization has addressed the social determinants related to mental health in a 2014 report entitled "Social Determinants of Mental Health."

MENTAL HEALTH

Goal 2: Reduce incidence of depression and anxiety.

Health indicator	2008-2010	2011-2013	2014-2016	CHIP 2019 Goal	HP 2020 Target
Adults reporting poor mental health	34.2%	36.2%	unavailable	32.0%	n/a

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
High school youth reporting depression	28.9%	32.8%	34.2%	27.0%	7.5%

Objective	Strategy	Lead	Progress	Status
1.2.1 By 2019, decrease the percentage of adults who report one or more poor mental health days in the past month to 32%. (Source: Behavioral Risk Factor Surveillance System)	Increase screening for depression and anxiety (e.g. sports physicals, universal screening in schools, universal screening in primary care) Increase number of mental health providers in county	PureView Health Center, Helena School District St. Peter's Hospital	PureView has set a goal of screening 100 percent of its patients age 12 or older for anxiety and depression using PHQ2 and GAD7 tests. PureView has hired a second psychiatric nurse practitioner.	
1.2.2 By 2019, reduce the percentage of high school students who report symptoms of depression in the past year to 27%. (Source: Youth Risk Behavior Survey)				

Other achievements/actions taken to reduce depression and anxiety: 2017 Montana Legislature passed HB 142, a law revising insurance law to give mental health coverage parity with physical health.

Data issues: None identified.

Barrier to progress: The group discussed concern that, if you screen, you are obligated to do something. This can be a problem if there aren't enough referral resources.

Revisions to original goals, objectives: None identified.

Social determinants/health inequities related to depression and anxiety: The World Health Organization has addressed the social determinants related to mental health in a 2014 report entitled “Social Determinants of Mental Health.”

MENTAL HEALTH

Goal 3: Address mental health in criminal justice system.

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target

Objective	Strategy	Lead	Progress	Status
1.3.1 By 2019, establish baseline percentage of jailed inmates who have a mental health diagnosis. (Source: Lewis and Clark County Jail records)	Establish a system to screen all inmates for mental health concerns.	~~Sheriff's Department, Local Mental Health Advisory Committee, Mental health centers~~ PureView Health Center	PureView has begun offering limited screening services at the jail.	
	Increase the capacity to provide case management and mental health therapy in the jail.	~~Mental health centers~~ PureView Health Center		

Other achievements/actions taken to improve mental health in criminal justice system: None identified.

Data issues: Have not yet determined an appropriate health indicator. Some discussed by the group were:

- Number of mentally ill admitted to jail.
- Amount of time mentally ill people spend in jail.
- Number of referrals from jail to mental health treatment.
- Rate of recidivism.

Barriers to progress: None identified.

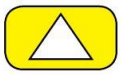
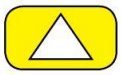
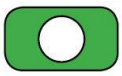
Revisions to original goals, objectives: None identified.

Social determinants/health inequities related to mental health in the criminal justice system: None identified. Group noted that inmates with diabetes are evaluated quickly to ensure they have access to diabetes medications. Mental health issues should be treated just as expediently.

SUBSTANCE ABUSE

Goal 1: Reduce binge drinking.

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
Adults engaged in binge drinking	24.1%	unavailable	unavailable	22.0%	24.4%
High schoolers who binge drink	19.0%	22.1%	24.8%	20.0%	22.7%

Objective	Strategy	Lead	Progress	Status
2.1.1 By 2019, reduce the percentage of adults who report binge drinking to 22%. (Source: Behavioral Risk Factor Surveillance System)	~~Increase access to~~ Provide Responsible Alcohol Sales and Service trainings.	County DUI Task Force		
	~~Sponsor regular over-service stings at bars and restaurants.~~	~~County DUI Task Force~~		
	Increase the number of employers who offer an Employee Assistance Program.	Insurance companies, Chamber of Commerce, Society for Human Resource Management, Montana Medicaid		
2.1.2 By 2019, reduce the percentage of high school students who report binge drinking to 20%. (Source: Youth Risk Behavior Survey)	Support implementation of alcohol education curriculum for youth.	Youth Connections		
	Offer ongoing alternative activities for youth.	Youth Connections, Helena Family YMCA	YC held Last Day of School Bash to deter youth from drinking on last school day.	
	Expand reach of the Pure Performance-Life of an Athlete Program.	Youth Connections	YC expanding Pure Performance program into middle schools using Americorps/VISTA volunteer.	

Other achievements/actions taken to reduce binge drinking:

- Local individual working with Helena community to develop indoor action sports park to give kids a place to hang out and stay out of trouble.

Data issues:

- Helena School District did not collect Youth Risk Behavior Survey for middle schools in 2017, so no data available for this age group.
- HB 111, passed by 2017 Montana Legislature, restricts Youth Courts from reporting "minor in possession" data to the state Department of Public Health and Human Services.

