



# 2021 COMMUNITY HEALTH NEEDS ASSESSMENT

St. Peter's Health Service Area

Sponsored by



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# INTRODUCTION

# PROJECT OVERVIEW

## Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2012, 2015, and 2018, 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 PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

## Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

## PRC Community Health Survey

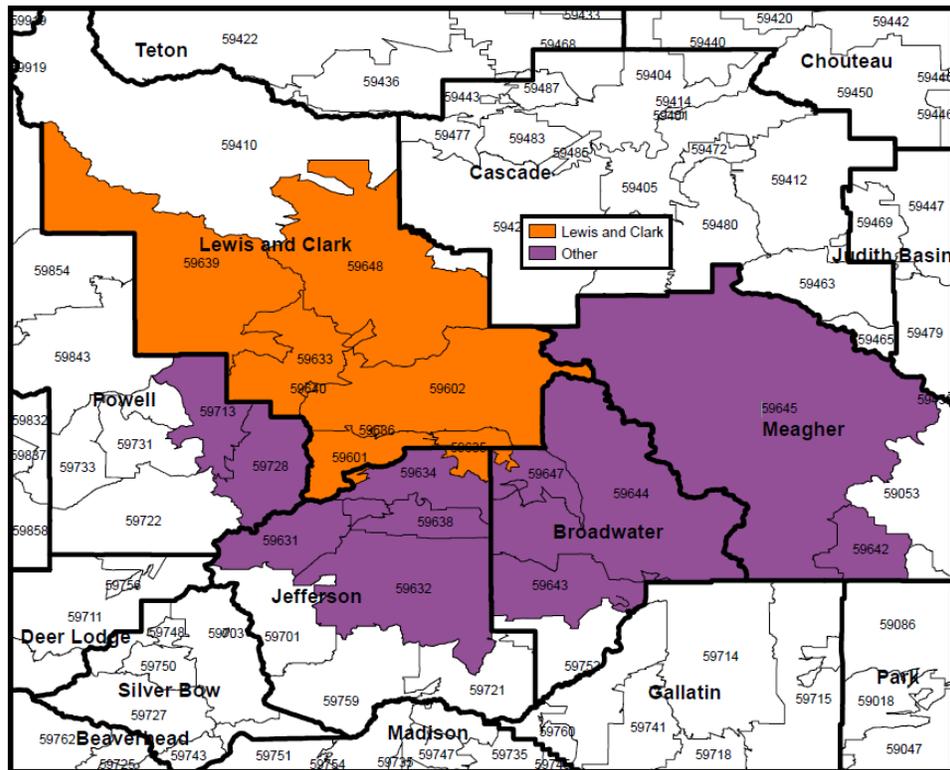
### Survey Instrument

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 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 the “SPH Service Area” in this report) is defined as each of the 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

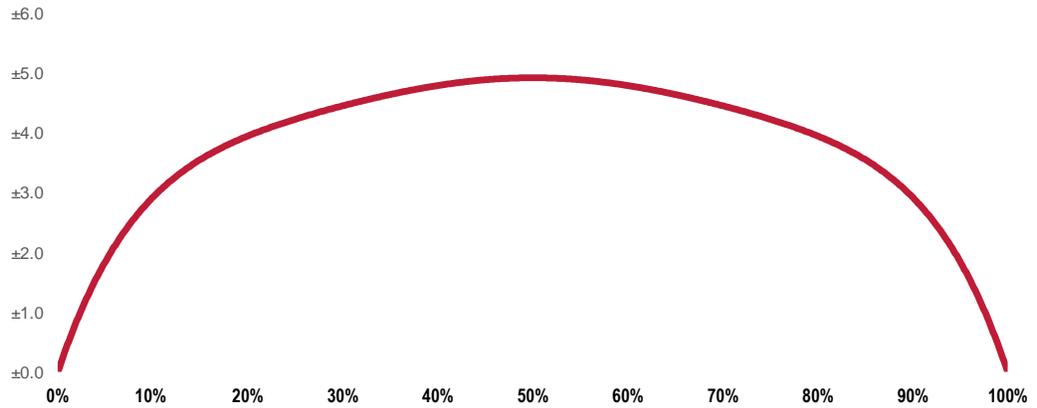
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — 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 306 in Lewis and Clark County and 94 in the remaining Other Counties area. 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  $\pm 4.9\%$  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.

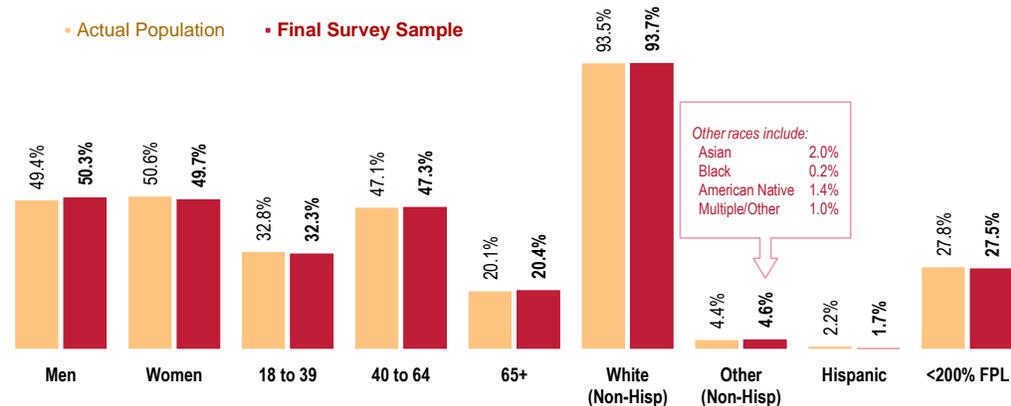
### Sample Characteristics

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 health care needs, and these children are not represented demographically in this chart.]



## Population & Survey Sample Characteristics (SPH Service Area, 2021)



Sources: • US Census Bureau, 2011-2015 American Community Survey.  
 • 2021 PRC Community Health Survey, PRC, Inc.  
 Notes: • FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

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.

### INCOME & RACE/ETHNICITY

**INCOME** ► 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 2020 guidelines place the poverty threshold for a family of four at \$26,200 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 ( $\geq 200\%$  of) the federal poverty level.

**RACE & ETHNICITY** ► While the survey data are representative of the racial and ethnic makeup of the population, the samples for Hispanic and non-White race groups were not of sufficient size for independent analysis.

### 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, 111 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:



## ONLINE KEY INFORMANT SURVEY PARTICIPATION

KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	20
Public Health Representatives	14
Other Health Providers	19
Social Services Providers	29
Other Community Leaders	29

Final participation included representatives of the organizations outlined below.

- Augusta School District 45
- Big Sky Way
- Blue Cross Blue Shield of MT
- Boyd Andrew Chemical Dependency
- Boyd Andrew Community Services
- Career Training Institute
- Carroll College
- Center for Mental Health
- Child Care Connections
- City-County Board of Health
- City-County Parks Board
- Community Development, City of Helena
- Community Resource Management
- Criminal Justice Services Department
- Dental Clinic Advisory Council
- East Helena City Council
- Environmental Protection Agency
- Family Outreach
- Florence Crittenton Home
- God's Love Homeless Shelter
- Good Samaritan Ministries
- Governor's Office
- Healthy Communities Coalition
- Helena Business Improvement District
- Helena Citizens Advisory Council
- Helena Citizens Council
- Helena College
- Helena Family YMCA
- Helena Food Share
- Helena High School
- Helena Housing Authority
- Helena Indian Alliance
- Helena Police Department
- Helena School Board
- Helena School District 1
- IMPACT Montana (National Guard)
- Intermountain
- Lewis and Clark County
- Lewis and Clark Emergency Physicians
- Lewis and Clark Public Health
- Missouri River Drug Task Force
- Montana Department of Environmental Quality
- Montana Department of Public Health and Human Services



- Montana Legal Services Association
- Montana No Kid Hungry
- Narrate Church
- NorthWestern Energy
- Our Place Drop-in Center
- PureView Board of Directors
- PureView Health Center
- Head Start of Rocky Mountain
- Rocky Mountain Development Council
- Smith and McGowan
- St. Peter's Board of Directors
- St. Peter's Health
- The Friendship Center
- The Salvation Army
- United Way of the Lewis and Clark Area
- Water Quality Protection District Board
- Youth Connections Coalition

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

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

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

## Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service



- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level data.

## Benchmark Data

### Trending

Similar surveys were administered in the SPH Service Area in 2012, 2015, and 2018 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 *2020 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 2030

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



Healthy People 2030's overarching goals are to:

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

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

## Determining Significance

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 Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
<b>Part V Section B Line 3a</b> A definition of the community served by the hospital facility	6
<b>Part V Section B Line 3b</b> Demographics of the community	36
<b>Part V Section B Line 3c</b> Existing health care facilities and resources within the community that are available to respond to the health needs of the community	188
<b>Part V Section B Line 3d</b> How data was obtained	6
<b>Part V Section B Line 3e</b> The significant health needs of the community	15
<b>Part V Section B Line 3f</b> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
<b>Part V Section B Line 3g</b> The process for identifying and prioritizing community health needs and services to meet the community health needs	16
<b>Part V Section B Line 3h</b> The process for consulting with persons representing the community's interests	9
<b>Part V Section B Line 3i</b> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	195



# SUMMARY OF FINDINGS

## Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the 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 HEALTH CARE SERVICES	<ul style="list-style-type: none"> <li>▪ Barriers to Access                             <ul style="list-style-type: none"> <li>– Appointment Availability</li> <li>– Finding a Physician</li> </ul> </li> <li>▪ Ratings of Local Health Care</li> </ul>
CANCER	<ul style="list-style-type: none"> <li>▪ Leading Cause of Death</li> <li>▪ Cancer Deaths                             <ul style="list-style-type: none"> <li>– Including Prostate and Colorectal Cancer Deaths</li> </ul> </li> <li>▪ Cancer Incidence                             <ul style="list-style-type: none"> <li>– Including Colorectal Cancer Incidence [Lewis and Clark County]</li> </ul> </li> </ul>
DIABETES	<ul style="list-style-type: none"> <li>▪ Blood Sugar Testing [Non-Diabetics]</li> <li>▪ Key Informants: Diabetes ranked as a top concern.</li> </ul>
HEART DISEASE & STROKE	<ul style="list-style-type: none"> <li>▪ Leading Cause of Death</li> <li>▪ High Blood Pressure Management</li> <li>▪ Overall Cardiovascular Risk</li> </ul>
INJURY & VIOLENCE	<ul style="list-style-type: none"> <li>▪ Unintentional Injury Deaths                             <ul style="list-style-type: none"> <li>– Including Motor Vehicle Crash, Falls [Age 65+] Deaths</li> </ul> </li> <li>▪ Falls [Age 45+]</li> <li>▪ Firearm-Related Deaths</li> <li>▪ Unlocked/Loaded Firearms [Other Counties]</li> <li>▪ Violent Crime Rate [Lewis and Clark County]</li> </ul>
KIDNEY DISEASE	<ul style="list-style-type: none"> <li>▪ Kidney Disease Deaths</li> </ul>

—continued on the following page—



## AREAS OF OPPORTUNITY (continued)

MENTAL HEALTH	<ul style="list-style-type: none"> <li>▪ “Fair/Poor” Mental Health</li> <li>▪ Diagnosed Depression</li> <li>▪ Symptoms of Chronic Depression</li> <li>▪ Suicide Deaths</li> <li>▪ Stress [Other Counties]</li> <li>▪ Mental Health Provider Ratio [Other Counties]</li> <li>▪ Receiving Treatment for Mental Health</li> <li>▪ Key Informants: Mental health ranked as a top concern.</li> </ul>
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	<ul style="list-style-type: none"> <li>▪ Overweight &amp; Obesity [Adults]</li> <li>▪ Meeting Physical Activity Guidelines</li> <li>▪ Fruit/Vegetable Consumption [Other Counties]</li> <li>▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.</li> </ul>
POTENTIALLY DISABLING CONDITIONS	<ul style="list-style-type: none"> <li>▪ Activity Limitations</li> <li>▪ High-Impact Chronic Pain</li> <li>▪ Sciatica/Chronic Back Pain</li> <li>▪ Arthritis/Rheumatism [Age 50+]</li> <li>▪ Osteoporosis [Age 50+]</li> <li>▪ Alzheimer’s Disease Deaths</li> </ul>
RESPIRATORY DISEASE	<ul style="list-style-type: none"> <li>▪ Lung Disease Deaths</li> <li>▪ Use a Wood-Burning Stove in the Home [Other Counties]</li> <li>▪ Concern Over Health Risks from Wood Stoves</li> </ul>
SUBSTANCE ABUSE	<ul style="list-style-type: none"> <li>▪ Cirrhosis/Liver Disease Deaths</li> <li>▪ Key Informants: Substance abuse ranked as a top concern.</li> </ul>
TOBACCO USE	<ul style="list-style-type: none"> <li>▪ Key Informants: Tobacco use ranked as a top concern.</li> </ul>



## Community Feedback on Prioritization of Health Needs

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

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

1. Mental Health
2. Substance Abuse
3. Nutrition, Physical Activity & Weight
4. Tobacco Use
5. Diabetes
6. Potentially Disabling Conditions
7. Cancer
8. Heart Disease & Stroke
9. Injury & Violence
10. Access to Health Care Services
11. Respiratory Disease
12. Kidney Disease

## Hospital Implementation Strategy

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

*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

## Reading the Summary Tables

- In the following tables, SPH Service Area results are shown in the larger, gray column.
- The columns to the left of the SPH Service Area column provide comparisons between Lewis and Clark County and the Other Counties combined, 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 2030 objectives. 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.

*Tip: Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.*

### TREND SUMMARY

(Current vs. Baseline Data)

#### SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 2012 (or earliest available data). Note that survey data reflect the ZIP Code-defined SPH Service Area.

#### 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).

Note that secondary data reflect county-level data.



DISPARITY BETWEEN SUBAREAS

SOCIAL DETERMINANTS	DISPARITY BETWEEN SUBAREAS	
	Lewis and Clark County	Other Counties
Linguistically Isolated Population (Percent)	 0.0	 0.1
Population in Poverty (Percent)	 11.2	 9.7
Children in Poverty (Percent)	 14.5	 11.3
No High School Diploma (Age 25+, Percent)	 5.0	 6.9
% Unable to Pay Cash for a \$400 Emergency Expense	 10.7	 17.9
% Worry/Stress Over Rent/Mortgage in Past Year	 16.4	 18.2
% Food Insecure	 12.8	 17.4

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	SPH SERVICE AREA vs. BENCHMARKS			TREND
	vs. MT	vs. US	vs. HP2030	
0.1	 0.3	 4.4		
10.8	 13.7	 14.1	 8.0	
13.7	 16.4	 19.5	 8.0	
5.6	 6.8	 12.3		
11.9		 24.6		
16.8		 32.2		 16.4
13.6		 34.1		 14.0

 better       similar       worse

DISPARITY BETWEEN SUBAREAS

OVERALL HEALTH	Lewis and Clark County	Other Counties
% "Fair/Poor" Overall Health	 15.9	 26.3

Note: 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.

DISPARITY BETWEEN SUBAREAS

ACCESS TO HEALTH CARE	Lewis and Clark County	Other Counties
% [Age 18-64] Lack Health Insurance		
% [Employed] Employer Offers a Wellness Program		
% Difficulty Accessing Health Care in Past Year (Composite)	 40.6	 45.0
% Cost Prevented Physician Visit in Past Year	 9.1	 4.7
% Cost Prevented Getting Prescription in Past Year	 6.2	 7.6
% Difficulty Getting Appointment in Past Year	 22.1	 23.0
% Inconvenient Hrs Prevented Dr Visit in Past Year	 10.3	 9.4

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
17.8	 15.2	 12.6		 12.4
	 better	 similar	 worse	

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
4.5	 12.3	 8.7	 7.9	 10.3
69.6				 56.4
41.4		 35.0		 42.1
8.3	 10.3	 12.9		 13.5
6.4		 12.8		 10.9
22.3		 14.5		 23.7
10.2		 12.5		 12.3

DISPARITY BETWEEN SUBAREAS

ACCESS TO HEALTH CARE (continued)	Lewis and Clark County	Other Counties
% Difficulty Finding Physician in Past Year	 14.5	 14.1
% Transportation Hindered Dr Visit in Past Year	 2.6	 8.6
% Skipped Prescription Doses to Save Costs	 6.9	 9.8
Primary Care Doctors per 100,000	 92.9	 64.1
% Have a Specific Source of Ongoing Care	 80.3	 74.3
% Have Had Routine Checkup in Past Year	 75.2	 64.0
% Child Has Had Checkup in Past Year		
% Two or More ER Visits in Past Year	 4.2	 9.6
% Treated at an Urgent Care Center in Past Year	 21.5	 16.0
% Rate Local Health Care "Fair/Poor"	 15.0	 23.6

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
14.4		 9.4		 12.0
3.7		 8.9		 3.2
7.4		 12.7		 11.0
84.8	 80.0	 76.6		
79.2		 74.2	 84.0	 78.6
73.3	 73.0	 70.5		 62.6
85.3		 77.4		 71.6
5.2		 10.1		 6.7
20.5				
16.5		 8.0		 23.9

 better     similar     worse

DISPARITY BETWEEN SUBAREAS

CANCER	Lewis and Clark County	Other Counties
Cancer (Age-Adjusted Death Rate)	 157.6	 154.6
Lung Cancer (Age-Adjusted Death Rate)		
Prostate Cancer (Age-Adjusted Death Rate)		
Female Breast Cancer (Age-Adjusted Death Rate)		
Colorectal Cancer (Age-Adjusted Death Rate)		
Cancer Incidence Rate (All Sites)	 502.0	 488.8
Female Breast Cancer Incidence Rate	 131.2	 125.3
Prostate Cancer Incidence Rate	 119.5	 116.3
Lung Cancer Incidence Rate	 55.0	 59.0
Colorectal Cancer Incidence Rate	 45.3	 37.7
% Cancer	 7.2	 13.7

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
<b>156.4</b>	 144.7	 149.3	 122.7	 167.2
<b>37.9</b>	 30.4	 34.9	 25.1	
<b>22.7</b>	 22.0	 18.6	 16.9	
<b>15.7</b>	 18.3	 19.7	 15.3	
<b>16.1</b>	 12.5	 13.4	 8.9	
<b>497.9</b>	 459.7	 448.7		
<b>129.6</b>	 128.5	 125.9		
<b>118.4</b>	 118.4	 104.5		
<b>56.2</b>	 53.7	 58.3		
<b>43.0</b>	 38.3	 38.4		
<b>8.4</b>	 14.2	 10.0		

Note: 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

DISPARITY BETWEEN SUBAREAS

DIABETES	Lewis and Clark County	Other Counties
Diabetes (Age-Adjusted Death Rate)	 17.6	 23.6
% Diabetes/High Blood Sugar	 10.0	 6.2
% Borderline/Pre-Diabetes	 6.6	 10.2
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	 45.0	 41.5

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
19.2	 20.2	 21.5		 17.2
9.3	 7.6	 13.8		 9.1
7.3		 9.7		 6.5
44.3		 43.3		 52.7

 better     similar     worse

DISPARITY BETWEEN SUBAREAS

HEART DISEASE & STROKE	Lewis and Clark County	Other Counties
Diseases of the Heart (Age-Adjusted Death Rate)	 149.7	 173.1
% Heart Disease (Heart Attack, Angina, Coronary Disease)	 3.5	 4.0
Stroke (Age-Adjusted Death Rate)	 26.1	 26.1
% Stroke	 2.6	 2.0

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
157.6	 158.4	 163.4	 127.4	 152.5
3.6	 6.7	 6.1		 6.2
26.1	 31.5	 37.2	 33.4	 33.1
2.5	 3.1	 4.3		 1.5

DISPARITY BETWEEN SUBAREAS

HEART DISEASE & STROKE (continued)	Lewis and Clark County	Other Counties
% Told Have High Blood Pressure	 34.3	 42.3
% [HBP] Taking Action to Control High Blood Pressure	 80.9	 88.8
% Told Have High Cholesterol	 34.8	 24.9
% [HBC] Taking Action to Control High Blood Cholesterol		
% 1+ Cardiovascular Risk Factor	 83.9	 89.9

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
35.7	 29.5	 36.9	 27.7	 33.5
82.6		 84.2		 94.1
33.1		 32.7		 28.5
92.4		 83.2		 85.9
85.0		 84.6		 78.2

 better    
  similar    
  worse

DISPARITY BETWEEN SUBAREAS

INFANT HEALTH & FAMILY PLANNING	Lewis and Clark County	Other Counties
Low Birthweight Births (Percent)	 8.4	 8.3
Infant Death Rate		
Births to Adolescents Age 15 to 19 (Rate per 1,000)	 21.9	 18.8
% [Parents] Child Was Breastfed/Fed Breast Milk		
% [Parents] Would Want Newborn to Receive All Vaccines		

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
8.4	 7.3	 8.2		 8.5
4.1	 5.5	 5.9	 5.0	
21.1	 24.6	 22.7	 31.4	
88.7				 81.7
88.4				 92.2

 better    
  similar    
  worse

DISPARITY BETWEEN SUBAREAS

INJURY & VIOLENCE	Lewis and Clark County	Other Counties
Unintentional Injury (Age-Adjusted Death Rate)	 49.4	 56.3
Motor Vehicle Crashes (Age-Adjusted Death Rate)		
[65+] Falls (Age-Adjusted Death Rate)		
% [Age 45+] Fell in the Past Year	 38.5	 45.1
% "Always" Wore a Motorcycle Helmet in the Past Year		
% "Always" Wore a Bicycle Helmet in the Past Year		
% Homes With Unlocked/Loaded Firearms	 26.0	 43.6
Firearm-Related Deaths (Age-Adjusted Death Rate)		
Homicide (Age-Adjusted Death Rate)		
Violent Crime Rate	 465.8	 372.1
% Victim of Violent Crime in Past 5 Years	 1.1	 0.0
% Victim of Intimate Partner Violence	 14.5	 16.9

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
51.6	 52.2	 48.9	 43.2	 56.7
13.3	 16.0	 11.3	 10.1	
128.4	 87.1	 65.1	 63.4	
39.9		 27.5		 46.2
52.0				 56.3
50.5				 42.7
28.9				
19.6	 19.6	 11.9	 10.7	
3.2	 3.5	 5.6	 5.5	
438.7	 393.7	 416.0		
0.9		 6.2		 2.6
14.9		 13.7		 14.2

DISPARITY BETWEEN SUBAREAS

KIDNEY DISEASE	Lewis and Clark County	Other Counties
Kidney Disease (Age-Adjusted Death Rate)		

Note: 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.