Barriers to progress:

- Community culture normalizes alcohol use. Local breweries and wine bars promote themselves as "family friendly."
- Shortage of law enforcement officers to respond to gatherings of underage drinkers.
- Inadequate access to treatment (therapists, treatment facilities). Public needs directory of treatment options.
- State provides no funding for prevention efforts.
- Coaches inconsistent in meting out consequences for youth athletes' "minor in possession" infractions.

Revisions to original goals, objectives: None identified.

Social determinants/health inequities related to binge drinking: Research has found an association between poverty and alcohol use and problems. Also see Alcohol and Inequities, World Health Organization, 2014.

According to Healthy People 2020, "determinants of substance abuse include several biological, social, environmental, psychological, and genetic factors. These factors can include gender, race and ethnicity, age, income level, educational attainment, and sexual orientation. Substance abuse is also strongly influenced by interpersonal, household, and community dynamics.

"Family, social networks, and peer pressure are key influencers of substance abuse among adolescents. For example, research suggests that marijuana exposure through friends and siblings was a primary determinant of adolescents' current marijuana use. Understanding these factors is key to reducing the number of people who abuse drugs and alcohol and improving the health and safety of all Americans."

SUBSTANCE ABUSE

Goal 2: Reduce underage drinking.

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
High schoolers who use alcohol	36.4%	35.3%	35.9%	32.0%	22.7%

Objective	Strategy	Lead	Progress	Status
2.2.1 By 2019, decrease the percentage of high school students who report current alcohol use to 32%. (Source: Youth Risk Behavior Survey)	Support development of a statewide social-host ordinance.	Youth Connections		
	Influence social norms around underage drinking.	Havre Help, Youth Connections	Havre Help launched statewide social media campaign called "Let's Face It" to deter underage drinking.	
	Conduct compliance checks at alcohol points of sale.	Havre Help, Youth Connections		

Other achievements/actions taken in past year to reduce underage drinking:

- Local individual working with Helena community to develop indoor action sports park to give kids a place to hang out and stay out of trouble.

Data issues:

- Helena School District did not collect Youth Risk Behavior Survey for middle schools in 2017, so no data available for this age group.
- HB 111, passed by 2017 Montana Legislature, restricts Youth Courts from reporting "minor in possession" data to the state Department of Public Health and Human Services.

Barriers to progress:

- Community culture normalizes alcohol use. Local breweries and wine bars promote themselves as "family friendly."
- Shortage of law enforcement officers to respond to gatherings of underage drinkers.
- Access to treatment (therapists, treatment facilities) inadequate.
- State provides no funding for prevention efforts.
- Inconsistent enforcement by athletic coaches of Minor in Possession infractions.
- 2017 Legislature killed HB 210, an effort to tighten restrictions on alcohol sales in the vicinity of schools.

Revisions to original goals, objectives: None identified

Social determinants/health inequities related to binge drinking: Research has found an association between poverty and alcohol use and problems. Also see Alcohol and Inequities, World Health Organization, 2014.

According to Healthy People 2020, "determinants of substance abuse include several biological, social, environmental, psychological, and genetic factors. These factors can include gender, race and ethnicity, age, income level, educational attainment, and sexual orientation. Substance abuse is also strongly influenced by interpersonal, household, and community dynamics.

"Family, social networks, and peer pressure are key influencers of substance abuse among adolescents. For example, research suggests that marijuana exposure through friends and siblings was a primary determinant of adolescents' current marijuana use. Understanding these factors is key to reducing the number of people who abuse drugs and alcohol and improving the health and safety of all Americans."

SUBSTANCE ABUSE

Goal 3: Reduce methamphetamine use.

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
High schoolers who have used meth	5.4%	5.1%	4.1%	4.0%	n/a

Objective	Strategy	Lead	Progress	Status
2.3.1 By 2019, reduce the percentage of high school students who report lifetime meth use to 4%. (Source: Youth Risk Behavior Survey)	Educate the community on meth use and prevention.	Missouri River Drug Task Force, School Resource Officers, Youth Connections		
	Support development of a street-crimes unit.	Missouri River Drug Task Force		
	Increase awareness of the dangers of meth.	Montana Meth Project		

Other achievements/actions taken in past year to reduce meth use:

- 2017 Montana Legislature passed HJ 6, calling for an interim study of meth use in the state. The study has been assigned to the interim Law and Justice Committee.

Data issues:

- Can Child Protective Services provide data on the numbers of children removed from their homes who have been exposed to drugs?
- Is it possible for health department to collect drug-use data from teens who come in for STD testing?
- Can we get data from Drug Court on age and substance of first use?

Barriers to progress:

- Only 5% of people who go into treatment for meth are successful. No support system for people coming out of treatment. Court-ordered AA/NA meetings are free and might help increase success.
- Community seems unaware of the magnitude of the meth problem and is unwilling to step up and try to make a change.

Revisions to original goals, objectives: None identified

Social determinants/health inequities related to meth use: According to Healthy People 2020, "determinants of substance abuse include several biological, social, environmental, psychological, and genetic factors. These factors can include gender, race and ethnicity, age, income level, educational attainment, and sexual orientation. Substance abuse is also strongly influenced by interpersonal, household, and community dynamics.

"Family, social networks, and peer pressure are key influencers of substance abuse among adolescents. For example, research suggests that marijuana exposure through friends and siblings was a primary determinant of adolescents' current marijuana use. Understanding these factors is key to reducing the number of people who abuse drugs and alcohol and improving the health and safety of all Americans."

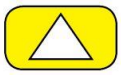
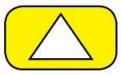
CHRONIC DISEASE

Goal 1: Increase physical activity.

Health indicator	2011	2013	2015	CHIP 2019 Goal	HP 2020 Target
Adults who are physically active	22.5%	unavailable	unavailable	26.0%	20.1%

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
High schoolers who are physically active	51.8%	53.8%	51.2%	60.0%	n/a

Objective	Strategy	Lead	Progress	Status
3.1.1 By 2019, increase the number of adults who participate in enough physical activity to meet recommended guidelines to 26%. (Source: BRFSS)	Support built environment policies that enhance access to and availability of physical activity opportunities.	Healthy Communities Coalition	Completed Active Living Wayfinding System plan for greater Helena area. In the process of encouraging adoption of sign system throughout the community. Healthy Communities Coalition hosted Inclusive Walk Audit training. City of Helena is installing and upgrading ADA-compliant ramps at local intersections. City of Helena has revised sidewalk snow removal policy to ensure faster snow removal. Increase enforcement of the policy is improving conditions. Helena Parks and Recreation has extended Centennial Trail to Spring Meadow Lake. Capital Transit has expanded to 2 routes. When people use public transportation, they tend to walk more.	

			Helena Recreation Association conducting feasibility study to build a recreation center with Olympic-sized pool.	
	Promote walking and bicycling, indoors and out.		New LCPH Living Life Well classes promote physical activity for people with chronic disease. May Commuter Challenge continues to promote active transportation to work. PureView and Sage medical clinics using Trails Rx to promote active transportation.	
	Enhance policies and educational campaigns that increase safety for pedestrians and bicyclists.		2017 Legislature passed House Bill 225, creating a $5 optional fee on motor vehicle registrations to help fund maintenance and repair of shared-use paths, as well as bicycle/pedestrian education.	
3.1.2 By 2019, increase the percentage of high school students who report being physically active at least 5 of the last 7 days to 60%. (Source: YRBS)	Increase physical activity opportunities available to school-aged children.		Health teacher at Capital High School has procured bicycles so freshmen can learn to ride safely around town. LCPH working with schools to develop wellness programs. Helena Parks and Recreation added more Kay's Kids summer recreation sites in 2017. Bike/Walk to School Month in September continues to encourage active transportation among school-aged children.	

Other achievements/actions taken to increase physical activity:

- Helena Family YMCA has applied for grant to teach water safety to all third graders.

Barriers to progress:

- The 2017 Montana Legislature killed HB 267, intended to establish a safe distance between cars and bicycles sharing the road after Senate President called cyclists "self-centered" and "rude."
- Lack of consistently continuous sidewalks.
- Modern technology taking away reasons to be active.
- Poverty, lack of resources, including time if working 2 low-wage jobs.
- Long distances, urban sprawl.
- Lack of facilities for physical activity.
- Lack of locations for non-organized sports and recreation.
- Weather
- Capital Hill Mall no longer available to those who want to walk indoors for exercise.
- No clearinghouse for organized recreational activities for adults.

Revisions to original goals, objectives: None indicated.

Social determinants/health inequities related to physical activity: According to Healthy People 2020, a number of factors affect a person's ability to eat a healthful diet, stay physically active, and achieve or maintain a healthy weight. The built environment has a critical impact on behaviors that influence health. For example, in many communities, there is nowhere to buy fresh fruit and vegetables, and no safe or appealing place to play or be active. These environmental factors are compounded by social and individual factors—gender, age, race and ethnicity, education level, socioeconomic status, and disability status—that influence nutrition, physical activity, and obesity. Addressing these factors is critically important to improving the nutrition and activity levels of all Americans; only then will progress be made against the nation's obesity epidemic and its cascading impact on health.

CHRONIC DISEASE

Goal 2: Improve nutrition to reduce overweight and obesity.