DISPARITY BETWEEN SUBAREAS

MENTAL HEALTH	Lewis and Clark County	Other Counties
% "Fair/Poor" Mental Health	 12.9	 28.7
% Lonely	 17.5	 29.1
% Diagnosed Depression	 26.2	 28.2
% Symptoms of Chronic Depression (2+ Years)	 31.3	 39.1
% Typical Day Is "Extremely/Very" Stressful	 12.6	 22.3
Suicide (Age-Adjusted Death Rate)	 24.1	 30.7
% Average <7 Hours of Sleep per Night	 33.8	 28.5

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
9.2	 9.7	 12.9		 6.4
	 better	 similar	 worse	

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
15.8		 13.4		 9.3
19.6		 23.8		 14.5
26.6	 24.1	 20.6		 16.8
32.7		 30.3		 23.8
14.4		 16.1		 13.8
26.0	 26.7	 14.0	 12.8	 21.8
32.9				 31.5

DISPARITY BETWEEN SUBAREAS

MENTAL HEALTH (continued)	Lewis and Clark County	Other Counties
Mental Health Providers per 100,000	 95.8	 15.1
% Have Ever Sought Help for Mental Health	 47.1	 41.3
% Taking Rx/Receiving Mental Health Trtmt	 22.6	 21.6
% Unable to Get Mental Health Svcs in Past Yr	 3.4	 4.4

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
73.1	 34.0	 42.6		
46.1		 30.0		 25.4
22.4		 16.8		 17.9
3.6		 7.8		 6.1

 better     similar     worse

DISPARITY BETWEEN SUBAREAS

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	Lewis and Clark County	Other Counties
Population With Low Food Access (Percent)	 19.0	 23.1
% "Very/Somewhat" Difficult to Buy Fresh Produce	 14.8	 10.7
% 5+ Servings of Fruits/Vegetables per Day	 32.5	 14.0
% No Leisure-Time Physical Activity	 16.1	 21.0

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
20.2	 24.3	 22.4		
14.0		 21.1		 18.1
29.1		 32.7		
17.0	 19.7	 31.3	 21.2	 17.0

DISPARITY BETWEEN SUBAREAS

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	DISPARITY BETWEEN SUBAREAS	
	Lewis and Clark County	Other Counties
% Meeting Physical Activity Guidelines	 26.4	 20.5
% Child [Age 2-17] Physically Active 1+ Hours per Day		
% "Very/Somewhat" Difficult to Access Places for Fitness	 21.4	 31.1
% Important to Improve Access to Trail, Parks, and Greenways	 86.5	 75.7
% Overweight (BMI 25+)	 69.9	 63.8
% Obese (BMI 30+)	 33.2	 30.8
% Medical Advice on Weight in Past Year	 25.8	 19.7
% [Overweights] Counseled About Weight in Past Year	 29.4	 21.7
% Children [Age 5-17] Overweight (85th Percentile)		
% Children [Age 5-17] Obese (95th Percentile)		

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	SPH SERVICE AREA vs. BENCHMARKS			
	vs. MT	vs. US	vs. HP2030	TREND
25.4	 28.4	 21.4	 28.4	 32.1
60.1		 33.0		
23.1				
84.7				
68.9	 64.7	 61.0		 58.2
32.8	 28.3	 31.3	 36.0	 21.3
24.7				 19.0
28.1		 24.7		
40.8		 32.3		 29.6
20.2		 16.0	 15.5	 14.9

 better       similar       worse

DISPARITY BETWEEN SUBAREAS

ORAL HEALTH	Lewis and Clark County	Other Counties
% Have Dental Insurance	 77.2	 71.6
% [Age 18+] Dental Visit in Past Year	 77.4	 67.3
% Child [Age 2-17] Dental Visit in Past Year		

Note: 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.

DISPARITY BETWEEN SUBAREAS

POTENTIALLY DISABLING CONDITIONS	Lewis and Clark County	Other Counties
% 3+ Chronic Conditions	 32.3	 38.0
% Activity Limitations	 27.4	 34.3
% With High-Impact Chronic Pain	 18.9	 29.6
% Sciatica/Chronic Back Pain	 24.8	 31.0
% [50+] Arthritis/Rheumatism	 41.1	 33.8

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
76.2		 68.7	 59.8	 64.2
75.6	 66.4	 62.0	 45.0	 71.3
89.6		 72.1	 45.0	 88.1

 better    
  similar    
  worse

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
33.3		 32.5		 39.2
28.6		 24.0		 21.4
20.9		 14.1	 7.0	
26.0		 16.5		 23.3
39.5		 33.1		 29.3

DISPARITY BETWEEN SUBAREAS

POTENTIALLY DISABLING CONDITIONS (continued)	Lewis and Clark County	Other Counties
% [50+] Osteoporosis	 14.9	 20.9
Alzheimer's Disease (Age-Adjusted Death Rate)		

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
16.2		 10.5	 5.5	 6.7
21.9	 21.7	 30.4		 16.2

 better    
  similar    
  worse

DISPARITY BETWEEN SUBAREAS

RESPIRATORY DISEASE	Lewis and Clark County	Other Counties
CLRD (Age-Adjusted Death Rate)	 62.2	 47.1
Pneumonia/Influenza (Age-Adjusted Death Rate)		
% [Age 65+] Flu Vaccine in Past Year	 87.9	 71.6
% [Adult] Ever Diagnosed With Asthma	 15.9	 11.9
% [Age 0-17] Child Has Been Diagnosed With Asthma		
% COPD (Lung Disease)	 9.7	 4.4

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
57.4	 50.4	 39.6		 59.1
11.4	 11.5	 13.8		 12.4
84.6	 60.2	 71.0		 59.8
15.1	 14.8	 17.3		 13.8
12.9		 14.6		 7.7
8.8	 6.8	 6.4		 7.8

DISPARITY BETWEEN SUBAREAS

RESPIRATORY DISEASE (continued)	Lewis and Clark County	Other Counties
% Use a Wood-Burning Stove to Heat the Home	 12.2	 36.9
% Do Not Think Wood-Burning Stoves Pose a Serious Health Issue	 53.6	 64.7
% [Respondents w/Stoves] Stove is EPA-Certified		

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
16.7				 22.1
55.6				 41.1
82.2				 71.0

 better     similar     worse

DISPARITY BETWEEN SUBAREAS

SEXUAL HEALTH	Lewis and Clark County	Other Counties
HIV Prevalence Rate	 53.4	 102.0
Chlamydia Incidence Rate	 357.1	 347.5
Gonorrhea Incidence Rate	 41.3	 37.8

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
64.2	 66.1	 372.8		
354.4	 468.1	 539.9		
40.3	 112.4	 179.1		

 better     similar     worse

DISPARITY BETWEEN SUBAREAS

SUBSTANCE ABUSE	Lewis and Clark County	Other Counties
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)		
% Excessive Drinker	 21.0	 20.4
% Drinking & Driving in Past Month	 3.7	 5.0
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)		
% Illicit Drug Use in Past Month	 0.3	 0.0
% Used a Prescription Opioid in Past Year	 11.0	 18.5
% Personal Use of Prescription Meds in the Past Year	 1.4	 9.0
% Have Expired Prescription Medications in the Home	 18.8	 20.0
% Personally Impacted by Substance Abuse	 38.5	 37.2
% Difficulty Finding Professional Help for Substance Abuse	 0.4	 0.0

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
9.6	 14.3	 11.1	 10.9	 6.5
20.9		 27.2		 19.7
3.9	 3.7			 3.7
9.1	 9.8	 18.8		 10.5
0.3		 2.0	 12.0	 1.0
12.4		 12.9		
2.8				 3.1
19.0				
38.2		 35.8		 41.3
0.3				 0.8

 better     similar     worse

DISPARITY BETWEEN SUBAREAS

TOBACCO USE	Lewis and Clark County	Other Counties
% Current Smoker	 9.0	 12.7
% Someone Smokes at Home	 5.3	 4.5
% [Household With Children] Someone Smokes in the Home		
% Currently Use Vaping Products	 2.4	 1.4

Note: 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.

SPH SERVICE AREA vs. BENCHMARKS

SPH Service Area	vs. MT	vs. US	vs. HP2030	TREND
9.7	 16.6	 17.4	 5.0	 13.8
5.2		 14.6		 7.5
3.5		 17.4		 7.4
2.2	 3.9	 8.9		 5.4

 better       similar       worse



# COMMUNITY DESCRIPTION

# POPULATION CHARACTERISTICS

## Total Population

The SPH Service Area, the focus of this Community Health Needs Assessment, is predominantly associated with Lewis and Clark County as well as the combined area of Broadwater, Jefferson, Meagher, and Powell counties, which encompasses 11,025.51 square miles and houses a total population of 93,518 residents, according to latest census estimates.

Total Population  
(Estimated Population, 2014-2018)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Lewis and Clark County	67,077	3,458.38	19.40
Other Counties	26,441	7,567.13	3.49
SPH Service Area	93,518	11,025.51	8.48
Montana	1,041,732	145,546.98	7.16
United States	322,903,030	3,532,068.58	91.42

Sources: 

- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).

Note: 

- "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 health care providers and the utilization of community resources.

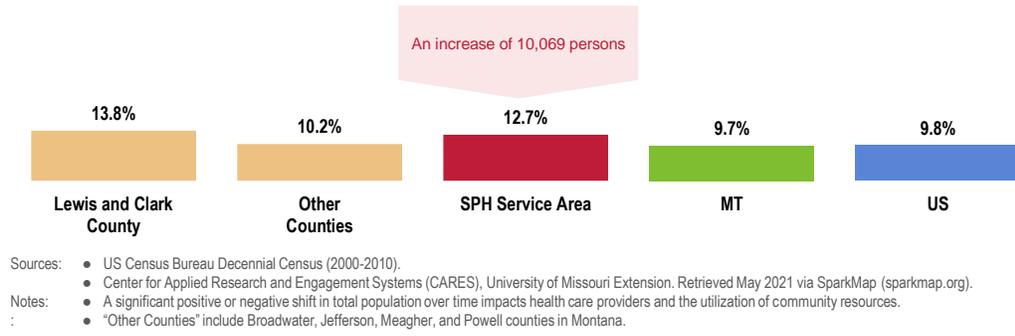
**Between the 2000 and 2010 US Censuses, the population of the SPH Service Area increased by 10,069 persons, or 12.7%.**

**BENCHMARK** ► A larger proportional increase compared with state and national figures.

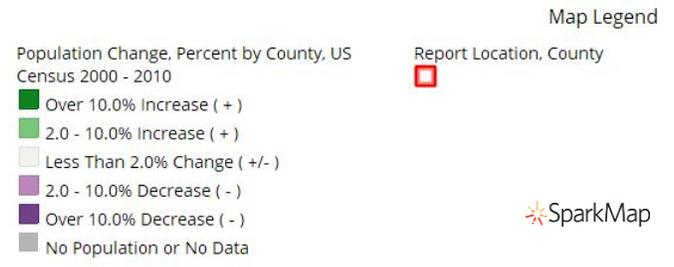
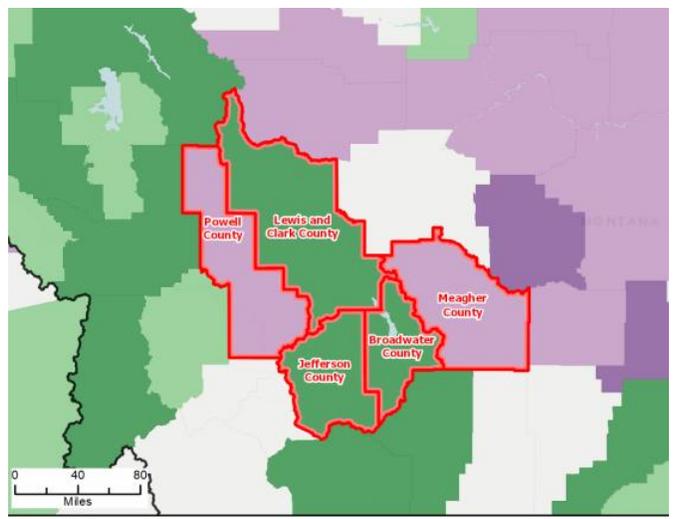
**DISPARITY** ► The percentage change was higher in Lewis and Clark County.



## Change in Total Population (Percentage Change Between 2000 and 2010)



This map shows the areas of greatest increase or decrease in population between 2000 and 2010.



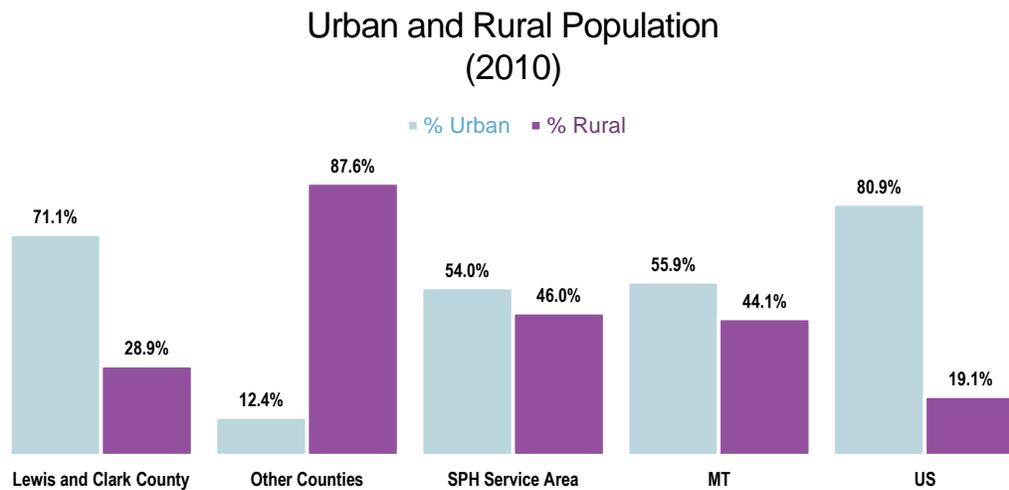
## Urban/Rural Population

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

**The SPH Service Area is a mix of urban and rural populations, with 54.0% of the population living in areas designated as urban.**

**BENCHMARK** ► A much lower proportion of urban residents than reported nationally.

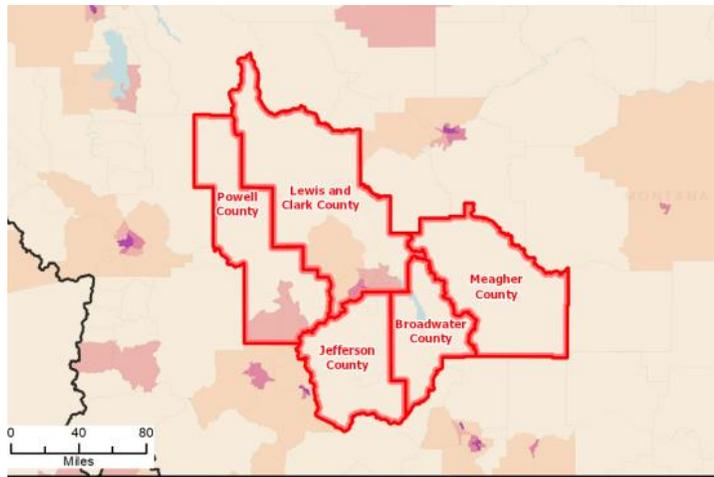
**DISPARITY** ► Lewis and Clark County is predominantly urban, while the Other Counties are predominantly rural.



- Sources:
- US Census Bureau Decennial Census.
  - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.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 the SPH Service Area.





## Age

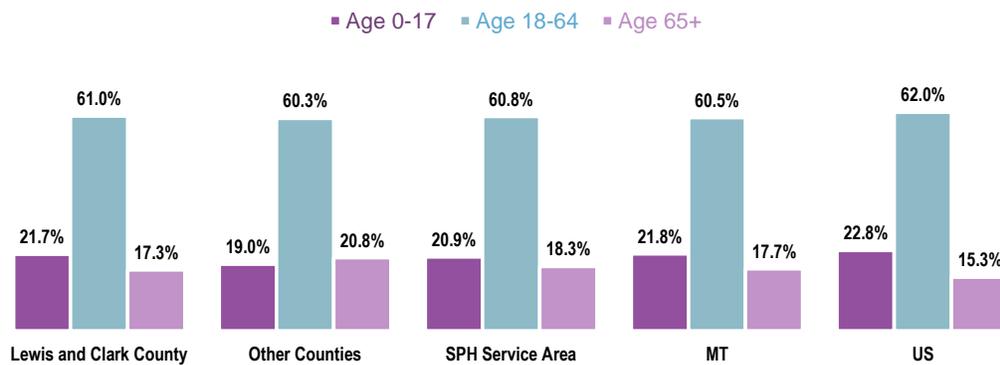
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

**In the SPH Service Area, 20.9% of the population are children age 0-17; another 60.8% are age 18 to 64, while 18.3% are age 65 and older.**

**BENCHMARK** ▶ A larger proportion of seniors (age 65+) when compared to the US.

**DISPARITY** ▶ The Other Counties region houses a larger population of older adults.

### Total Population by Age Groups (2014-2018)



Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).

Note:

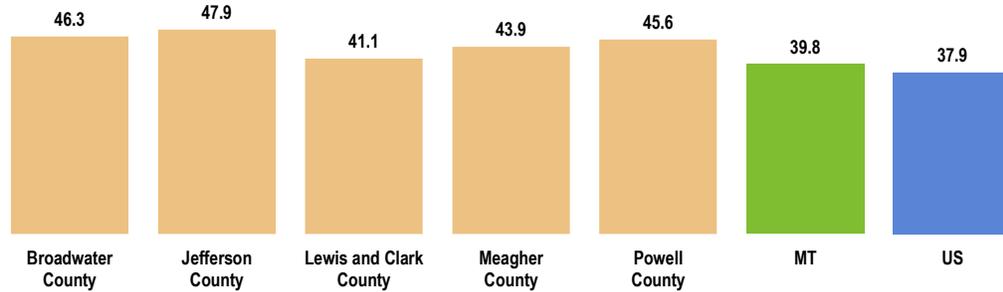
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Median Age

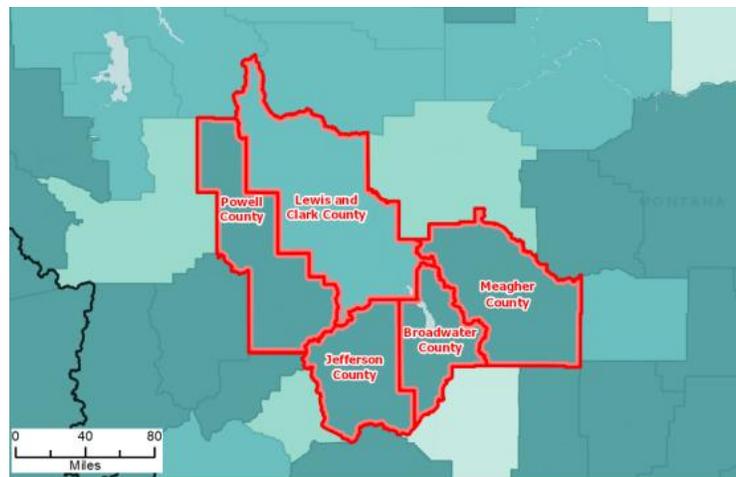
The SPH Service Area is “older” than the state and especially the nation in that the median age of each county is higher.