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
Adults who are obese	23.1%	unavailable	unavailable	22.5%	30.5%
High schoolers who are overweight or obese	28.0%	29.2%%	28.8%	26.0%	n/a

Objective	Strategy	Lead	Progress	Status
3.2.1 By 2019, decrease the percentage of adults who are obese to 22.5%. (Source: BRFSS)	Increase participation in community gardens.	Healthy Communities Coalition	New community gardens have been established; waivers now available for those who can't afford to rent a bed.	
	Increase accessibility and affordability of healthy foods.		Helena Food Share added a farm stand in cooperation with Helena Community Gardens to offer more fresh produce. They also are conducting fresh food drives at local grocery stores. Local community-supported agriculture (CSA) programs are expanding. Breakfast now offered in all District 1 schools.	
	Offer community classes on how to prepare whole grains, legumes, and fresh produce.		Montana State University SNAP Ed Program hosting food-preparation educational classes at a variety of locations. Also leads tours of Farmers Market with SNAP recipients.	
	Increase knowledge of healthy food and beverage choices.		Volunteers dressed up as vegetables and went into schools to talk about nutrition.	

3.2.2 By 2019, decrease the percentage of high school students who describe themselves as slightly or very overweight to 26%. (Source: YRBS)	Increase the number of worksites and schools that offer wellness and nutrition programs.		Several schools are creating wellness programs. Helena School District 1 setting up a district-level wellness committee to support individual schools.	
	Replace sugary drinks in vending machines or remove vending machines from workplaces and schools.		Capital High School planning to add healthy alternatives to vending machines.	

Other achievements/actions taken to reduce overweight and obesity:

- Local BackPack Program for students has expanded. Local breweries are helping by donating Kamut as a healthier option in addition to commercially packed food.

Data issues:

- Getting data from BRFSS and YRBS only every other year makes it hard to track progress. Should we include Prevention Needs Assessment data in CHIP?
- Adult obesity incidence is self-reported and may be unreliable. Is it possible to get this information from driver's licenses? Is it reliable enough to be a meaningful indicator of change?

Barriers to progress:

- Need mobile food pantry
- People using community gardens may not be our target population
- Need water-bottle-filler drinking fountains in schools

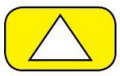
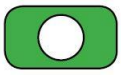
Revisions to original goals, objectives: None indicated.

Social determinants/health inequities related to overweight and obesity: According to Healthy People 2020, a number of factors affect a person's ability to eat a healthful diet, stay physically active, and achieve or maintain a healthy weight. The built environment has a critical impact on behaviors that influence health. For example, in many communities, there is nowhere to buy fresh fruit and vegetables, and no safe or appealing place to play or be active. These environmental factors are compounded by social and individual factors—gender, age, race and ethnicity, education level, socioeconomic status, and disability status—that influence nutrition, physical activity, and obesity. Addressing these factors is critically important to improving the nutrition and activity levels of all Americans; only then will progress be made against the nation's obesity epidemic and its cascading impact on health.

CHRONIC DISEASE

Goal 3: Reduce tobacco use.

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
Adults who are current smokers	18.9%	unavailable	unavailable	17.0%	12.0%
High schoolers who currently smoke cigarettes	18.4%	14.6%	11.9%	12.0%	16.0%

Objective	Strategy	Lead	Progress	Status
3.1.1 By 2019, reduce the percentage of adults who report current smoking to 17%. (Source: BRFSS)	Track changes in marketing and manufacture of tobacco products.	Healthy Communities Coalition	Continue to track information from state Tobacco Use Prevention Program and epidemiologist.	
3.1.2 By 2019, reduce the percentage of high school students who currently smoke cigarettes to 12.0%. (Source: YRBS)	Support policies needed to restrict use of tobacco and vaping products by teens and tweens.		Goal met for high schoolers who currently smoke cigarettes.	
	Collaborate with youth-serving organizations such as Youth Connections.			

Other achievements/actions taken to reduce tobacco use:

- Helena Parks and Recreation adopted a tobacco-free parks policy effective in all developed city parks.
- Signage has been increased to designate tobacco-free places.
- Ongoing statewide media campaign on point-of-sale tobacco marketing and its impacts on youth.

Data issues:

- Should indicator be changed to recognize increase in e-cigarette use? (No decision provided.)

Barriers to progress:

- 2017 Montana Legislature killed all bills aimed at regulating use, sales, and taxation of e-cigarettes.

Revisions to original goals, objectives: None provided.

Social determinants/health inequities related to tobacco use: According to Healthy People 2020, A broad range of social, environmental, psychological, and genetic factors have been associated with tobacco use, including gender, race and ethnicity, age, income level, educational attainment, geographic location, and disability. Motivation to begin and to continue smoking is strongly influenced by the social environment, although genetic factors are also known to play a role. Smoke-free protections, tobacco prices and taxes, and the implementation of effective tobacco prevention programs all influence tobacco use.

Among adolescents and young adults, in particular, tobacco use is influenced by:

- Use of tobacco and approval of tobacco use by peers or siblings
- Smoking by parents or guardians
- Accessibility of tobacco products
- Exposure to tobacco use promotional campaigns
- Low self-image or self-esteem

COMMUNICABLE DISEASE

Goal 1: Reduce sexual risk behaviors.