### Median Age (2014-2018)



Sources:   
 • US Census Bureau American Community Survey 5-year estimates.   
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).

The following map provides an illustration of the median age in the SPH Service Area.



Map Legend

Median Age by County, ACS 2014-18

- Over 45.0
- 40.1 - 45.0
- 35.1 - 40.0
- Under 35.1
- No Data or Data Suppressed

Report Location, County



SparkMap



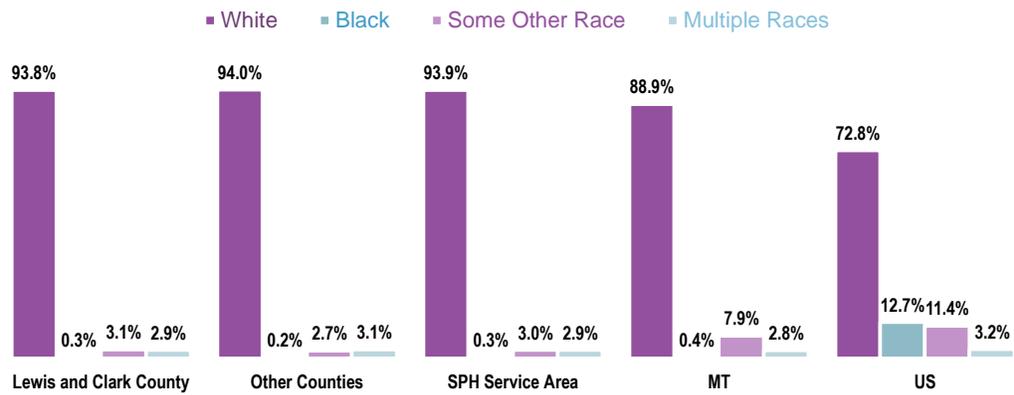
# Race & Ethnicity

## Race

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

**BENCHMARK** ▶ A much less diverse population than that of Montana and especially of the US.

Total Population by Race Alone  
(2014-2018)



Sources: 

- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).

  
 Note: 

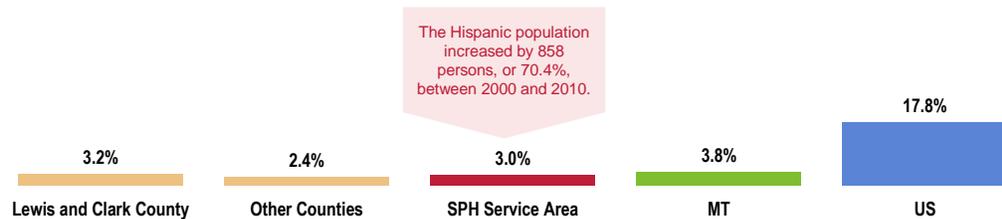
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Ethnicity

A total of 3.0% of SPH Service Area residents are Hispanic or Latino.

**BENCHMARK** ▶ A fraction of the US population of Hispanics or Latinx.

Hispanic Population  
(2000-2010)



Sources: 

- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).

  
 Notes: 

- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



# Linguistic Isolation

There are almost no households in the service area in which **no** person age 14 or older is proficient in English (speaking only English or speaking English “very well”).

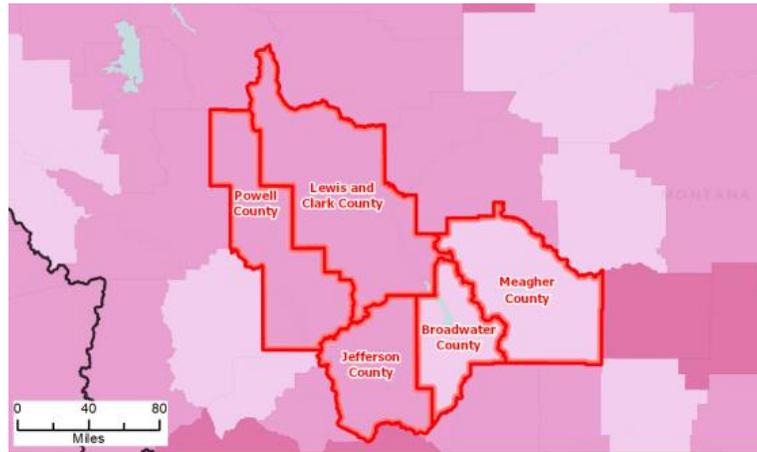
**BENCHMARK** ▶ Well below the state and national (especially) percentages.

**DISPARITY** ▶ The only indication of linguistic isolation is outside Lewis and Clark County.

## Linguistically Isolated Population (2014-2018)



- Sources:
- US Census Bureau American Community Survey 5-year estimates.
  - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).
- Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English "very well."
  - "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



Map Legend

Population in Linguistically Isolated Households, Percent by County, ACS 2014-18

- Over 3.0%
- 1.1 - 3.0%
- 0.1 - 1.1%
- No Population in Linguistically Isolated Households
- No Data or Data Suppressed

Report Location, County



# SOCIAL DETERMINANTS OF HEALTH

## ABOUT SOCIAL DETERMINANTS OF HEALTH

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

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

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

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

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

- Healthy People 2030 (<https://health.gov/healthypeople>)

## Poverty

**The latest census estimate shows 10.8% of the SPH Service Area total population living below the federal poverty level.**

**BENCHMARK** ▶ Lower than state and national figures but failing to satisfy the Healthy People 2030 objective.

**DISPARITY** ▶ Lower outside Lewis and Clark County.

**Among just children (ages 0 to 17), this percentage in the SPH Service Area is 13.7% (representing an estimated 2,631 children).**

**BENCHMARK** ▶ Lower than state and national figures but failing to satisfy the Healthy People 2030 objective.

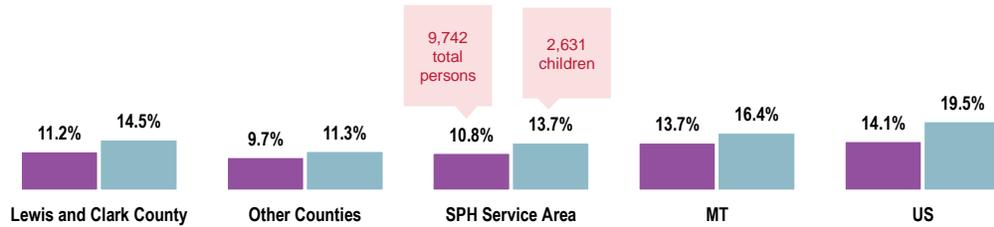
**DISPARITY** ▶ Worse in Lewis and Clark County.



## Population in Poverty (Populations Living Below the Poverty Level; 2014-2018)

Healthy People 2030 = 8.0% or Lower

■ Total Population ■ Children



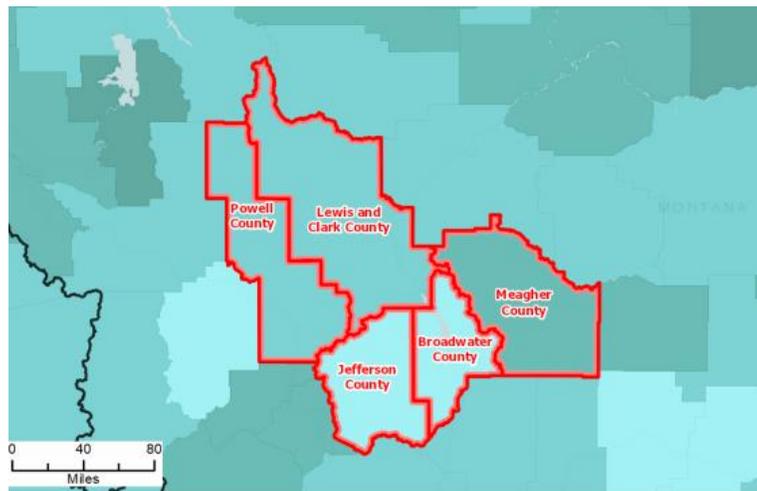
Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes:

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

The following maps highlight concentrations of persons living below the federal poverty level.



Map Legend

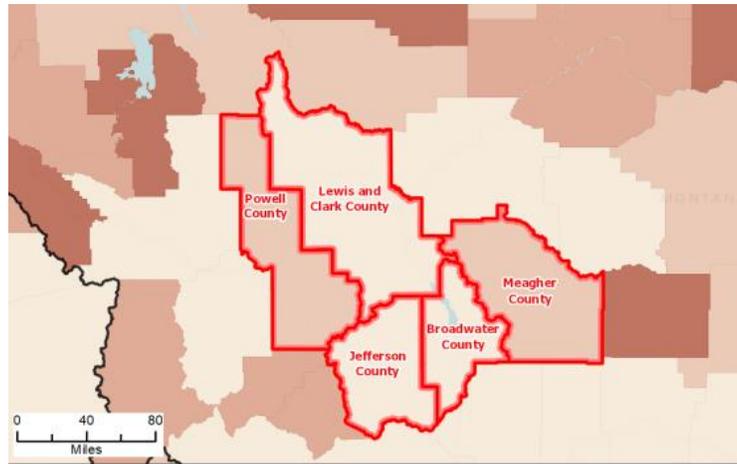
Population Below the Poverty Level, Percent by County, ACS 2014-18

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed

Report Location, County

SparkMap





Map Legend

Population Below the Poverty Level, Children (Age 0-17), Percent by County, ACS 2014-18

- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed

Report Location, County



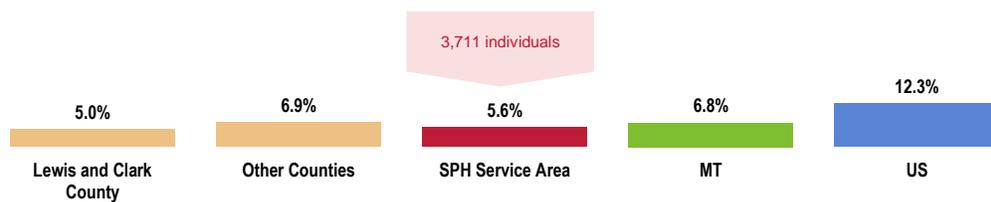
## Education

Among the SPH Service Area population age 25 and older, an estimated 5.6% (over 3,700 people) do not have a high school education.

**BENCHMARK** ▶ Lower than the state and especially the nation.

**DISPARITY** ▶ Higher outside Lewis and Clark County.

### Population With No High School Diploma (Population Age 25+ Without a High School Diploma or Equivalent, 2014-2018)



- Sources:
- US Census Bureau American Community Survey 5-year estimates.
  - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.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.



# Financial Resilience

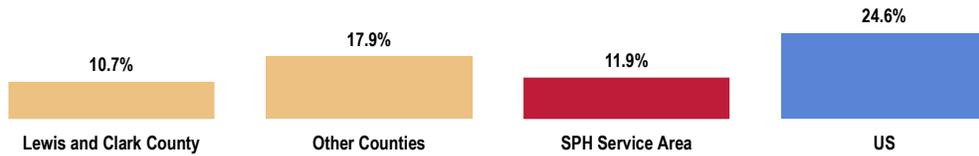
Respondents were asked: "Suppose that you have an emergency expense that costs \$400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

**A total of 11.9% of SPH Service Area residents would not be able to afford an unexpected \$400 expense without going into debt.**

**BENCHMARK** ▶ Well below the US prevalence.

**DISPARITY** ▶ Reported more often among women, adults under 65, and those in low-income households especially.

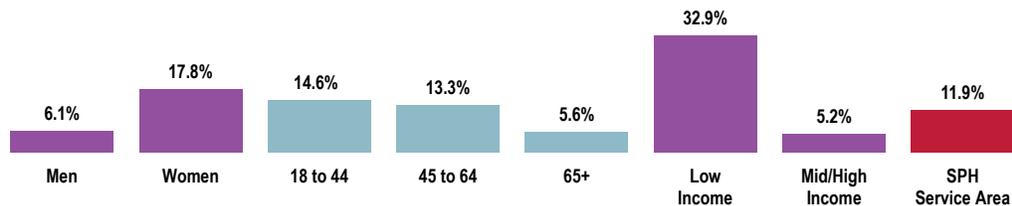
## Do Not Have Cash on Hand to Cover a \$400 Emergency Expense



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 63]  
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.  
• Includes respondents who say they would not be able to pay for a \$400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.  
• "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Do Not Have Cash on Hand to Cover a \$400 Emergency Expense (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 63]

Notes: • Asked of all respondents.  
• Includes respondents who say they would not be able to pay for a \$400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

NOTE: For indicators derived from the population-based survey administered as part of this project, text describes significant differences determined through statistical testing. The reader can assume that differences (against or among local findings) that are not mentioned are ones that are not statistically significant.

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

Here, "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.

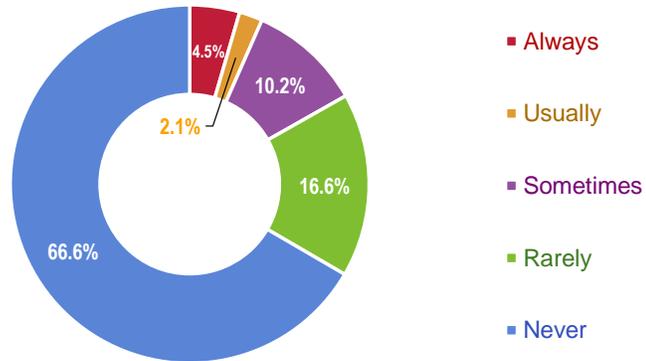


# Housing

## Housing Insecurity

Most surveyed adults rarely, if ever, worry about the cost of housing.

Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year (SPH Service Area, 2021)



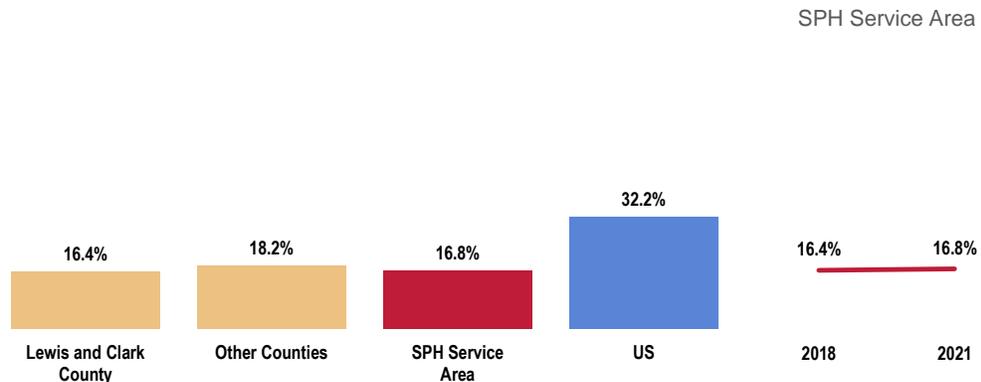
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 66]  
 Notes: • Asked of all respondents.

However, 16.8% report that they were “sometimes,” “usually,” or “always” worried or stressed about having enough money to pay their rent or mortgage in the past year.

**BENCHMARK** ▶ Just over half the national prevalence.

**DISPARITY** ▶ Higher among women, adults under 65, and those in low-income households.

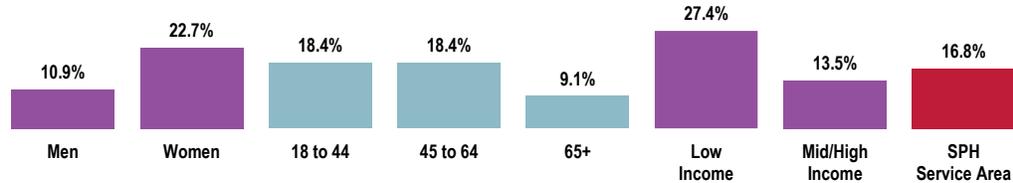
“Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 66]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 : • “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## “Always/Usually/Sometimes” Worried About Paying Rent/Mortgage in the Past Year (SPH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 66]  
Notes: ● Asked of all respondents.

## Food Access

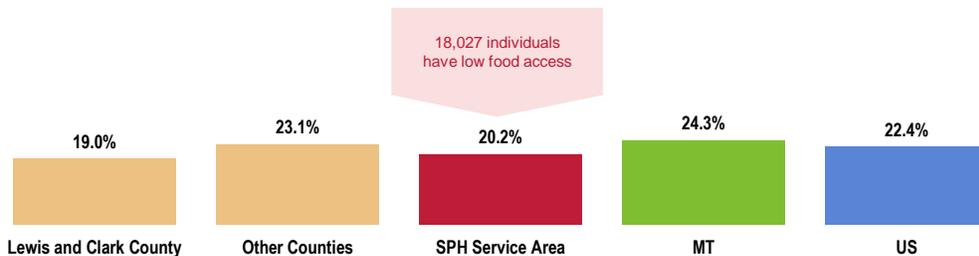
### Low Food Access

**US Department of Agriculture data show that 20.2% of the SPH Service Area population (representing over 18,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.**

**BENCHMARK** ► Lower than the Montana percentage.

**DISPARITY** ► Higher in the Other Counties region.

### Population With Low Food Access (Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2015)

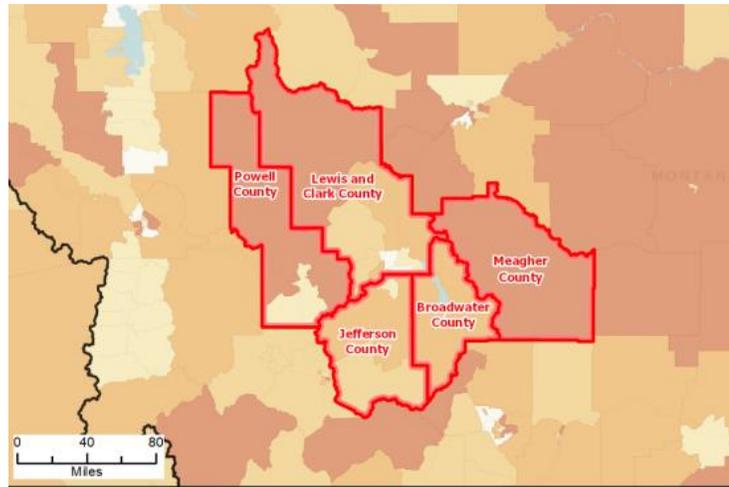


Sources: ● US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).  
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).  
Notes: ● This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.  
: ● "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

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

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





## Food Insecurity

Overall, 13.6% 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.

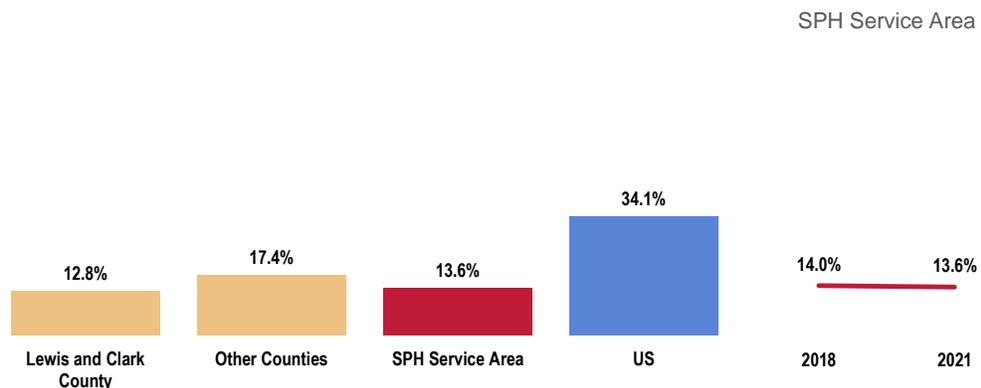
- BENCHMARK** ▶ Considerably lower than the US prevalence.
- DISPARITY** ▶ Highest among women and low-income respondents.

Surveyed adults were asked: “Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was “Often True,” “Sometimes True,” or “Never True” for you in the past 12 months:

- I worried about whether our food would run out before we got money to buy more.
- The food that we bought just did not last, and we did not have money to get more.”

Those answering “Often” or “Sometimes True” for either statement are considered to be food insecure.

## Food Insecurity

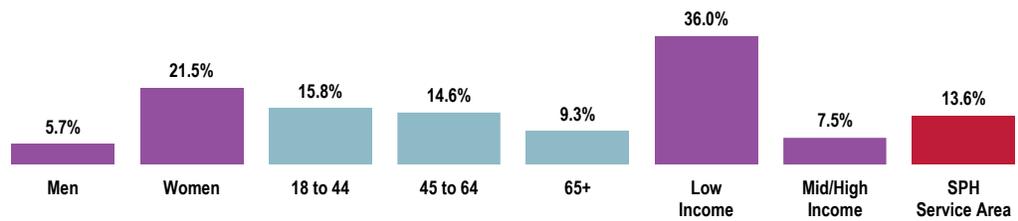


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 112]  
 • 2020 PRC National Health Survey, PRC, Inc.

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.



## Food Insecurity (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 112]  
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.





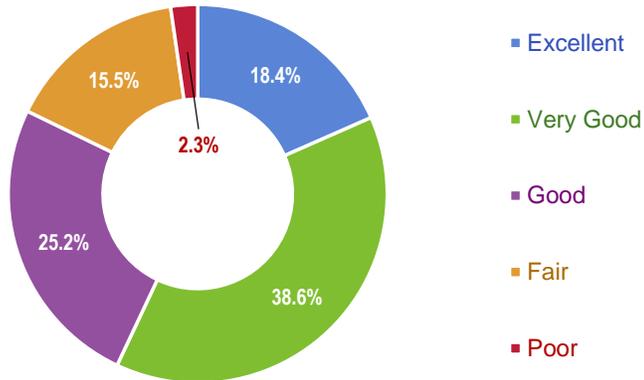
# HEALTH STATUS

# OVERALL HEALTH STATUS

Most SPH Service Area residents rate their overall health favorably (responding “excellent,” “very good,” or “good”).

The initial inquiry of the PRC Community Health Survey asked: “Would you say that in general your health is: Excellent, Very Good, Good, Fair, or Poor?”

Self-Reported Health Status  
(SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]  
Notes: • Asked of all respondents.

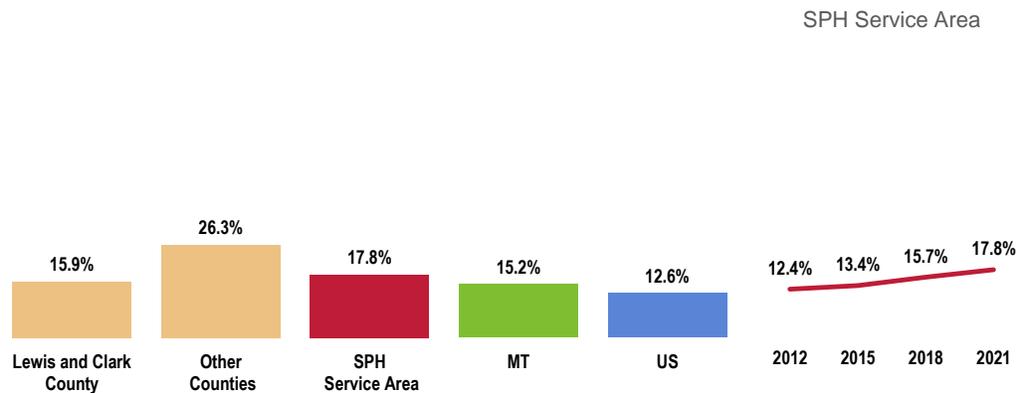
However, 17.8% of SPH Service Area adults believe that their overall health is “fair” or “poor.”

**BENCHMARK** ▶ Worse than the national prevalence.

**TREND** ▶ Marks a statistically significant increase since 2012.

**DISPARITY** ▶ Much higher outside Lewis and Clark County. Reported more often among women, adults age 45 to 64, and especially those respondents in low-income households.

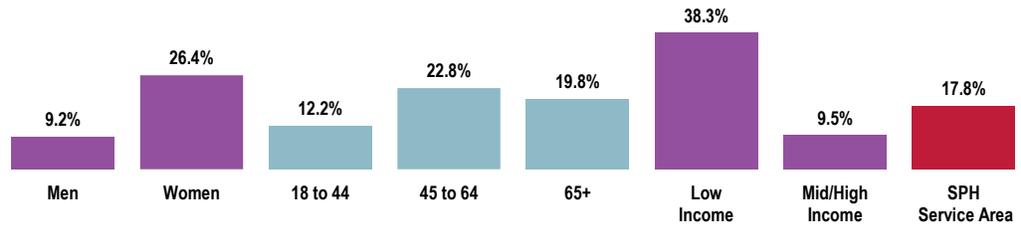
## Experience “Fair” or “Poor” Overall Health



Sources: • 2021 PRC Community Health Survey, PRC, 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): 2019 Montana data.  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.  
: • “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Experience “Fair” or “Poor” Overall Health (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]  
Notes: • Asked of all respondents.



# MENTAL HEALTH

## ABOUT MENTAL HEALTH & MENTAL DISORDERS

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

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

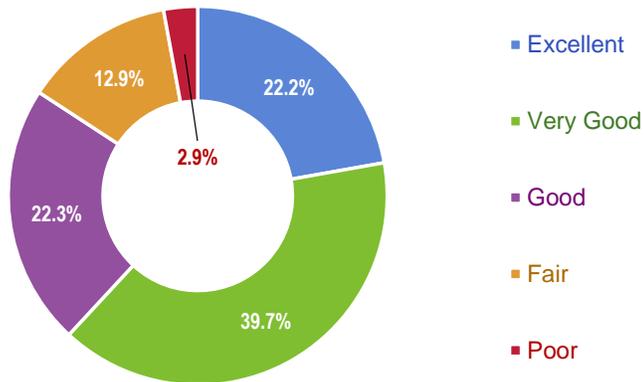
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Mental Health Status

**Most SPH Service Area adults rate their overall mental health favorably (“excellent,” “very good,” or “good”).**

“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?”

Self-Reported Mental Health Status  
(SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 90]  
Notes: • Asked of all respondents.

**However, 15.8% believe that their overall mental health is “fair” or “poor.”**

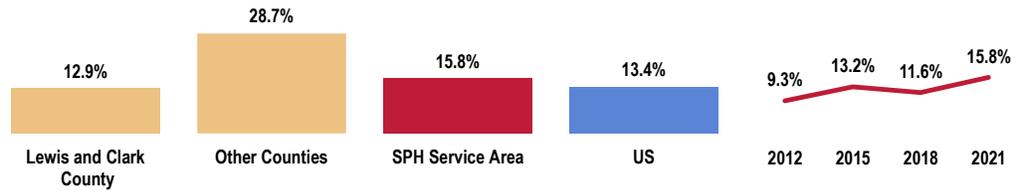
**TREND** ▶ Marks a statistically significant increase from 2012 survey findings.

**DISPARITY** ▶ Significantly higher in the Other Counties region.



## Experience “Fair” or “Poor” Mental Health

SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 90]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 : • “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Depression

### Diagnosed Depression

A total of 26.6% 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).

**BENCHMARK** ▶ Above the US figure.

**TREND** ▶ Increasing significantly since 2015.

## Have Been Diagnosed With a Depressive Disorder

SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 93]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.  
 • 2020 PRC National Health Survey, PRC, 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.



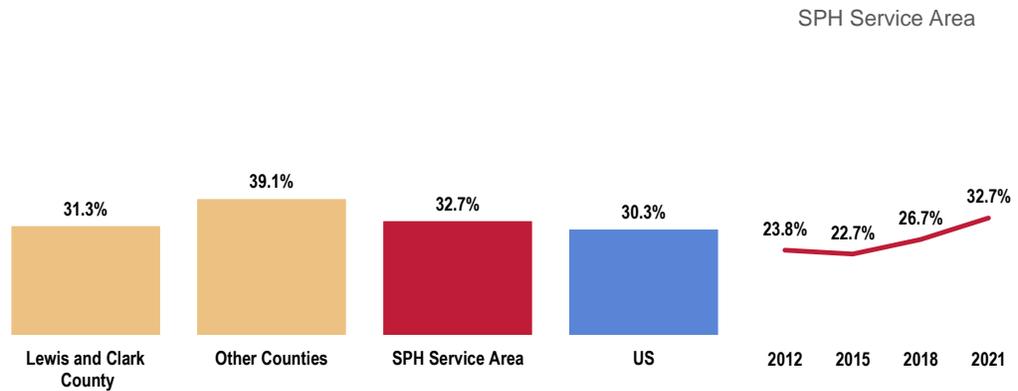
## Symptoms of Chronic Depression

A total of **32.7%** 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).

**TREND** ▶ A statistically significant increase from 2012 and 2015 survey findings.

**DISPARITY** ▶ Statistically higher among women and low-income respondents.

### Have Experienced Symptoms of Chronic Depression



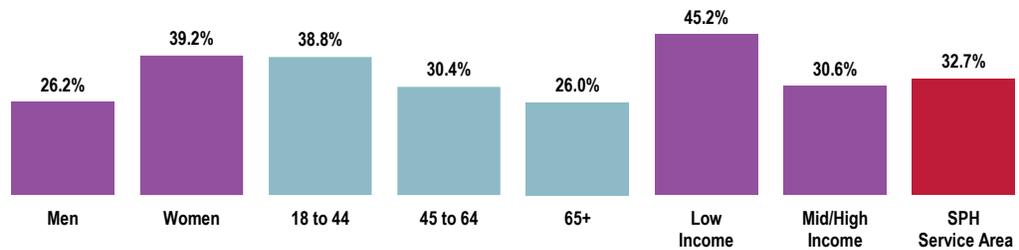
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 91]  
 • 2020 PRC National Health Survey, PRC, Inc.

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.

### Have Experienced Symptoms of Chronic Depression (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 91]

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.

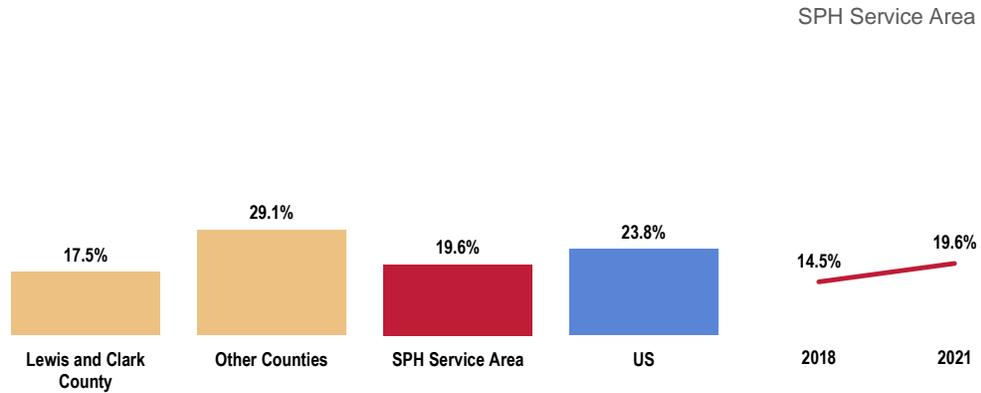


## Loneliness

One in five service area adults (19.6%) is considered to be lonely, determined using a three-point Loneliness Scale (regarding a lack of companionship, feelings of isolation, or feeling left out).

DISPARITY ► Considerably higher outside Lewis and Clark County.

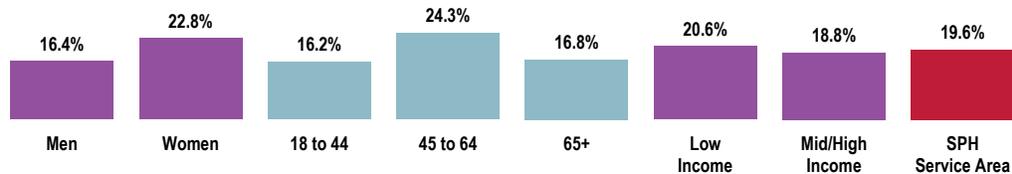
### Lonely



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 346]  
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.  
 • Here, "lonely" is defined as respondents who score 6-9 points in a series of three questions from the Loneliness Scale (regarding lacking companionship or feeling isolated or feeling left out). Points were awarded based on "hardly ever" (1), "some of the time" (2), or "often" (3) responses  
 • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

### Lonely



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 346]

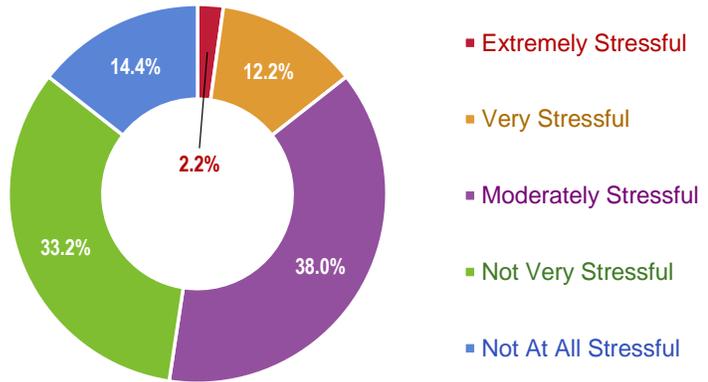
Notes: • Asked of all respondents.  
 • Here, "lonely" is defined as respondents who score 6-9 points in a series of three questions from the Loneliness Scale (regarding lacking companionship or feeling isolated or feeling left out). Points were awarded based on "hardly ever" (1), "some of the time" (2), or "often" (3) responses



# Stress

A majority of surveyed adults characterize most days as no more than “moderately” stressful.

Perceived Level of Stress On a Typical Day  
(SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 92]  
Notes: • Asked of all respondents.

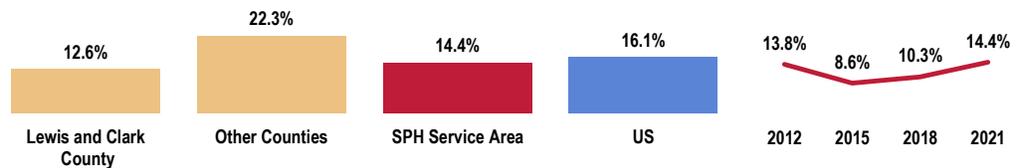
**In contrast, 14.4% of SPH Service Area adults feel that most days for them are “very” or “extremely” stressful.**

**TREND** ▶ Similar to benchmark findings but increasing since the 2015 and 2018 survey administrations.

**DISPARITY** ▶ Much higher outside Lewis and Clark County. Correlates with age among survey respondents.

Perceive Most Days As “Extremely” or “Very” Stressful

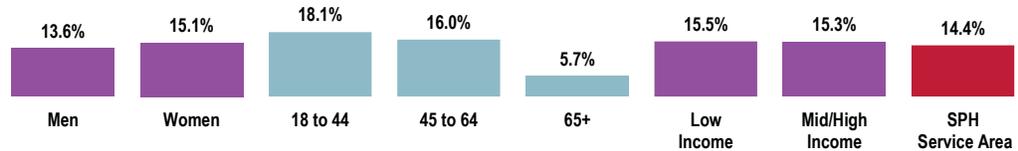
SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 92]  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.  
: • “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Perceive Most Days as “Extremely” or “Very” Stressful (SPH Service Area, 2021)



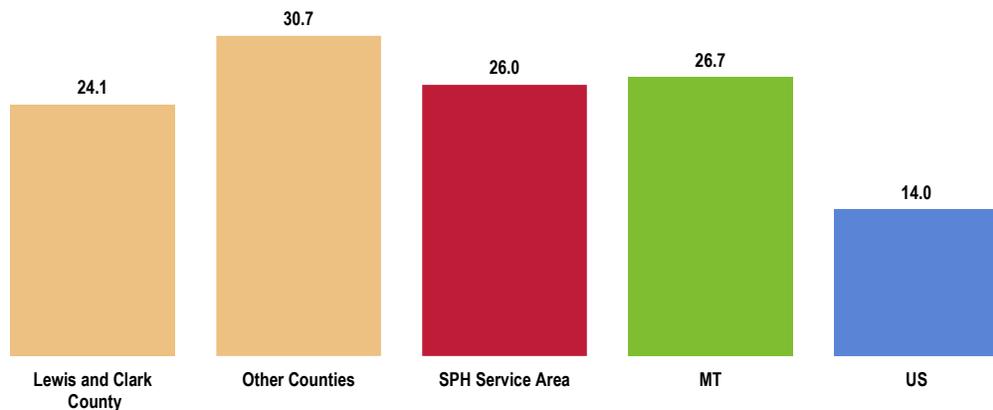
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 92]  
Notes: • Asked of all respondents.

## Suicide

**In the SPH Service Area, there were 26.0 suicides per 100,000 population (2017-2019 annual average age-adjusted rate).**

- BENCHMARK** ▶ Much worse than the US rate and far from the Healthy People 2030 objective.
- TREND** ▶ Increasing over time, in keeping with the statewide trend.
- DISPARITY** ▶ Higher in the Other Counties.

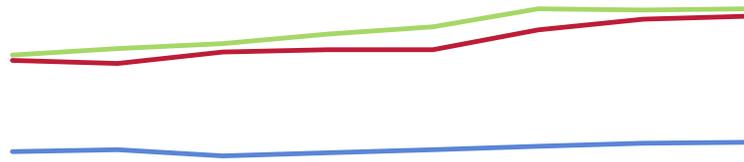
### Suicide: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population) Healthy People 2030 = 12.8 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>  
Note: • “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Suicide: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2030 = 12.8 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SPH Service Area	21.8	21.5	22.6	22.8	22.8	24.7	25.7	26.0
MT	22.3	22.9	23.4	24.3	25.0	26.7	26.6	26.7
US	13.1	13.3	12.7	13.0	13.3	13.6	13.9	14.0

Sources:   
 • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.   
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

## Mental Health Treatment

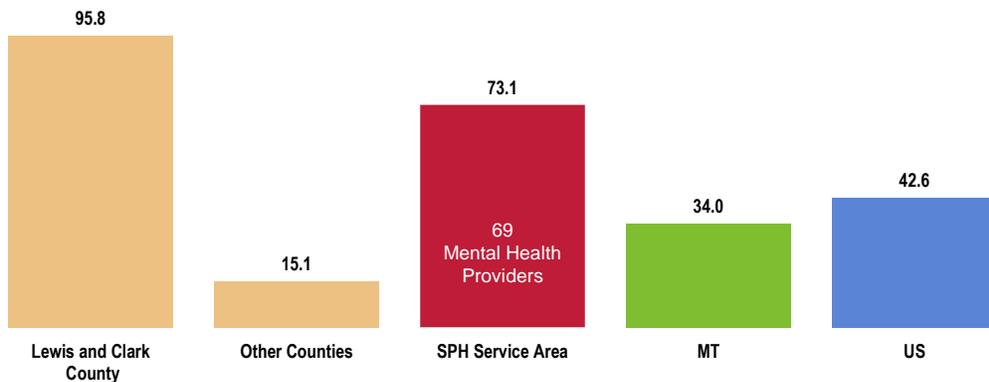
### Mental Health Providers

In the SPH Service Area in 2020, there were 73.1 mental health providers for every 100,000 population.

**BENCHMARK** ► Well above the state and national ratios.

**DISPARITY** ► A much lower ratio outside Lewis and Clark County.

### Access to Mental Health Providers (Number of Mental Health Providers per 100,000 Population, 2020)



Sources:   
 • University of Wisconsin Population Health Institute, County Health Rankings.   
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap ([sparkmap.org](http://sparkmap.org)).   
 Notes:   
 • This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.   
 Note:   
 • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in the SPH Service Area and residents in the SPH Service Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.



## Currently Receiving Treatment

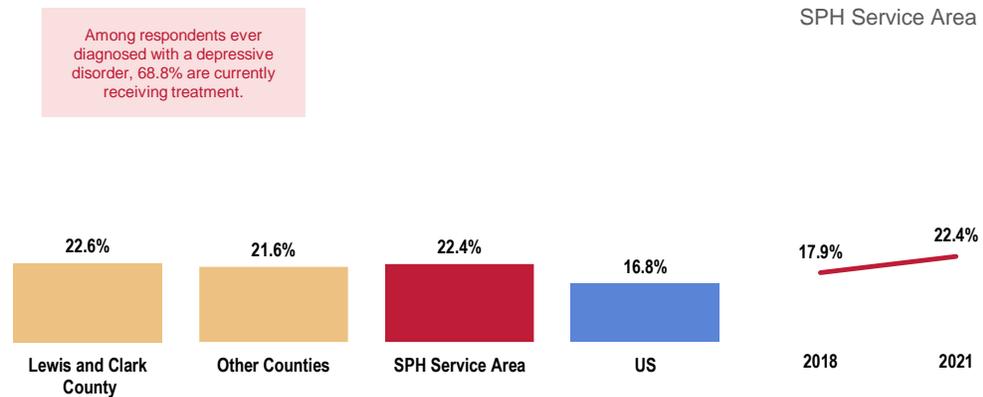
A total of 22.4% are currently taking medication or otherwise receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

**BENCHMARK** ▶ Higher than the national prevalence.

**TREND** ▶ The increase over time is not yet statistically significant.

## Currently Receiving Mental Health Treatment

Among respondents ever diagnosed with a depressive disorder, 68.8% are currently receiving treatment.



- Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 94]
  - 2020 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.
  - "Treatment" can include taking medications for mental health.
  - "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Accessing Mental Health Services

### Seeking Professional Help

A total of 46.1% of survey respondents have ever sought professional help for a mental or emotional issue.

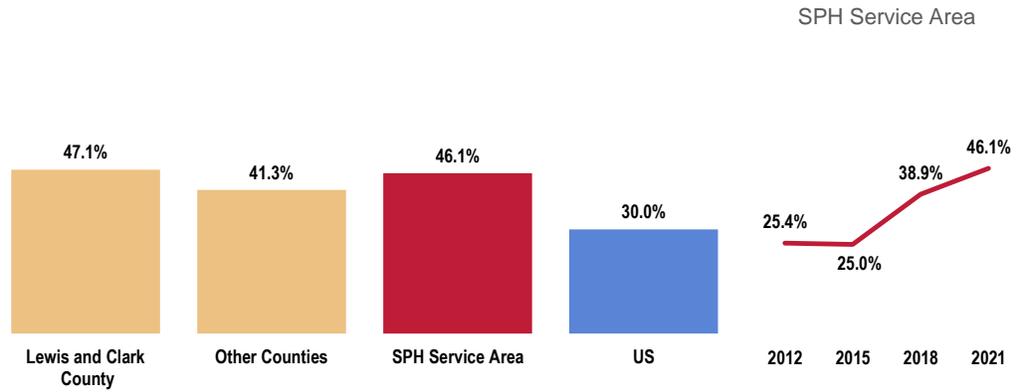
**BENCHMARK** ▶ Well above the US figure.

**TREND** ▶ Increasing significantly from 2012 and 2015 survey findings.

**DISPARITY** ▶ Reported less often among men and adults age 45 and older.

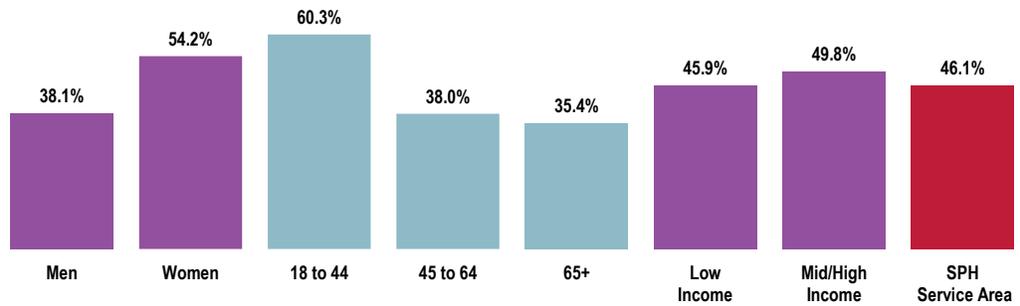


## Have Sought Help for Mental/Emotional Health



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 328]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 : • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Have Sought Help for Mental/Emotional Health (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 328]  
 Notes: • Asked of all respondents.

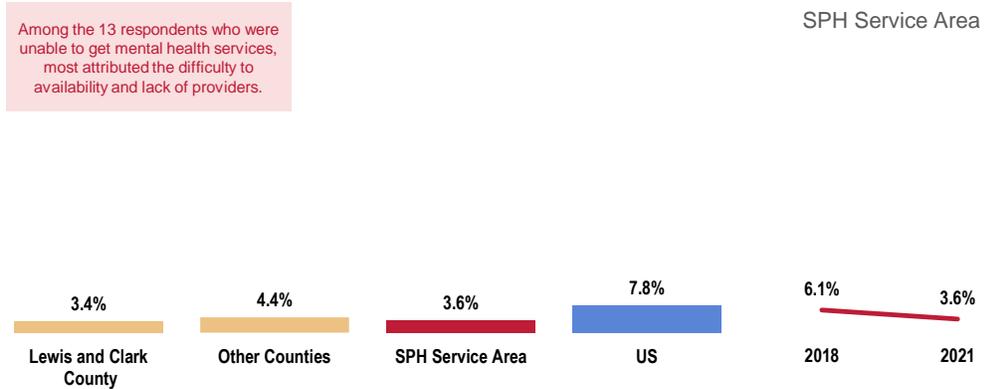


## Difficulty Accessing Care

A total of 3.6% 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.

**BENCHMARK** ▶ Half the national percentage.

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



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 95, 329]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 : • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

### Unable to Get Mental Health Services When Needed in the Past Year (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 95]  
 Notes: • Asked of all respondents.



# Key Informant Input: Mental Health

The greatest share of key informants taking part in an online survey characterized *Mental Health* as a “major problem” in the community.

## Perceptions of Mental Health as a Problem in the Community (Key Informants, 2021)



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

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

### Contributing Factors

Access to and perceived acceptability of accessing mental health services. De-stigmatization is an issue in many places, but Montana has an independent, man-up, cowboy culture that makes it extra difficult to admit to having a problem. Helena also tends to be fairly insular and it can be difficult for newcomers or those struggling to break into existing social groups and feel accepted in the community. – Public Health Representative

In our community it is people aging and trying to navigate the physical and mental challenges they face on a daily basis. We have many people living alone and those challenges can seem overwhelming at times, trying to care for a disabled or sick spouse. Many in our community do not have family close enough to help out to provide help locating resources. It can be a large problem and frightening not only for the sick individual but for the spouse trying to be everything that is needed at home. We need resources in each small community that people can see for help, home health caregivers that can relate to the problems at hand and give our people support and a friendly face. They need someone to lean on. Our community has a number of bars that can disrail a good family life and problems grow from that. – Community Leader

Access to care. Compassion, understanding of mental health issues as disease that can be treated. – Community Leader

This is an ongoing issue in many communities. Instability of care that one receives for mental health issues. Access to adequate care. Affordability of adequate mental health care. Suicide rates increasing. – Public Health Representative

Able to access comprehensive mental health services, and the lack of providers for children and those specializing in perinatal and family therapy. There is also still a huge stigma for especially parents admitting to mental health challenges. – Social Services Provider

Mental health professionals are booked, and hard to find access. US model of treating symptoms with low frequency sessions could be considerably more effective. Stigma for mental health in Montana is significant. Stigma for mental health in traditional US workplace also very significant - employees would never risk disclosing mental health to their employer, especially with new legislation lengthening time for probation (fire without cause). – Community Leader

Clinical care and peer support, shelter and housing. – Social Services Provider

There are not enough resources for people who have mental health problems. Many are homeless and have addictions and we do not have enough safe housing options to help them succeed. The housing options for people with nothing are very limited, sometimes infested with drugs and not safe. – Physician

Access to services, homelessness, inability to stay employed, inability to stay housed. – Social Services Provider

Lack of access to affordable quality mental health services. Lack of training for police response to mental health calls. Lack of access to medication prescribers with specialized knowledge of meds. Cost of meds and lack of access to affordable insurance for adults living in poverty. Lack of access to stable housing for low income people with mental health needs. – Social Services Provider

Lack of access to therapist and professionals. Inadequate or non-existent health insurance coverage or government supported programs. Social stigma and stereotypes. – Public Health Representative



Not enough therapists. Not enough beds for youth. School district does not require mental health screening. Marijuana legalization will greatly increase mental health issues as it increases depression and anxiety, but the marijuana industry keeps touting it as medicine and pushes it for use in PTSD, which it's contraindicated for that diagnosis. The legislature chooses not to look at research regarding the link between mental health and substance use. – Social Services Provider

As with other areas in the country, people with mental health issues remain on the fringes and in the shadows of the community. Mental health issues may contribute to drug abuse, homelessness, and may lead to illegal activities that place these folks in prisons and custody environments that do nothing to address underlying mental health conditions. – Community Leader

It is hard to overcome the stigma of being mentally ill/having a mental illness. People see it as a bad thing and don't want to get treatment or see a therapist. There is limited access to therapists. Not all insurances cover therapy, if they do it is not for enough sessions per year. Very limited treatment if a person needs to be cared for outside the home in the Helena area. Loss of Journey Home is a major issue. Transportation to get to appointments is difficult at best if a patient doesn't have a car. The bus is not always the best answer for a person with a mental health issue. Lack of case management services. It comes and goes with Medicaid money. Now that we have some money available to use there is no one to hire. The wages for those positions are never comparable to wages for other jobs that can be much less stressful. – Social Services Provider

Homelessness, specialty care like psychiatry, inconsistent/lack of payment method for wrap around case management. – Public Health Representative

Lack of support and feelings of isolation. Catching mental health issues early to begin a treatment program. Strengthening programs and practices in K-12 schools to help identify mental health issues and support resources. – Social Services Provider

Mental Health continues to be one of the main challenges for our community. It continues to be a challenge with our homeless community. The suicide rate in the county is not coming down The COVID quarantine probably exacerbated some existing problems for individuals. Resources are limited. – Community Leader

Finding housing and proper care. Substance abuse. So many just roam the streets and no one wants to be accountable for them. No accountability if they commit crimes and not enough safe and monitored housing available for them. Basically, so many of them should be in a mental health facility and not on their own where they are led to self destruction or hurting others. – Social Services Provider

Isolation, loneliness and stressful lives were a problem before Covid and will continue to be. Lack of health care, child care, good paying jobs, transportation and other stresses contribute to chaotic lives and mood issues. Complicating this situation, access to high quality affordable mental health is extremely limited in Helena - Physician

## Access to Care/Services

Access to both preventive and crisis care. – Public Health Representative

The waitlist to get mental health services can be up to four weeks. – Social Services Provider

Access to evidence based services for all but particularly low SES sub populations. – Public Health Representative

I think we need more crisis responders and more short term care facilities where people can get help if they are in a crisis state but don't necessarily need to go to Warm Springs. – Public Health Representative

Comprehensive substance abuse treatment (including inpatient care with intensive counseling), more family support and outpatient resources particularly for pediatric psychiatric care. The ER is great for acute issues, but is not the solution to chronic psychiatric illness and seems to be increasingly the "solution" to nonemergent psychiatric issues. There needs to be more walk-in psychiatric services available and/or more community awareness for the services that are available. – Physician

Finding and continuing care. – Community Leader

Passion for serving individuals with mental health, building a stronger community team with referrals of individuals in need instead of discharging. – Social Services Provider

Access to timely services, and the continuation of services. Lack of variety of service levels. – Social Services Provider

Lack of services. – Social Services Provider

While progress is being made in terms of public awareness, there may be limited resources (e.g. counseling and ongoing management resources) that are accessible and affordable for many people in our community, especially those who are not adequately insured, low-income. – Social Services Provider

Access to mental health services. No crisis stabilization facility (Journey Home), even though we have a facility. Limited programs to assist the individuals that have mental health issues (not just the severely mentally ill individuals, but people in all spectrums of mental health) - Other Health Provider

Access to care and stigma. – Other Health Provider

Access long waiting lists, uncertain where to seek help, shortage of licensed professionals. – Other Health Provider



Access to services, no crisis de-escalation center, unreasonably long waits at the Emergency Room, transportation. – Public Health Representative

Lack of services across the continuum, no prevention activities. Completely disorganized system. No solid Community Mental Health Center presence. A mess. – Community Leader

There is a growing awareness of the need to address mental health issues. As a result, we are seeing more services that wrapped around the medical home model. – Other Health Provider

Very under served for mental health in the Helena area. Not enough inpatient beds, not enough outpatient psychiatrists for the level of complexity that we have in our community. – Physician

Not getting wrap around services and lack of collaboration. – Social Services Provider

Unable to access treatment either because of lack of resources or lack of quality treatments. – Social Services Provider

Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also, the quality of support seems to be reduced for medical services due to COVID concerns. – Social Services Provider

Available resource when a crisis exists that would be better handled by a professional instead of the police. – Community Leader

Care for mental health patients who have no insurance. The uninsured are sent to the Center for Mental Health, where there have been staffing problems, problems getting patients in. – Physician

## Lack of Providers

Lack of providers, especially for children with mental health issues. – Community Leader

Limited therapists. – Physician

Access to counselors is by and large the biggest problem for people with mental health issues. – Other Health Provider

Not enough practitioners to meet the needs of residents. No inpatient treatment that also manages chronic illness such as diabetes. – Other Health Provider

Parents tell me that finding a therapist to help their adolescent is difficult, especially one that will see their child after school. This seems to be the biggest barrier to accessing mental health services for their children. – Other Health Provider

Access is challenging. We often work with clients for months to find a therapist with an opening in their schedule. Pureview, HIA, AWARE and C4MH provide quality services but clients often complain that they cannot see their provider as frequently as they need/want to see them because of capacity issues. We have a lot of resources in the community to address mental health, but demand is far higher than capacity. It also cannot be ignored that for many of these issues in the survey, the lack of overall resources and basic needs make these issues compound on one another. – Social Services Provider

## Care Coordination

Having supportive housing, wrap-around services to keep them in the community, recruiting the correct type of people who will stay working with this tough population, Having enough housing and staff to keep patient from advancing to higher levels of care and the non existent discharge planning from the Montana State Hospital dropping Patient off at homeless shelters who are not equipped to assist with this population making recidivism almost automatic. – Social Services Provider

Coordination of services between and among practitioners, missing services crisis prevention and stabilization. Low reimbursement rates and insurance administrative burden. – Physician

Persons with SDMI lack coordinated comprehensive community services supporting them where they live and work. Needs to be a better connection between housing and mental health support. – Social Services Provider

Lack of overall care coordination. I know that a coordinator was hired for the county to start addressing this, but in my interactions there's been a lack of actually listening to the mental health players in this community, rather than coming in with pre-conceived ideas that do nothing to advance overall integration of a community system. – Other Health Provider

## Affordable Care/Services

Access to affordable care. – Social Services Provider

People do not have the time or money to necessary to receive quality mental health services even when they're identified as needing such services. – Community Leader

To be able to afford a therapist and to be able to get to see one. One has to travel distances to see a therapist. No local resources. – Public Health Representative

## Awareness/Education

Lack of information and referrals. Misunderstandings and stigma. – Social Services Provider



Stigma. If you have a broken bone, people understand and are sympathetic. If you are struggling with mental health issues, no one wants to talk about it, hear about it, acknowledge it. So those issues often go unaddressed and untreated, potentially leading to greater problems for individuals, families, and our entire community. – Community Leader

I hear that people don't know what services are available, have no transportation to get there, don't want to go. – Social Services Provider

## Follow-Up/Support

Lack of support and lack of understanding in current programs. – Social Services Provider

Emergency room mental health support and compassion to serve those with mental health. Adequate programming and following along (case management) for those with mental health housing/jobs or daily socialization needs and integration especially after coming out of treatment or resettling into the community. – Social Services Provider

## COVID-19

Struggles with mental health are up 30% during COVID times. – Other Health Provider

People feeling alone and isolated due to COVID restrictions. – Public Health Representative





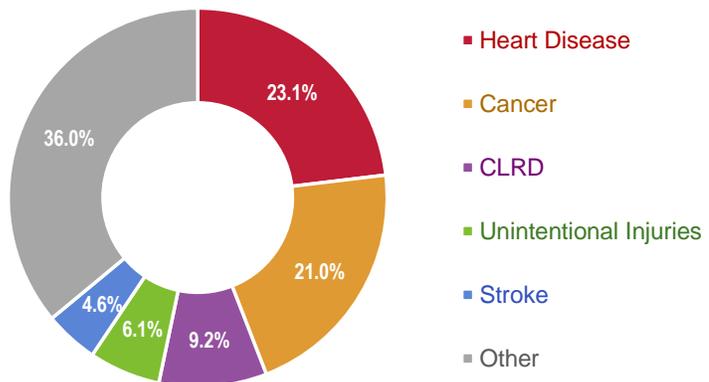
# DEATH, DISEASE & CHRONIC CONDITIONS

# LEADING CAUSES OF DEATH

## Distribution of Deaths by Cause

Together, heart disease and cancers accounted for the largest share of all deaths in the SPH Service Area in 2019.

Leading Causes of Death  
(SPH Service Area, 2019)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.  
Notes: • Lung disease is CLRD, or chronic lower respiratory disease.

## Age-Adjusted Death Rates for Selected Causes

### AGE-ADJUSTED DEATH RATES

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

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

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



The following chart outlines 2017-2019 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.

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

### Age-Adjusted Death Rates for Selected Causes (2017-2019 Deaths per 100,000 Population)

	SPH Service Area	Montana	US	HP2030
<b>Diseases of the Heart</b>	157.6	158.4	163.4	127.4*
<b>Malignant Neoplasms (Cancers)</b>	156.4	144.7	149.3	122.7
<b>Fall-Related Deaths (65+)</b>	128.4	87.1	65.1	63.4
<b>Chronic Lower Respiratory Disease (CLRD)</b>	57.4	50.4	39.6	n/a
<b>Unintentional Injuries</b>	51.6	52.2	48.9	43.2
<b>Cerebrovascular Disease (Stroke)</b>	26.1	31.5	37.2	33.4
<b>Intentional Self-Harm (Suicide)</b>	26.0	26.7	14.0	12.8
<b>Alzheimer's Disease</b>	21.9	21.7	30.4	n/a
<b>Firearm-Related</b>	19.6	19.6	11.9	10.7
<b>Diabetes Mellitus</b>	19.2	20.2	21.5	n/a
<b>Motor Vehicle Deaths</b>	13.3	16.0	11.3	10.1
<b>Pneumonia/Influenza</b>	11.4	11.5	13.8	n/a
<b>Cirrhosis/Liver Disease</b>	9.6	14.3	11.1	10.9
<b>Kidney Diseases</b>	9.2	9.7	12.9	n/a
<b>Drug-Induced</b>	9.1	9.8	18.8	n/a
<b>Homicide</b>	3.2	3.5	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 May 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>.

Note: 

- \*The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.