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
~~Annual number of chlamydia cases~~				~~<120~~	~~n/a~~
Number of chlamydia contacts w/ intervention	unavailable	unavailable	84.0%	85.0%	n/a

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
~~High schoolers who've never had intercourse~~	~~54.4%~~	~~58.2%~~	~~53.2%~~	~~60.0%~~	~~80.2% (females) 79.2% (males)~~
Sexually active high schoolers who use condoms	26.2%	23.6%	25.5%	~~65.0~~ 68.0%	55.6% (females) 81.5% (males)

Objective	Strategy	Lead	Progress	Status
4.1.1 ~~By 2019, decrease the annual number of reported chlamydia cases in the county to under 120.~~ By 2017, establish a baseline number of chlamydia contacts who receive intervention at LCPH. By 2019, increase the number of chlamydia contacts receiving intervention to 85% (Source: Lewis and Clark Public Health)	Follow 2015 Sexually Transmitted Disease Treatment Guidelines, including routine screening, follow-up, and Expedited Partner Therapy/Patient Delivered Partner Therapy. Support implementation of group-based comprehensive risk-reduction interventions delivered to adolescents.	Lewis and Clark Public Health, health-care providers, Planned Parenthood, schools		

~~**4.1.2 By 2019, increase the percentage of high schoolers who report never having had intercourse to 60%. (Source: YRBS)**~~				
4.1.3 By 2019, increase the percentage of sexually active high school students who report using a condom at last intercourse to ~~65~~ 68%. (Source: YRBS)				

Other achievements/actions taken to reduce sexual risk behaviors: None indicated.

Data issues: Need to establish a baseline of chlamydia contacts receiving intervention by Lewis and Clark Public Health.

Barriers to progress: None identified.

Revisions to original goals, objectives:

- Delete Objective 4.1.2
- Increase target for Objective 4.1.3 by 3%
- Revise Objective 4.1.1 to "increase the number of chlamydia contacts receiving intervention to 85%.

Social determinants/health inequities related to sexual risk behaviors: According to Healthy People 2020, "reproductive and sexual health, particularly the spread of STDs including HIV and the prevalence of unintended pregnancy, are determined in part by social, economic, and behavioral factors. Stigma is still a major barrier to people accessing reproductive and sexual health services. For example, the continued stigma around HIV and its association with men who have sex with men can prevent people from getting tested and knowing their serostatus.

"Many other factors affect an individual's reproductive and sexual health decision-making, including access to medical care, social norms, educational attainment, age, income, geographic location, insurance status, sexual orientation, and dependency on alcohol or other drugs. Addressing these determinants is key to reducing health disparities and improving the health of all Americans."

COMMUNICABLE DISEASE

Goal 2: Increase immunization rates.

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
Adults who get annual flu shot	34.8% (region)	unavailable	unavailable	36.0%	80.0%
Toddlers who are fully vaccinated	67.6%	unavailable	unavailable	75.0%	80.0%
Teens fully immunized for HPV	unavailable	unavailable	unavailable	unavailable	80.0%
~~Number of pertussis cases~~		~~23~~		~~<20~~	~~n/a~~

Objective	Strategy	Lead	Progress	Status
4.2.1 By 2019, increase the percentage of adults who report receiving an annual influenza vaccination to 36%. (Source: BRFSS)	Increase community demand for vaccinations through education and private administrative policy development. Encourage providers and health systems to regularly administer vaccinations and to actively promote patient vaccinations. Increase understanding of county-wide vaccination rates through analysis of St. Peter's Hospital and Medical Group vaccination data.	Lewis and Clark Public Health, St. Peter's Hospital, health-care providers, pharmacies		
4.2.2 By 2019, increase the percentage of children aged 19-35 months who have received all age-appropriate vaccinations to 75%. (Source: MT DPHHS)				
4.2.3 By 2019, increase the percentage of 12- to 18-year-olds fully vaccinated for HPV . Source: MT DPHHS				

Other achievements/actions taken to increase immunization rates: None identified.

Data issues:

- Delete pertussis health indicator because number of pertussis cases reported is influenced by surveillance efforts as well as immunization rates.

Barriers to progress: None indicated.

Revisions to original goals, objectives: Add health indicator related to immunization of 12-18-year-olds for HPV.

Social determinants/health inequities related to immunizations: None identified by group.

MATERNAL AND CHILD HEALTH

Goal: Reduce adverse childhood experiences (ACEs).

Health indicator	2004-2008	2011-2013	2014-2016	CHIP 2019 Goal	HP 2020 Target
Teen birth rate per 1,000	36.3	26.0	unavailable	22.0	n/a

Health indicator	2010-2014	2015	2017	CHIP 2019 Goal	HP 2020 Target
WIC infants breastfeeding at 3 months	29.7%	unavailable	unavailable	32.0%	n/a

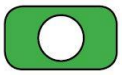
Health indicator	2011-2013	2014-2015	2016-2017	CHIP 2019 Goal	HP 2020 Target
Children living in poverty	14.0%	unavailable	unavailable	13.5%	n/a

Health indicator	2013	2015	2016	CHIP 2019 Goal	HP 2020 Target
Child abuse and neglect allegations	unavailable	3028	unavailable	<2,800 cases	n/a
Family/partner assault cases	unavailable	301	unavailable	<285 cases	n/a

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
High schoolers forced to have intercourse	10.9%	11.4%	11.6%	10.5%	n/a

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
Adults who are heavy drinkers	8.7%	unavailable	unavailable	7.5%	n/a

Health indicator	2008-2010	2011-2013	2014-2016	CHIP 2019 Goal	HP 2020 Target
Adults reporting poor mental health	34.2%	36.2%	unavailable	32.0%	n/a

Objective	Strategy	Lead	Progress	Status
5.1.1 By 2019, decrease the teen birth rate to 22 births per 1,000 teenaged girls. (Source: Montana Vital Statistics)	Expand access to training and professional development related to ACEs in the following areas: Resiliency/ACE-Master Trainer • Attachment resiliency and competency trauma informed training • Positive community norming • Perinatal mood disorders • Process/systems/infrastructure Strengthen systems and infrastructure serving families in the following areas: • Awareness of available services • Appropriate referrals • Capacity of providers • Transportation • Insurance • Screening tools • Breastfeeding policies Expand and increase access to the following support services for families: • Evidence-based home visiting • Evidence-based therapy modules • Public Health-RN Connect • Trauma-informed parenting classes • Breastfeeding support • Parent support groups • High-quality child care, including emergency and respite care	Early Childhood Coalition	Trainings: • Perinatal support international training: 2013, 2016 • Circle of Security training: 2013, 2014 • WIC Breastfeeding Learning Collaborative: 2014, 2015, 2016 • ACE master training: 2014 • ACE trainings: 370 people training in 15 sessions over 25 months • Resiliency training at ChildWise conference, Family Outreach • ARC training for therapists, case managers, Parents as Teachers and SafeCare home visitors, RNs, child-care staff, educators • Perinatal Mood Disorder training: Hosted 2 trainings for more than 300 people	
5.1.2 By 2019, increase the percentage of infants in the WIC program who are exclusively breastfeeding at 3 months to 32%. (Source: Lewis and Clark Public Health)				
5.1.3 By 2019, decrease the percentage of families with children under 18 who live in poverty to 13.5%. (Source: US Census Bureau)				

5.1.4 By 2019, decrease the number of Child Protective Services child abuse and neglect allegations annually to less than 2800. (Source: Montana Child Protective Services Division)			Process/systems: • Helena affiliate of Elevate Montana formed Awareness of services: • Met with public defender to educate on ACES and community work around resiliency and referral • Presentation to 30 Court Appointed Special Advocates (CASA) • Outreach to child protective service workers about talking to families about effects of trauma Referral network/system: • CONNECT referral system linking 48 agencies; 730 referrals in 2016 • Home visiting task force working to improve network Capacity of providers: • State Family and Child Health Services supported community living program for caregivers 18-24 years old	
5.1.5 By 2019, reduce the number of family or partner aggravated or non-aggravated assault cases to less than 285. (Source: Montana Board of Crime Control)				
5.1.6 By 2019, decrease the percentage of high school students who report ever being physically forced to have sexual intercourse to 10.5%. (Source: YRBS)				

5.1.7 By 2019, decrease the percentage of adults who are heavy drinkers to 7.5%. (Source: BRFSS)			• Elevate Montana Helena affiliate training 13 ACE trainers Transportation: • Capital Transit System expanded to include a second fixed route Insurance: • Expansion of Medicaid in Montana has led to increased enrollment Screening tools: • Office of Public Instruction and STARS have list of recommendations Breastfeeding policies: • Child and Adult Care Food Program has new requirements • St. Peter's Hospital adopted baby-friendly policy	
5.1.8 By 2019, decrease the percentage of adults who report 1 or more poor mental health days in the past month to 32%. (Source: BRFSS)				

Other achievements/actions taken to reduce ACEs: None indicated.

Data issues: None indicated.

Barriers to progress: The group identified the following barriers:

- Need to find funding to continue ACE training; low trainer capacity
- Attachment, Regulation and Competency (ARC) trauma-informed training expensive; need local trainers
- Need funding and more opportunities for perinatal mood disorder trainings; hard to schedule so providers can attend
- Need to get agencies across sectors to use CONNECT referral system consistently; don't have good flow of referrals
- Need to increase capacity of providers
- Limited reimbursement for breastfeeding support
- Need more capacity for emergency and respite child care

Revisions to original goals, objectives: None

Health inequities related to ACEs: Differences in life opportunities, exposures, and stresses (including adverse childhood experiences) lead to differences in underlying health status.

ENVIRONMENTAL HEALTH AND INJURY

Goal 1: Reduce particulate air pollution.