# CARDIOVASCULAR DISEASE

## ABOUT HEART DISEASE & STROKE

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

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

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

## Age-Adjusted Heart Disease & Stroke Deaths

### Heart Disease Deaths

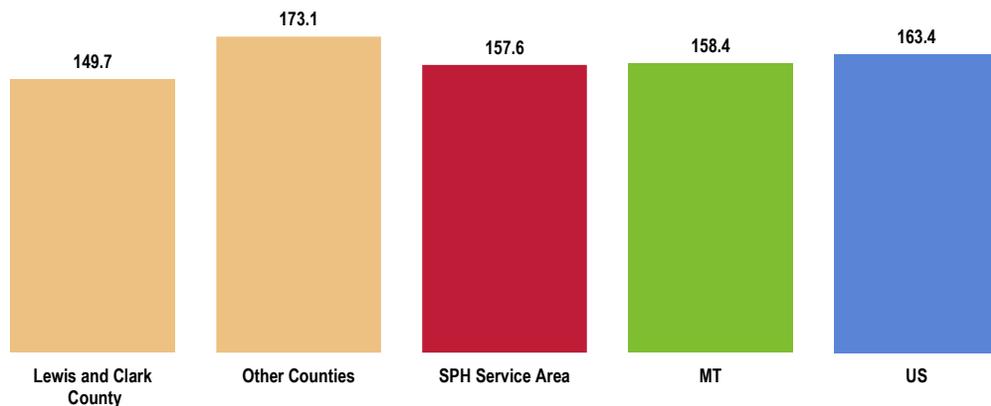
**Between 2017 and 2019, there was an annual average age-adjusted heart disease mortality rate of 157.6 deaths per 100,000 population in the SPH Service Area.**

**BENCHMARK** ▶ Fails to satisfy the Healthy People 2030 objective.

**DISPARITY** ▶ Lower in Lewis and Clark County.

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

**Heart Disease: Age-Adjusted Mortality**  
(2017-2019 Annual Average Deaths per 100,000 Population)  
Healthy People 2030 = 127.4 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 May 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: 

- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Heart Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2030 = 127.4 or Lower (Adjusted)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SPH Service Area	152.5	147.6	138.8	136.9	138.6	153.5	155.7	157.6
MT	154.0	154.1	151.0	152.6	152.7	155.1	157.5	158.4
US	191.6	188.5	169.1	168.4	167.0	166.3	164.7	163.4

Sources: 

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: 

- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

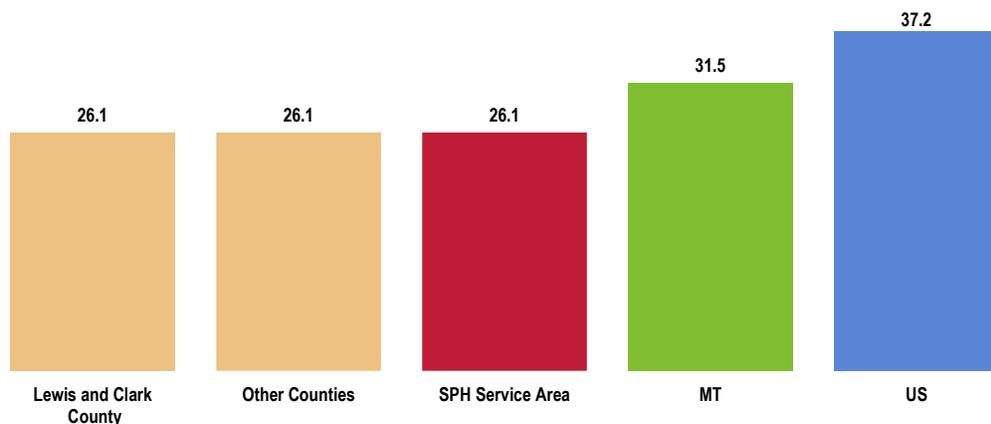
## Stroke Deaths

**Between 2017 and 2019, there was an annual average age-adjusted stroke mortality rate of 26.1 deaths per 100,000 population in the SPH Service Area.**

**BENCHMARK** ► Well below the state and US rates. Satisfies the Healthy People 2030 objective.

**TREND** ► Overall decreasing in recent years.

## Stroke: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population) Healthy People 2030 = 33.4 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 May 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

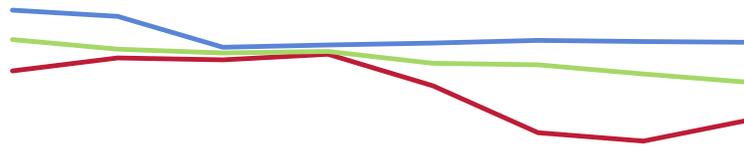
: 

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



## Stroke: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SPH Service Area	33.1	35.0	34.7	35.5	31.0	24.3	23.1	26.1
MT	37.6	36.2	35.7	35.9	34.2	34.0	32.7	31.5
US	41.8	40.9	36.5	36.8	37.1	37.5	37.3	37.2

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

## Prevalence of Heart Disease & Stroke

### Prevalence of Heart Disease

**A total of 3.6% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.**

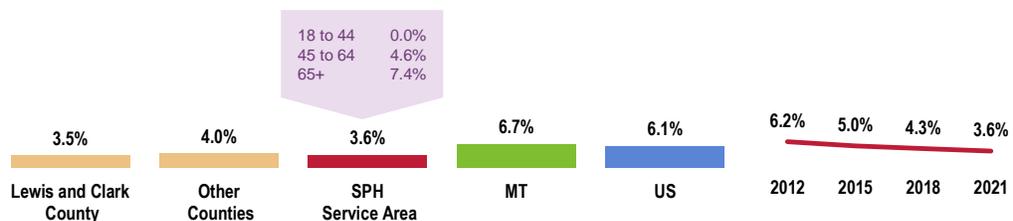
**BENCHMARK** ► Lower than the Montana and US percentages.

**TREND** ► The decrease over time is not yet statistically significant.

**DISPARITY** ► Increases with age among survey respondents.

### Prevalence of Heart Disease

SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 114]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.  
• 2020 PRC National Health Survey, PRC, 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.



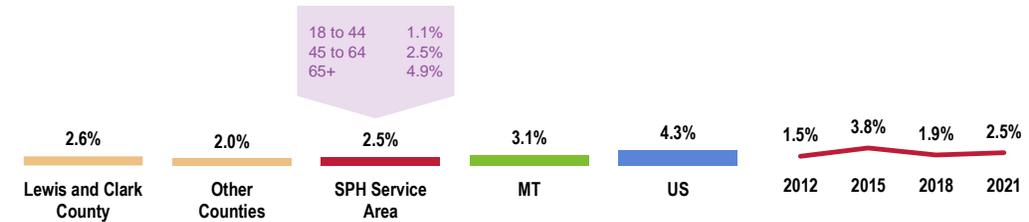
## Prevalence of Stroke

A total of 2.5% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

DISPARITY ► Increases with age among service area adults.

### Prevalence of Stroke

SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 29]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Montana data.  
 • 2020 PRC National Health Survey, PRC, Inc.

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

## Cardiovascular Risk Factors

### Blood Pressure & Cholesterol

A total of 35.7% of SPH Service Area adults have been told by a health professional at some point that their **blood pressure** was high.

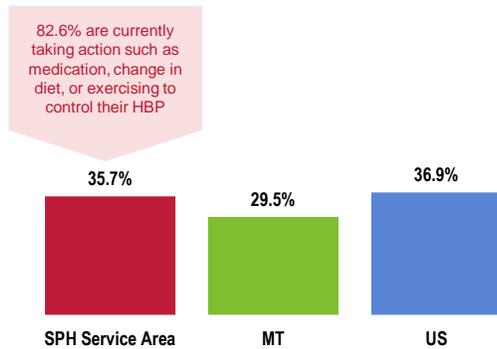
BENCHMARK ► Higher than the state prevalence. Fails to satisfy the Healthy People 2030 objective.

A total of 33.1% of adults have been diagnosed with **high cholesterol levels**.

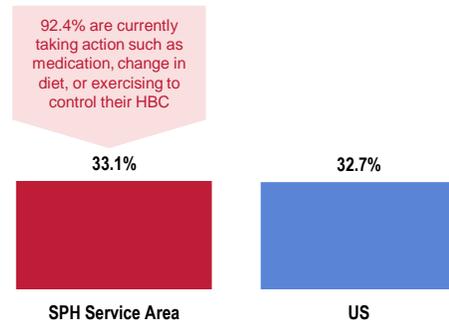


## Prevalence of High Blood Pressure

Healthy People 2030 = 27.7% or Lower



## Prevalence of High Blood Cholesterol

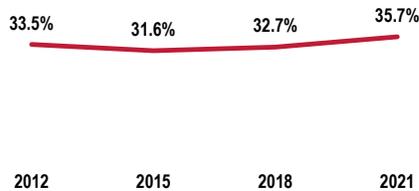


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 35-36, 306, 308]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

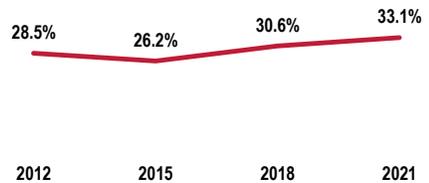
Notes: • Asked of all respondents.

## Prevalence of High Blood Pressure (SPH Service Area)

Healthy People 2030 = 27.4% or Lower



## Prevalence of High Blood Cholesterol (SPH Service Area)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 35-36]  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

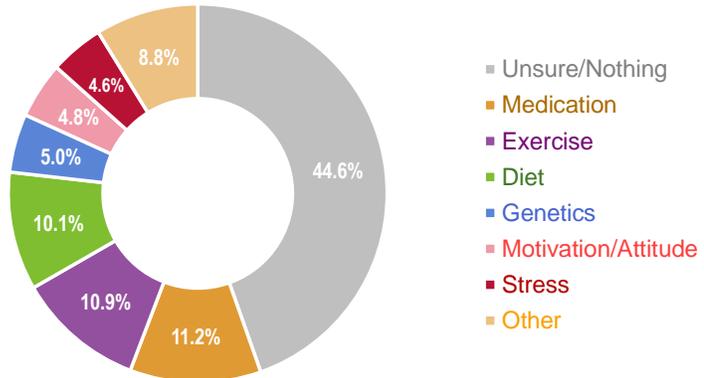
Notes: • Asked of all respondents.



## Barriers to Managing High Blood Pressure and Cholesterol

Asked to report on the greatest barrier to managing their high blood pressure numbers, the most comment responses among adults with high blood pressure related to medication, exercise, and diet.

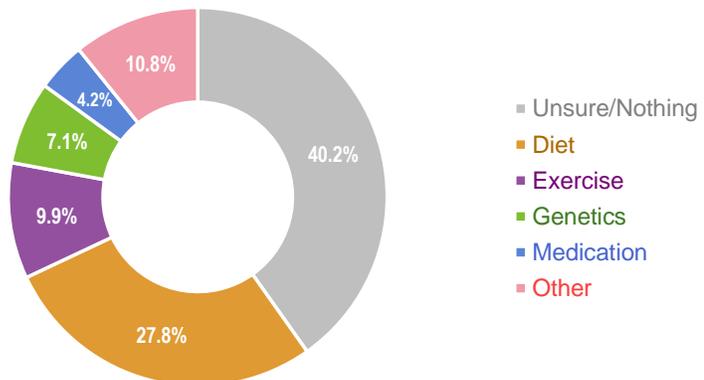
**Greatest Barrier in Taking Action to Control High Blood Pressure**  
(Adults Who Have Been Diagnosed With High Blood Pressure, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 307]  
Notes: • Asked of those respondents who have been diagnosed with high blood pressure.

Those with high blood cholesterol levels were most likely to report difficulties with diet, followed distantly by references to exercise, genetics, and medication issues.

**Greatest Barrier in Taking Action to Control High Blood Cholesterol**  
(Adults Who Have Been Diagnosed With High Blood Pressure, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 309]  
Notes: • Asked of those respondents who have been diagnosed with high blood pressure.



## Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

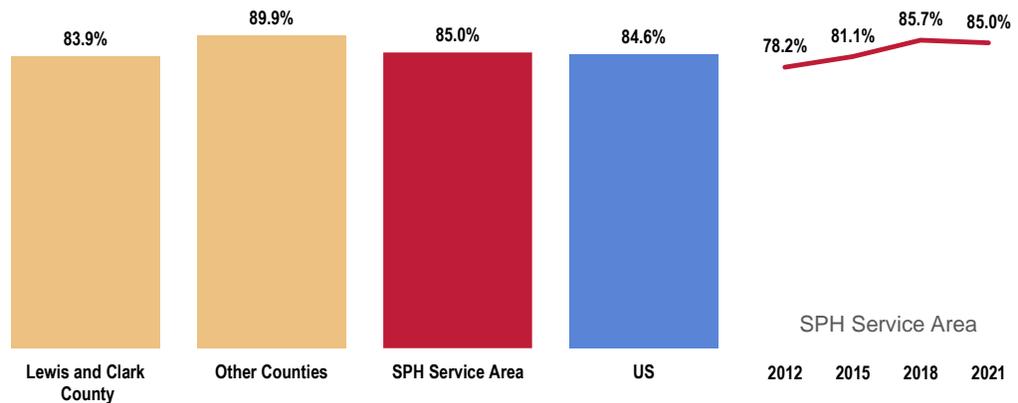
**A total of 85.0% of SPH Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.**

**TREND** ▶ Denotes a statistically significant increase since 2012 (steady since 2018).

**DISPARITY** ▶ Reported more often among male respondents.

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

### Present One or More Cardiovascular Risks or Behaviors

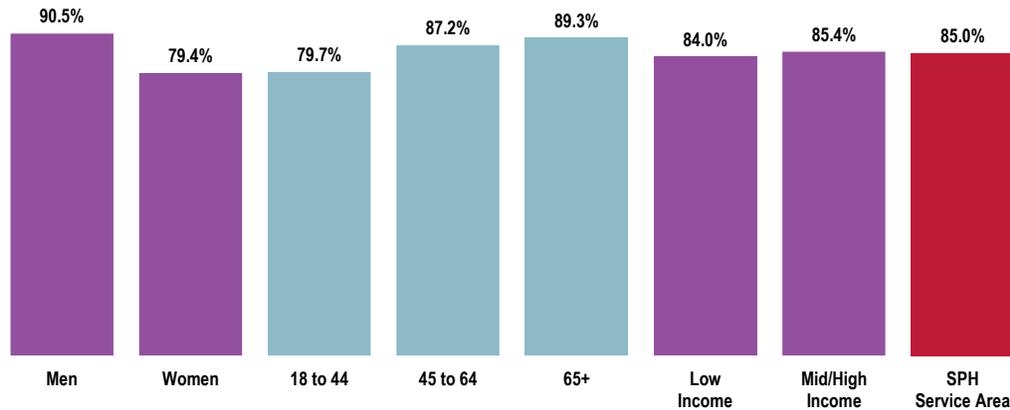


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 115]  
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Reflects 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) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.  
• "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Present One or More Cardiovascular Risks or Behaviors (SPH Service Area, 2021)

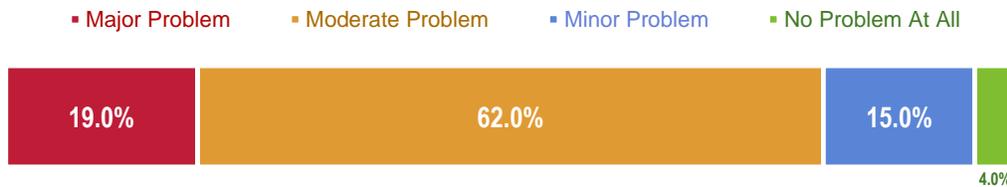


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 115]  
 Notes: • Reflects all respondents.  
 • Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

## Key Informant Input: Heart Disease & Stroke

The greatest share of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a “moderate problem” in the community.

### Perceptions of Heart Disease and Stroke as a Problem in the Community (Key Informants, 2021)



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

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

#### Leading Cause of Death

It is the second most common reason for death in Montana. People are not taking care of their bodies. Most people are overweight. Social exercise seems scary to people because they feel like they are too out of shape and won't fit in. – Social Services Provider

These are the number one cause of death. – Physician

#### Incidence/Prevalence

I feel like I'm seeing an increasing amount of younger people who are having strokes, and as people age I see heart disease as a limiting factor for overall health and wellbeing. – Other Health Provider

It is in every community. – Other Health Provider

Currently the prevalence of this preventable disease is high in our community. – Public Health Representative



## Access to Care/Services

Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also the quality of support seems to be reduced for medical services due to COVID concerns. – Social Services Provider

Again, a problem that is not widely understood. Particularly for prevention especially if you do not have access to a regular health care provider. – Community Leader

## Contributing Factors

Lack of built in healthy environment. – Social Services Provider

Lack of exercise, family history. – Community Leader

## Awareness/Education

So many people have heart disease. Need more education, opportunities for affordable programs to encourage weight loss, activity, etc. to decrease heart disease. – Public Health Representative



# CANCER

## ABOUT CANCER

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

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

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

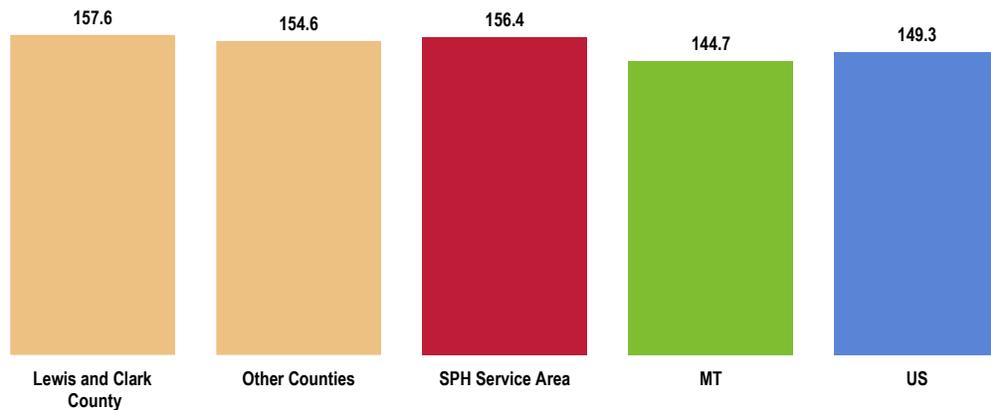
## Age-Adjusted Cancer Deaths

### All Cancer Deaths

**Between 2017 and 2019, there was an annual average age-adjusted cancer mortality rate of 156.4 deaths per 100,000 population in the SPH Service Area.**

**BENCHMARK** ▶ Far from satisfying the Healthy People 2030 objective.

**Cancer: Age-Adjusted Mortality**  
(2017-2019 Annual Average Deaths per 100,000 Population)  
Healthy People 2030 = 122.7 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 May 2021.

• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Note: • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Cancer: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 122.7 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SPH Service Area	167.2	157.4	154.3	163.2	158.6	154.9	152.9	156.4
MT	160.3	158.0	155.2	155.8	153.0	151.8	146.4	144.7
US	174.8	171.6	163.6	161.0	158.5	155.6	152.5	149.3

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

## Cancer Deaths by Site

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

Other leading sites include prostate cancer, colorectal cancer (both sexes), and female breast cancer.

### BENCHMARK

Lung Cancer ► Higher than the Montana rate. Fails to satisfy the Healthy People 2030 objective.

Prostate Cancer ► Higher than the US rate. Fails to satisfy the Healthy People 2030 objective.

Colorectal Cancer ► Higher than both state and national rates. Fails to satisfy the Healthy People 2030 objective.

Female Breast Cancer ► Lower than both state and national rates.

## Age-Adjusted Cancer Death Rates by Site (2017-2019 Annual Average Deaths per 100,000 Population)

	SPH Service Area	MT	US	HP2030
<b>ALL CANCERS</b>	<b>156.4</b>	<b>144.7</b>	<b>149.3</b>	<b>122.7</b>
<b>Lung Cancer</b>	<b>37.9</b>	<b>30.4</b>	<b>34.9</b>	<b>25.1</b>
<b>Prostate Cancer</b>	<b>22.7</b>	<b>22.0</b>	<b>18.6</b>	<b>16.9</b>
<b>Colorectal Cancer</b>	<b>16.1</b>	<b>12.5</b>	<b>13.4</b>	<b>8.9</b>
<b>Female Breast Cancer</b>	<b>15.7</b>	<b>18.3</b>	<b>19.7</b>	<b>15.3</b>

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.

• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Note: • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



# Cancer Incidence

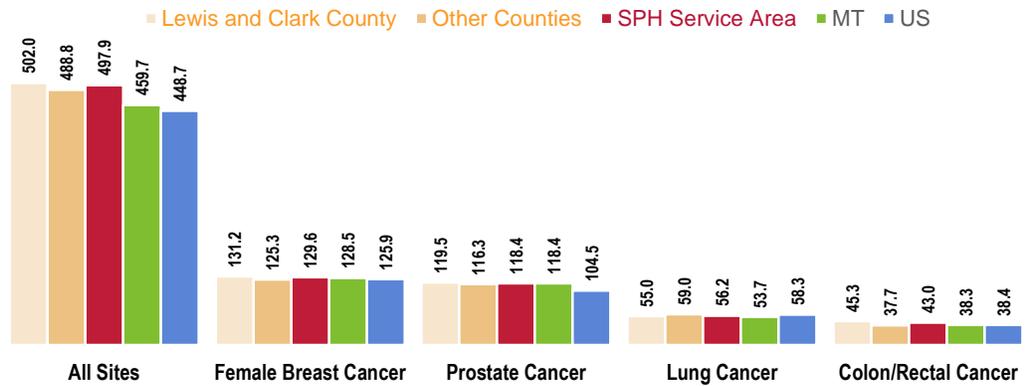
“Incidence rate” or “case rate” is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

**The highest cancer incidence rates are for female breast cancer and prostate cancer.**

**BENCHMARK** ▶ Service area rates for each site are similar to Montana and US benchmarks.

**DISPARITY** ▶ The colorectal cancer incidence rate is higher in Lewis and Clark County.

**Cancer Incidence Rates by Site**  
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2013-2017)



- Sources:
- State Cancer Profiles.
  - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).
- Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.
  - “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



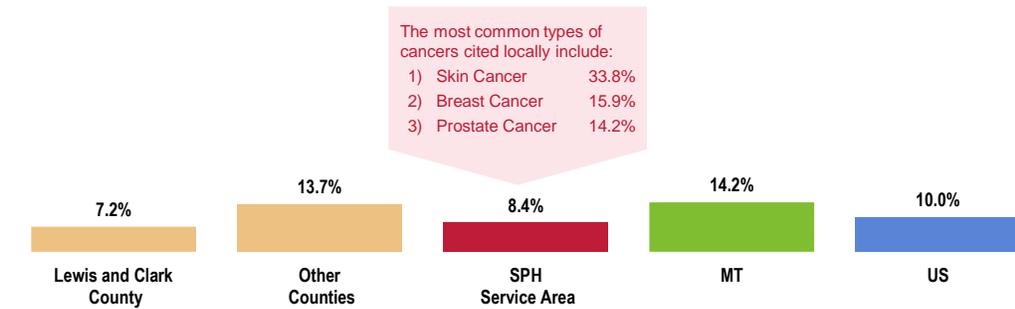
# Prevalence of Cancer

A total of 8.4% of surveyed SPH Service Area adults report having ever been diagnosed with cancer. The most common types include skin cancer, breast cancer, and prostate cancer.