Health indicator	2013	2015	2016	CHIP 2019 Goal	HP 2020 Target
Number of 'poor' and 'watch' days	54	22	28	<10	n/a
~~Number of wood stoves~~	~~n/a~~	~~n/a~~			~~n/a~~

Objective	Strategy	Lead	Progress	Status
6.1.1 By 2019, reduce the number of $PM_{2.5}$ 24-hour designated "poor" and "watch" days to 10 or fewer. (Source: Lewis and Clark Public Health) ~~**6.1.2 By 2019, establish a baseline number of wood stoves. (Source: Lewis and Clark Public Health)**~~	Increase enforcement of wood stove use to decrease violations of county air-quality regulations. Increase community education on regulation requirements. Increase education on effective burning practices. Pursue EPA's Environmental Education Grant and Wood Stove Exchange funding.	Lewis and Clark Public Health	Aggressively enforced local air-quality regulations during the 2016-17 season. Increased the number of violation letters issued during poor air-quality episodes. Plan to conduct a workshop in Fall 2017 with Smitty's Fireplace Shop to educate on effective burning practices. Conducted a media campaign in February to encourage good burning practices. Included radio ads and PSAs.	

Other achievements/actions taken to reduce particulate pollution: None indicated.

Barriers to progress:

- Can't control cold weather or weather systems that cause inversions, which are the key reason we have poor air quality episodes.
- Montana Department of Environmental Quality did not apply for EPA's wood stove exchange funding.

Revisions to original goals, objectives: Consider eliminating "number of wood stoves" data because it's difficult to collect. The hospital did include a question in its 2015 community health needs assessment.

Health inequities related to air pollution: The American Lung Association reports these disparities: "The burden of air pollution is not evenly shared. Poorer people and some racial

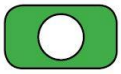
and ethnic groups are among those who often face higher exposure to pollutants and who may experience greater responses to such pollution….
"Multiple, large studies show evidence that low socioeconomic status consistently increased the risk of premature death from fine particle pollution among 13.2 million Medicare recipients…. [Researchers have also found] greater risk for premature death for African Americans [and] greater risk for people living in areas with higher unemployment or higher use of public transportation.

"Scientists have speculated that there are three broad reasons why disparities may exist. First, groups may face greater exposure to pollution because of factors ranging from racism to class bias to housing market dynamics and land costs. For example, pollution sources may be located near disadvantaged communities, increasing exposure to harmful pollutants. Second, low social position may make some groups more susceptible to health threats because of factors related to their disadvantage. Lack of access to health care, grocery stores and good jobs; poorer job opportunities; dirtier workplaces or higher traffic exposure are among the factors that could handicap groups and increase the risk of harm. Finally, existing health conditions, behaviors, or traits may predispose some groups to greater risk."

ENVIRONMENTAL HEALTH AND INJURY

Goal 2: Reduce lead exposure.

Health indicator	2013	2015	2016	CHIP 2019 Goal	HP 2020 Target
Number of kids 0-6 being screened for lead	unavailable	31	116	unavailable	10% improvement
Number with blood lead level over 5 ug/dl	unavailable	2	3	0	n/a

Objective	Strategy	Lead	Progress	Status
6.2.1 By 2019, reduce the number of children whose blood lead level exceeds 5 ug/dl annually to 0. (Source: Lewis and Clark Public Health)	Increase capacity of LCPH to work with renovation, repair, and painting contractors to reduce risk of lead exposure. Expand distribution of educational materials related to lead poisoning to increase public awareness, especially outside of East Helena and in schools. Target all clinics and well-child checkups. Provide information to all Medicaid providers about requirement for screening. Advertise in physicians' waiting rooms.	Lewis and Clark Public Health		
6.2.2 By 2019, increase the number of children 0-6 (Medicaid, MIDIS, LEAP) who are being screened for blood lead level. (Source: Lewis and Clark Public Health) NEW			Outreach to Head Start and a local pediatric clinic contributed to a 274% increase in lead screening from 2015 to 2016. This far surpassed the goal of 10%.	

Other achievements/actions taken to reduce lead exposure: None indicated.

Data issues: None indicated.

Barriers to progress:

- Lack of knowledge among medical providers and parents about the need for screening.
- Lack of follow-up on Medicaid-required screening for children ages 0-2.

Revisions to original goals, objectives:

- Added 6.2.2 and defined which children whose screening would be tracked.

Health inequities related to lead exposure: A study published in June 2015 by the National Institutes of Health found that blood lead levels were significantly higher in males, in children living in rural areas, and in children with lower household total monthly income and lower father's educational attainment. The blood lead level was significantly higher in children who spent more time playing outdoors.

ENVIRONMENTAL HEALTH AND INJURY

Goal 3: Support safe driving behaviors to reduce motor vehicle crashes.