**BENCHMARK** ▶ Well below the statewide prevalence.

**DISPARITY** ▶ Increases with age and is reported more often among women in the service area.

## Prevalence of Cancer



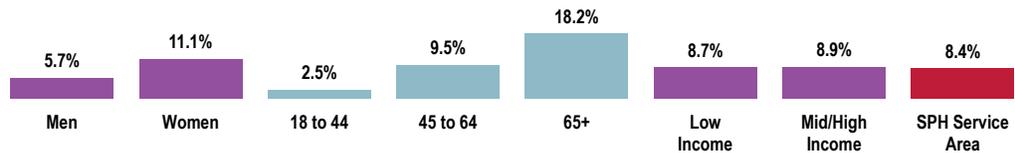
The most common types of cancers cited locally include:

- 1) Skin Cancer 33.8%
- 2) Breast Cancer 15.9%
- 3) Prostate Cancer 14.2%

Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 25-26]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.  
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Reflects all respondents.  
 • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Prevalence of Cancer (SPH Service Area, 2021)



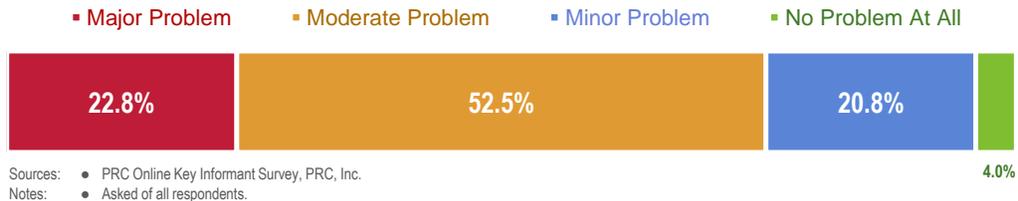
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 25]  
 Notes: • Reflects all respondents.



# 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, 2021)



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

### Incidence/Prevalence

- Many of my friends who practice regular health care are experiencing some form of cancer. So far I have not, but will I? – Community Leader
- I believe that cancer is a major problem in any community. – Social Services Provider
- Many cancer clusters within the state. – Other Health Provider
- Having cancer is the major problem. We have outstanding delivery of care for cancer patients. Access to specialty care is adequate. It still may be in a patient’s best interest, when warranted, to travel to a cancer center that deals with thousands of cancer cases. – Other Health Provider
- I have many family members and friends that have had various types of cancer and treatment has been hard to get in Helena. My sister-in-law is at the Mayo Clinic in Rochester now getting treatment. – Community Leader
- Cancer on the rise and St. Peters not treating people right. – Community Leader

### Access to Care/Services

- Helena lacks a facility that is focused on cancer prevention, diagnosis, treatment, and consultation services comprised by a team of specialists whose goal is to treat individuals holistically. The very vocal community response to the loss of one of our physicians was nothing if not symptomatic of the absence of such a service. Given the region’s aging demographics and ever-increasing risk factors, it is irresponsible to expect folks to travel to Missoula, Great Falls, etc., to ensure competent treatment. – Community Leader
- The major disruption at the hospital with the former lead physician at the Cancer Center has seemed to cause a lot of disruption in cancer care in our community. – Social Services Provider
- Uncertainty of treatment center and community discontent around that situation. – Physician
- No plan or coordination for oncology in Helena. SPH has completely dismantled what shortage of care existed without a plan for expand services, in the middle of a global pandemic. Oncology needs to have a stronger focus, with dedicated physicians, understanding and knowing their patients. If not them, hopefully a healthcare provider comes in with a plan to treat these people. – Community Leader

### Lack of Providers

- Current lack of permanent oncologist. Lack of training in primary care regarding survivorship. – Physician
- Loss of one of our oncologist at St. Peter’s Health. – Social Services Provider
- Staffing of oncologist. – Public Health Representative

### Continuity of Care

- Due to all of the staffing changes and lack of continuity of care for the cancer center patients. – Social Services Provider

### Prevention/Screenings

- Limited screening and treatment. – Other Health Provider



# RESPIRATORY DISEASE

## ABOUT RESPIRATORY DISEASE

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

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

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

## Age-Adjusted Respiratory Disease Deaths

### Chronic Lower Respiratory Disease Deaths (CLRD)

Between 2017 and 2019, there was an annual average age-adjusted CLRD mortality rate of 57.4 deaths per 100,000 population in the SPH Service Area.

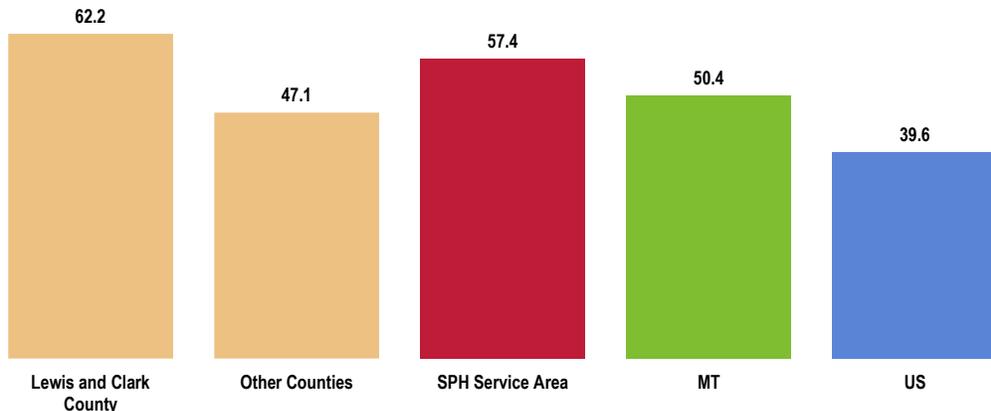
**BENCHMARK** ▶ Worse than the US rate.

**TREND** ▶ Increasing in recent years, following a decreasing trend in the area.

**DISPARITY** ▶ Much higher in Lewis and Clark County than the Other Counties.

Note: Chronic lower respiratory disease (CLRD) includes lung diseases such as emphysema, chronic bronchitis, and asthma.

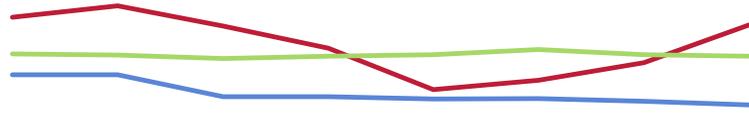
CLRD: Age-Adjusted Mortality  
(2017-2019 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.  
Notes: • CLRD is chronic lower respiratory disease.  
: • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## CLRD: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SPH Service Area	59.1	61.6	57.1	52.2	43.0	45.1	49.0	57.4
MT	50.9	50.7	49.9	50.4	50.8	51.9	50.8	50.4
US	46.3	46.3	41.4	41.4	40.9	41.0	40.4	39.6

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.  
Notes: • CLRD is chronic lower respiratory disease.

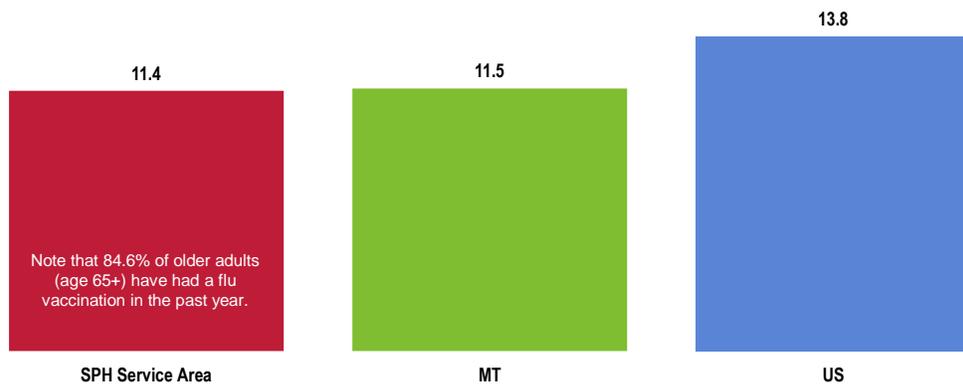
## Pneumonia/Influenza Deaths

**Between 2017 and 2019, the SPH Service Area reported an annual average age-adjusted pneumonia influenza mortality rate of 11.4 deaths per 100,000 population.**

**BENCHMARK** ► Lower than the national rate.

**TREND** ► No clear trend is apparent in the service area; rates have decreased in Montana and the US in recent years.

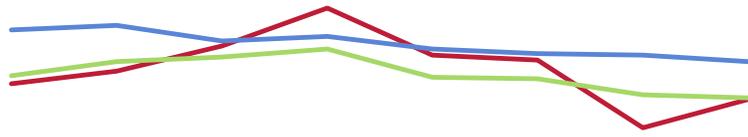
## Pneumonia/Influenza: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.  
• 2021 PRC Community Health Survey, PRC, Inc. [Item 323]  
Note: • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Pneumonia/Influenza: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— SPH Service Area	12.4	13.2	14.8	17.2	14.2	13.9	9.6	11.4
— MT	12.9	13.8	14.1	14.6	12.8	12.7	11.7	11.5
— US	15.8	16.1	15.1	15.4	14.6	14.3	14.2	13.8

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.



# Prevalence of Respiratory Disease

## Asthma

### Adults

**A total of 15.1% of SPH Service Area adults have been diagnosed with asthma as an adult.**

**DISPARITY** ▶ Reported more often among women and respondents in low-income households.

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

### Prevalence of Asthma

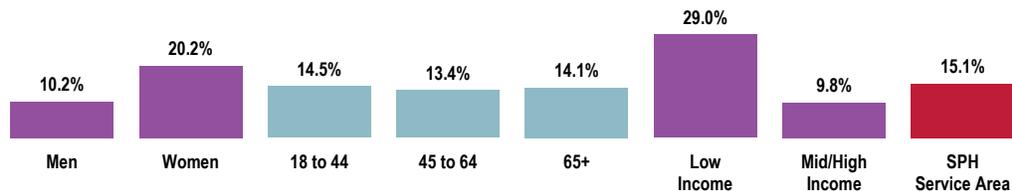
SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, 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); 2019 Montana data.  
 • 2020 PRC National Health Survey, PRC, Inc.

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

### Prevalence of Asthma (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 30]  
 Notes: • Asked of all respondents.  
 • Includes those who have ever been diagnosed with asthma and report that they still have asthma.

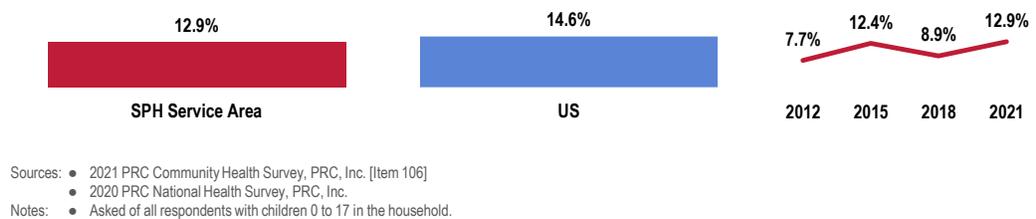


## Children

Among SPH Service Area children under age 18, 12.9% currently have been diagnosed with asthma.

### Current Asthma in Children (Parents of Children Age 0-17)

SPH Service Area



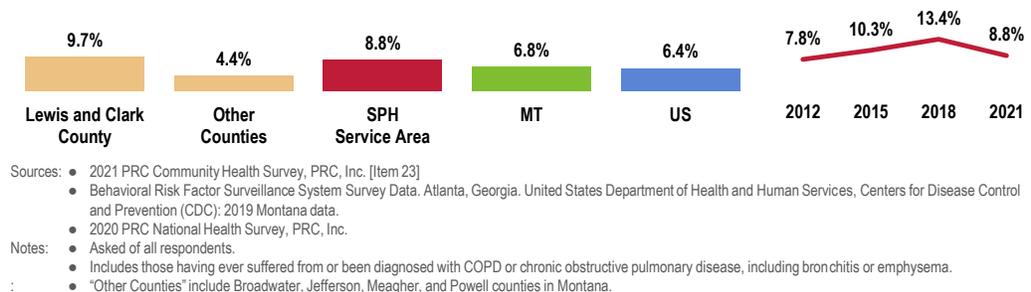
## Chronic Obstructive Pulmonary Disease (COPD)

A total of 8.8% of SPH Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

**TREND** ► Down from what had been an increasing prevalence in the service area.

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

SPH Service Area



Note: COPD includes lung diseases such as emphysema and chronic bronchitis.



# Wood-Burning Stoves

## Stove Prevalence

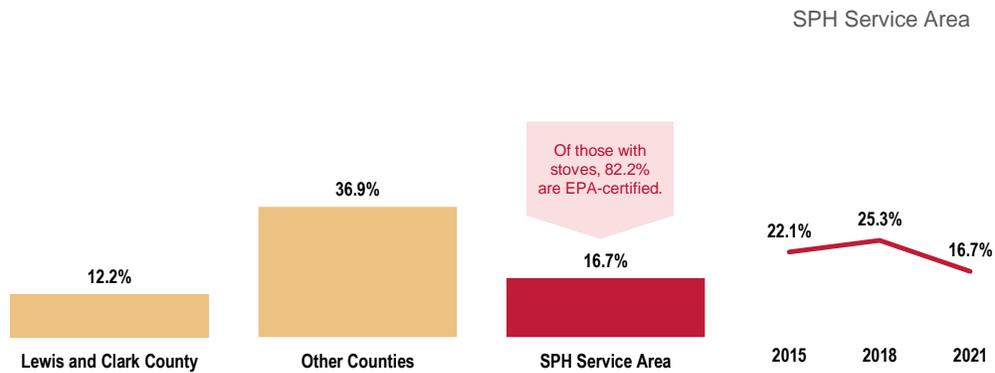
**A total of 16.7% of service area adults use a wood-burning stove to heat their homes; respondents with stoves report that 82.2% of these stoves are EPA-certified.**

**DISPARITY** ▶ The prevalence of wood-burning heat sources is considerably higher outside Lewis and Clark County. Reported more often among low-income respondents and those age 45 and older.

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).

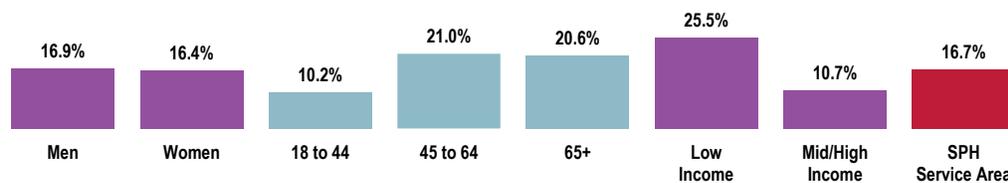
These microscopic particles can get into your eyes and respiratory system, where they can cause health problems such as burning eyes, runny nose, and illnesses such as bronchitis. In addition to particle pollution, wood smoke contains several toxic air pollutants, including benzene, formaldehyde, acrolein, and ethane (EPA).

### Use a Wood-Burning Stove to Heat the Home



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 313-314]  
 Notes: ● Asked of all respondents.  
 : ● "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

### Use a Wood-Burning Stove to Heat the Home (SPH Service Area, 2021)



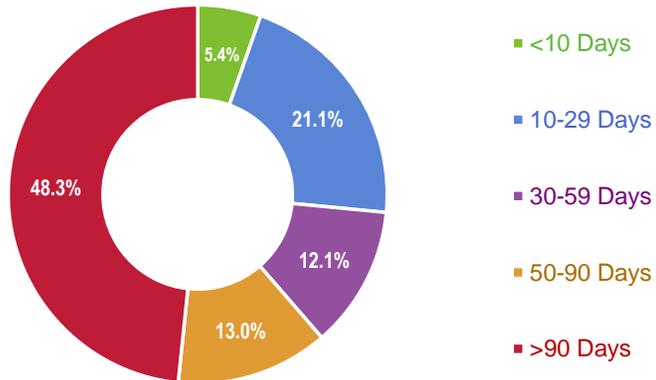
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 313]  
 Notes: ● Asked of all respondents.



## Frequency of Stove Use

Among survey respondents who use wood-burning stoves to heat their homes, 48.3% used the stove more than 90 days in the past year.

### Frequency of Wood-Burning Stove Use in the Past Year (Respondents With Wood-Burning Stoves, 2021)

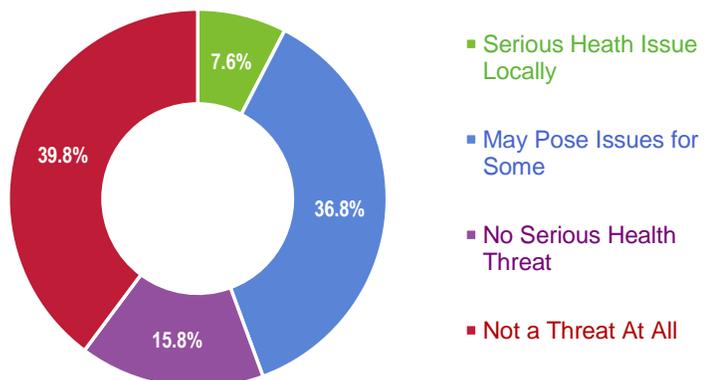


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 315]  
Notes: • Asked of those respondents who have a wood-burning stove.

## Perceptions of Wood Smoke

While most respondents do not think wood smoke is a serious health issue for community members, a total of 44.4% consider wood smoke to be a serious health issue locally.

### Opinion of Wood Smoke as a Serious Health Issue (SPH Service Area, 2021)



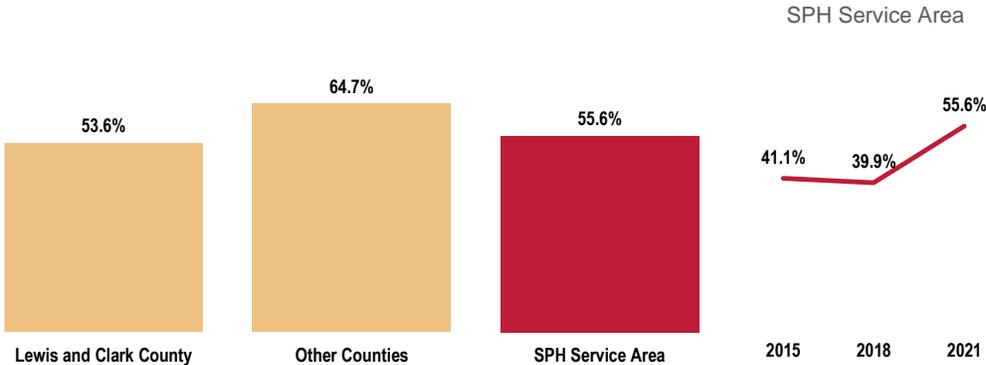
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 316]  
Notes: • Asked of all respondents.



TREND ► Denotes a significant increase from previous survey administrations.

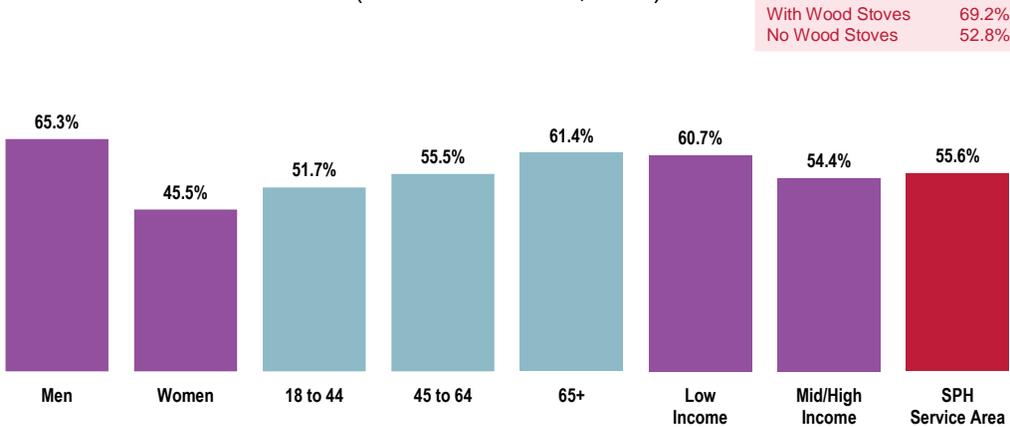
DISPARITY ► Reported more often among men in the service area.