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
High schoolers who text/email while driving	78.8%	75.8%	41.9%	57.8%	n/a
High schoolers who rarely/never wear a seat belt while driving	9.2%	7.4%	7.9%	7.6%	n/a
Adults who don't always wear a seat belt	24.8%	unavailable	n/a	15.2%	8.0%

Objective	Strategy	Lead	Progress	Status
6.3.1 By 2019, decrease the percentage of high school students who report texting or emailing while driving to 57.8%. (Source: YRBS)	Support passage of a statewide primary seat-belt law. Support passage of a statewide policy banning cell phone use while driving. Increase education and awareness ~~around~~ bout occupant safety and safe driving behaviors, especially among teens. Increase use of and knowledge about child safety restraint seats.	~~Montana Buckle Up Coalition~~ Tri-County Buckle Up Montana		
6.3.2 By 2019, reduce the percentage of high school students who never or rarely wear a seat belt to 7.6% (Source: YRBS)			Tri-County Buckle Up Montana has launched a Facebook page to reach the teen population. Ongoing monthly Alive at 25 defensive driving classes offered to residents ages 14-25. Statewide Occupant Protection Emphasis Area Team has been established and is meeting regularly to discuss strategies and action steps to support increased seat belt usage among teens and adults.	

6.3.3 By 2019, reduce the percentage of adults who report that they do not always wear a seat belt to 15.2%. (Source: BRFSS)			Traffic safety and occupant protection featured at Governor's Stay Active Challenge/Health Fair in Capitol Rotunda. An employer toolkit to educate and enhance seat belt usage in the workplace was developed and is being distributed as a way to reach the adult population during the work day with the goal of having adults develop habits they will use in their personal vehicles and personal lives.	

Other achievements/actions taken to support safe driving behaviors:

- Judges Swingley and Wood "refer" those ages 15-25 with traffic offenses to the Alive at 25 Class to provide additional safe driving education. This 4-hour class is taught once a month by the Montana Highway Patrol and coordinated by Tri-County Buckle Up Montana.
- Helena Police Department has increased patrols around the high schools to deter dangerous driving behaviors.
- Montana Office of Public Education website includes tips, toolkits, and information for teens and parents to increase safe driving behaviors.
- Montana Department of Transportation has partnered with the Families, Career and Community Leaders of America (FCCLA) to promote teen traffic safety by offering mini-grants to the Families Acting for Community Traffic Safety Students (FACTS) program, which is a national peer-education outreach through which students strive to save lives by educating youth in their community about traffic safety.

Data issues:

- The group identified additional data sources available on the Montana Department of Transportation website.

Barriers to progress:

- 2017 Montana Legislature chose once again not to adopt a primary seat belt law.
- Legislature killed three separate bills aimed at reducing distracted driving.
- Lack of additional funding and personnel to provide occupant protection outreach and education.
- Limited availability of the Tri-County Buckle Up Montana coordinator, which is a part-time, grant-funded position.

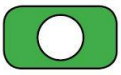
Revisions to original goals, objectives: The group wanted to add an objective related to the proper use of child-restraint seats. No target was identified. The group also discussed whether the safe-driving goal more appropriately belongs with the Substance Abuse small group rather than with Environmental Health.

Health inequities related to safe driving behaviors: None identified by group.

ACCESS TO HEALTH CARE

Goal: Improve navigability of the health-care system.

Health indicator	2013	2015	2017	CHIP 2019 Goal	HP 2020 Target
Adults with specific source of ongoing care	76.5%	69.5%		84.1%	95.0%

Objective	Strategy	Lead	Progress	Status
7.1.1 By 2019, increase the percentage of adults who report having a specific source of ongoing care to 84.1%. (Source: PRC Survey)	Identify list of health-care resources and navigators. Adopt Consented Referral System community-wide. Research clearinghouse options for assisting public in finding, selecting, and establishing primary care. Educate public on mid-levels and physician integration with mid-level visits. Hire emergency department case manager to educate and schedule non-emergent patients with primary-care provider.	Lewis and Clark Public Health St. Peter's Hospital	47 agencies are signed up for the consented referral system, now called CONNECT. Partners in Pediatrics and PureView Health Center signed up within the past year. United Way is taking the lead in revitalizing the 211 referral system. St. Peter's Hospital has hired an Emergency Department case manager.	  

Other achievements/actions taken to improve navigability of the health-care system:

- St. Peter's Hospital/Medical Group has also committed to hiring 30 new medical providers by 2019.

Data issues:

- Can we get data on emergency room and urgent care visits?
- Can we get data on wait times, number of physicians accepting new patients, and utilization of advanced practice providers?
- Can we get data on PureView and God's Love patients?

Barriers to progress: None identified.

Revisions to original goals, objectives: None.

Health inequities related to access to health care: One 2014 study published by the National Institutes of Health found no differences in the use of health care services across socioeconomic groups. Inequalities were evident in the access to and quality of these services.

The inability to afford health insurance due to socioeconomic status is a huge disparity affecting access to health care. Educational level may also play a role in an individual's ability to navigate the complexities of the health-care system.

Appendix II: CHIP Progress Meeting — Small Group Participants

May 15, 2017

**Indicates group leader*

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