### Do Not Think Wood Smoke Poses a Serious Heath Issue



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 316]  
 Notes: • Asked of all respondents.  
 : • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

### Do Not Think Wood Smoke Poses a Serious Heath Issue (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 316]  
 Notes: • Asked of all respondents.



# 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, 2021)



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

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

### Environmental Contributors

- Population with increasing diagnoses of respiratory diseases. Patterns of unhealthy air quality caused by drought, dust/allergens, and wildfires. Continued high use of tobacco products and vaping, and possibly even weed. – Community Leader
- Wood smoke during winter inversions and summer forest fires. – Public Health Representative

### Vulnerable Populations

- I observe that respiratory problems are noticeable particularly among lower-income households. Children and young people have asthma, and then adults with obvious breathing issues—COPD etc.—using oxygen. Frequently the respiratory disease is related to smoking or occupational disease or both. – Social Services Provider

### Access to Care/Services

- Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also, the quality of support seems to be reduced for medical services due to COVID concerns. – Social Services Provider

### Incidence/Prevalence

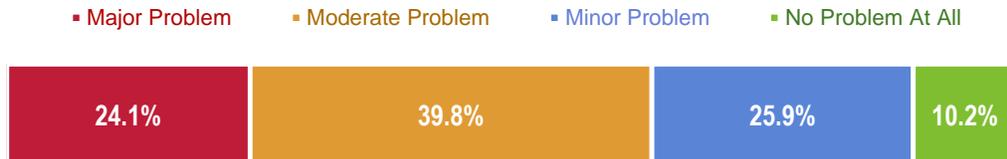
- Hearsay and seniors coming into the Senior Center on oxygen. – Social Services Provider



# Key Informant Input: Coronavirus Disease/COVID-19

The greatest share of key informants taking part in an online survey characterized *Coronavirus Disease/COVID-19* as a “moderate problem” in the community.

## Perceptions of Coronavirus Disease/COVID-19 as a Problem in the Community (Key Informants, 2021)



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

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

### Lack of Mask Compliance

Infection rate and challenges to compliance to local health mandates. – Social Services Provider

Many people in our community do not believe it is a real risk and they do not take it seriously. It is a concern that variants will continue to cause harm in our community because people refuse to take safety precautions. – Social Services Provider

Lack of masking. Also, it seems that all the people who want to be immunized are, so I believe we'll continue to have coronavirus problem in our community for some time to come. – Other Health Provider

I believe this is still an ongoing concern/issue and that our community is divided based on the protocols. Increased mental health concerns are showing up and school-age children are being overlooked. – Social Services Provider

Citizens that do not vaccinated or do other activities to avoid the spread of this disease and do not respect at risk members of the community. – Other Health Provider

For the past year, 90% of the population (roughly 360 folks) have not worn masks except in school or county buildings. We just had a few COVID mobile clinics and less than 1/2 of the population received COVID vaccine. It has been underreported here because many folks do not want to share any information with any government agency. – Public Health Representative

Community members are loosening their personal safety measures. – Public Health Representative

### Cultural/Personal Beliefs Around Vaccination

Currently there is some resistance to getting vaccinated. – Physician

People don't trust the science. – Other Health Provider

One major issue facing our community is large number of anti-vax proponents spreading misinformation. We had severe bed shortages in our hospital during the winter months and while we have seen many older adult adhering to masking and vaccine recommendation, many younger and middle-age adults are not. Since the emerging variants seem to convey worse disease in younger individuals this lack of belief and/or adherence to recommendations places the entire community at risk as we know there is likely a decline in immunity over time even with immunization. – Physician

We have a strong anti-tax, anti-science culture. – Community Leader

### Education/Awareness

The LCC Health Department has done a fantastic job doing the best they can to manage it. But many people have relied on anything besides truth and science to destroy the good that has been done. – Community Leader

Lack of health knowledge by the general public. By this I mean the fact that so many people don't understand health issues or are uninformed. For instance, some of the things people said and believed about COVID-19.

The fact that people don't know the difference between the county health department and the state health department. The fact that people don't know what is available and how health systems work together. – Public Health Representative



There are limitations to what public health can do to keep the community safe. State government and public opinion has made local regulations unenforceable. Vaccine hesitancy is preventing us from getting to a place that will protect the community. – Public Health Representative

### Incidence/Prevalence

Without question this virus has been a major problem over the past year, due to the impact on the healthcare system, the illnesses suffered by many and the impact of death. While cases are lessening, the problems associated are not over. One thing extending the potential continuance of this as a problem is the high level of vaccine reluctance and resistance in our communities. – Social Services Provider

It is a major problem in every community. Our community, unlike some in Montana, has embraced masking, social distancing and hand washing. We need to continue to be diligent. – Other Health Provider

Novel illness that is killing people. – Physician

### Access to Care/Services

Many rural communities and access to health, as well as lack of education. – Other Health Provider

There is protocol other states do with people who have Covid and the people do not have to be hospitalized to get meds and treatment. People in this state need access immediately to inhalers, and the other medications that help people infected with Covid to get through it easier when not in the hospital. – Other Health Provider

### Impact on Quality of Life

It is unknown the long-term impacts of COVID-19, but the immediate impact from physical illness, to isolation, substance use, and mental well-being have been catastrophic. – Other Health Provider



# INJURY & VIOLENCE

## ABOUT INJURY & VIOLENCE

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

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

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

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

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

## Unintentional Injury

### Age-Adjusted Unintentional Injury Deaths

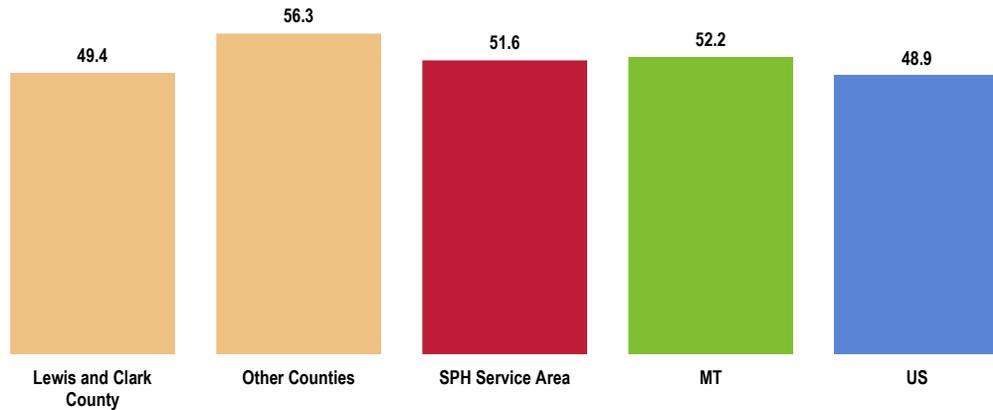
**Between 2017 and 2019, there was an annual average age-adjusted unintentional injury mortality rate of 51.6 deaths per 100,000 population in the SPH Service Area.**

**BENCHMARK** ► Fails to satisfy the Healthy People 2030 objective.



## Unintentional Injuries: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 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 May 2021.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Note: • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Unintentional Injuries: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SPH Service Area	56.7	57.6	53.7	57.0	59.5	60.9	55.3	51.6
MT	54.3	55.8	54.4	55.5	54.3	53.5	51.8	52.2
US	41.2	41.7	39.7	41.0	43.7	46.7	48.3	48.9

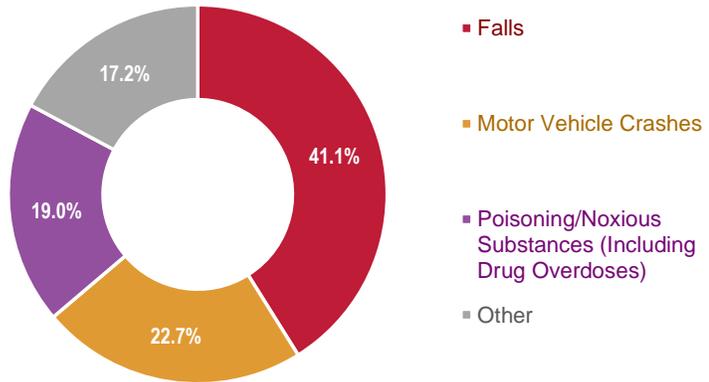
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>



## Leading Causes of Unintentional Injury Deaths

Falls, motor vehicle crashes, and poisoning (including unintentional drug overdose) accounted for most unintentional injury deaths in the service area between 2017 and 2019.

Leading Causes of Unintentional Injury Deaths  
(SPH Service Area, 2017-2019)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.

### Falls

#### ABOUT FALLS

Falls are the leading cause of fatal and nonfatal injuries for persons aged  $\geq 65$  years .... 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.

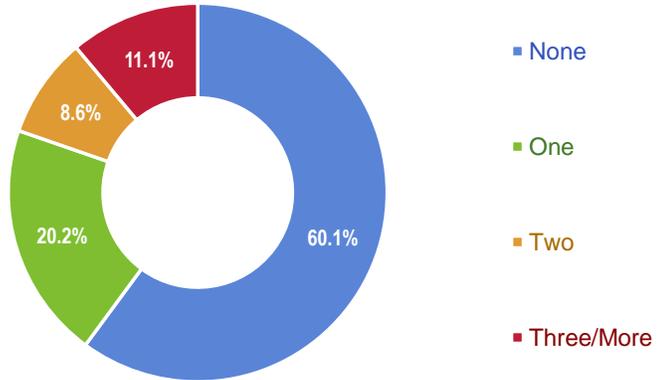
Modifiable fall risk factors include muscle weakness, gait and balance problems, poor vision, use of psychoactive medications, and home hazards. Falls among older adults can be reduced through evidence-based fall-prevention programs that address these modifiable risk factors. Most effective interventions 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, most have not fallen in the past year.

Number of Falls in Past 12 Months  
(Adults Age 45 and Older; SPH Service Area, 2021)

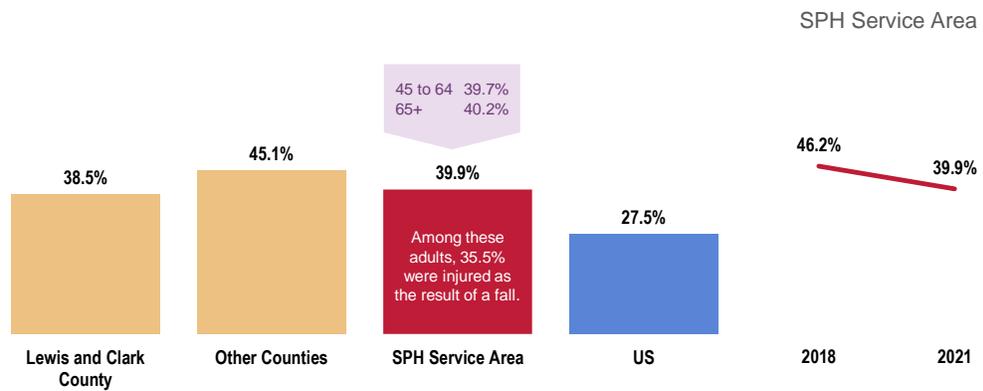


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 334]  
Notes: • Asked of all respondents age 45+.

However, 39.9% have experienced a fall at least once in the past year.

**BENCHMARK** ► Well above the national prevalence.

Fell One or More Times in the Past Year  
(Adults Age 45 and Older)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 334-335]  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of those respondents age 45 and older.  
: • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Helmet Use

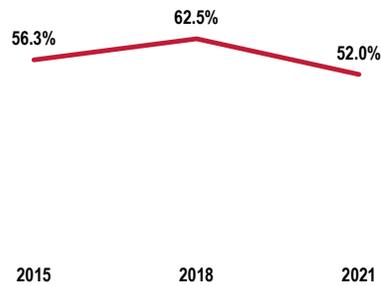
Among respondents who rode a **motorcycle** in the past year, 52.0% “always” wore a helmet when doing so.

TREND ► Statistically unchanged over time.

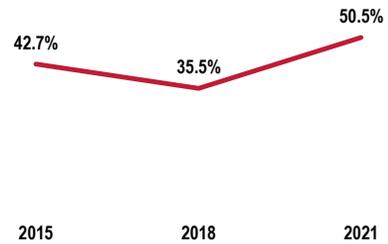
Among adults who rode a **bicycle** in the past year, 50.5% “always” wore a helmet.

TREND ► A statistically significant increase from 2018 survey findings (similar to 2015).

“Always” Wore a Motorcycle Helmet in the Past Year  
(SPH Adults Who Ride Motorcycles)



“Always” Wore a Bicycle Helmet in the Past Year  
(SPH Adults Who Ride Bicycles)



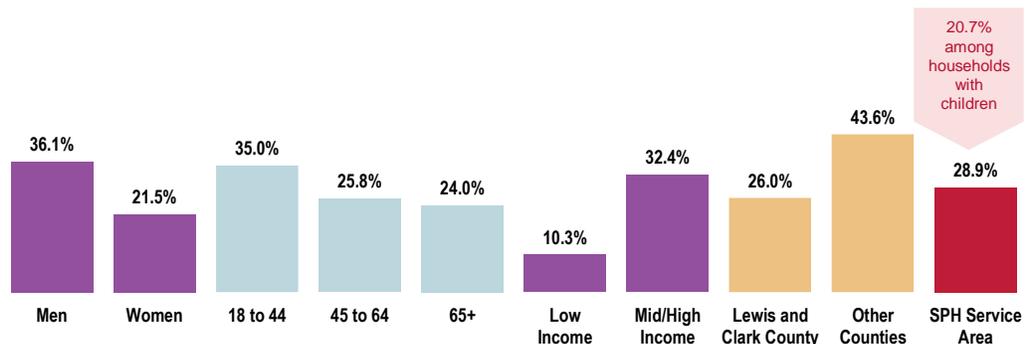
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 310-311]  
Notes: • Asked of those respondents who rode motorcycles and/or bicycles in the past year.

## Firearms

Among area adults, 28.9% have an unlocked, loaded gun or firearm in or around the home.

DISPARITY ► Much higher outside Lewis and Clark County. Reported more often among men, young adults, and respondents in higher-income households.

### Have an Unlocked/Loaded Firearm Kept in or Around the Home



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 312]  
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

In the SPH Service Area, there were 3.2 homicides per 100,000 population (2017-2019 annual average age-adjusted rate).

**BENCHMARK** ► Lower than the US rate and satisfies the Healthy People 2030 objective.

**RELATED ISSUE**  
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

**Homicide: Age-Adjusted Mortality**  
(2010-2019 Annual Average Deaths per 100,000 Population)  
Healthy People 2030 = 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 May 2021.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

## Violent Crime

### Violent Crime Rates

Between 2015 and 2017, the service area reported 438.7 violent crimes per 100,000 population.

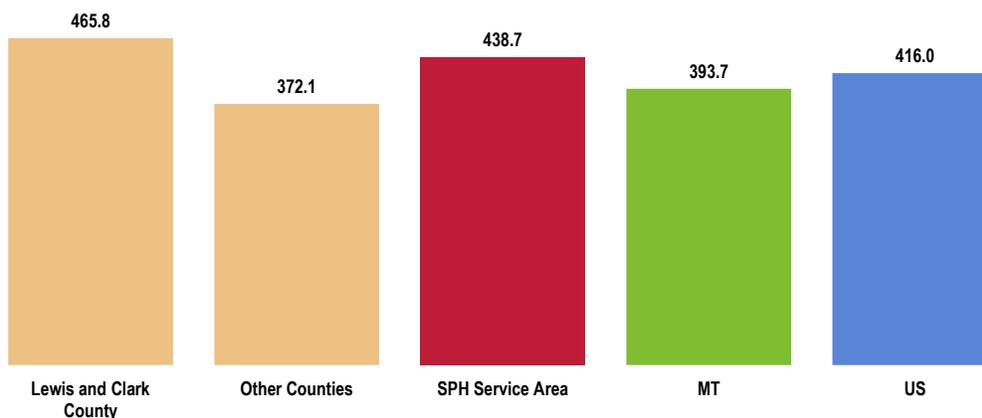
**DISPARITY** ► Unfavorably high in Lewis and Clark County.

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.



## Violent Crime (Rate per 100,000 Population, 2015-2017)



Sources: 

- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).

Notes: 

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

## Community Violence

**Just less than one percent of surveyed SPH Service Area adults acknowledges being the victim of a violent crime in the area in the past five years.**

**BENCHMARK** ► Dramatically lower than the national percentage.

**TREND** ► The decrease over time is not yet significant.

## Victim of a Violent Crime in the Past Five Years

SPH Service Area



Sources: 

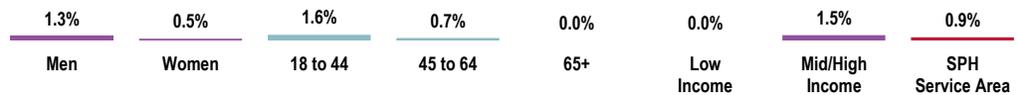
- 2021 PRC Community Health Survey, PRC, Inc. [Item 38]
- 2020 PRC National Health Survey, PRC, Inc.

Notes: 

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



## Victim of a Violent Crime in the Past Five Years (SPH Service Area, 2021)



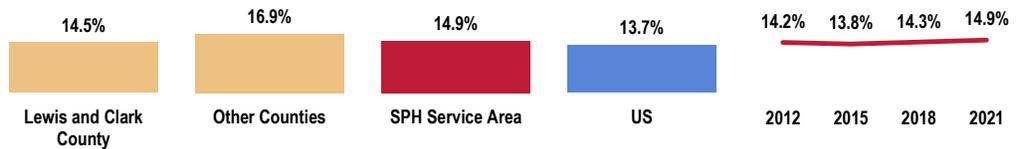
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 38]  
 Notes: • Asked of all respondents.

### Family Violence

**A total of 14.9% of SPH Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.**

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

SPH Service Area



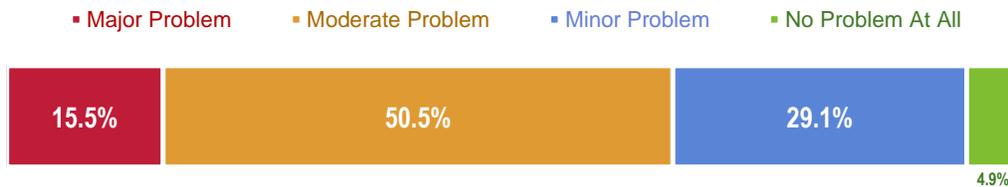
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 39]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 : • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



# Key Informant Input: Injury & Violence

Half 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, 2021)



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

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

### Injury

Violence is a longstanding issue. I have friends who work with domestic violence. Many people don't see it because it tends to be pretty invisible to many. Injury is a broader issue. We have lots of roads, high speed limits and a high rate of motor vehicle accidents. In addition, we have lots of guns and a suicide problem. – Community Leader

Domestic violence, rape is rarely talked about but affects over 20% of ant population. One of the leading causes of death for teens is alcohol related car crashes. A leading cause of death for kids is injury. – Other Health Provider

Suicide is a leading cause of death in MT. Also, a good deal of domestic violence in the area. COVID-19 has exacerbated that situation. – Public Health Representative

Traumatic brain injuries. Lack of treatment/housing opportunities. Lack of awareness regarding the injury. – Social Services Provider

Ranch/farm accidents. Also, a huge recreational area where folks get injured. We have domestic violence incidences too. Bar fights can happen also with alcohol the driving force. There is a cultural mentality that 'boys will be boys' about fighting. – Public Health Representative

### Incidence/Prevalence

Law enforcement statistics and our statistics, as well as state and national statistics indicate this is a major problem. Our clients encounter numerous barriers and we see many offenders emboldened as time goes on. – Social Services Provider

We manage an emergency solutions grant for homeless and nearly homeless people. The actual work is carried out by Good Samaritan Ministries, but I hear the stories of violence. My son is also a deputy sheriff and I hear stories there, too. – Social Services Provider

It is in every community. – Other Health Provider

### Domestic Violence

Rates of domestic violence has continued to increase, including calls for services; law enforcement. – Social Services Provider

Some form of domestic violence continues to be a challenge in this community. – Community Leader

### Contributing Factors

Judges, lawyers, and law enforcement not understanding the psychology of family violence. Continued practice of blaming the victim of domestic assaults instead of holding the abuser accountable. Children having no rights inside the child welfare system. Lack of safe, affordable housing contributes to the victimization of people living at no or low income and people with mental illness. – Social Services Provider



## Access to Care/Services

Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also the quality of support seems to be reduced for medical services due to COVID concerns. At times it can take months to get appointments or complete the process to take care of the issue or injury. – Social Services Provider

## Gun Safety

Lack of gun safety. We have such a backwards notion of the 2nd amendment that we forget to protect people by securing guns properly. Countries with fewer guns have less gun violence. – Physician



# DIABETES

## ABOUT DIABETES

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

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

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

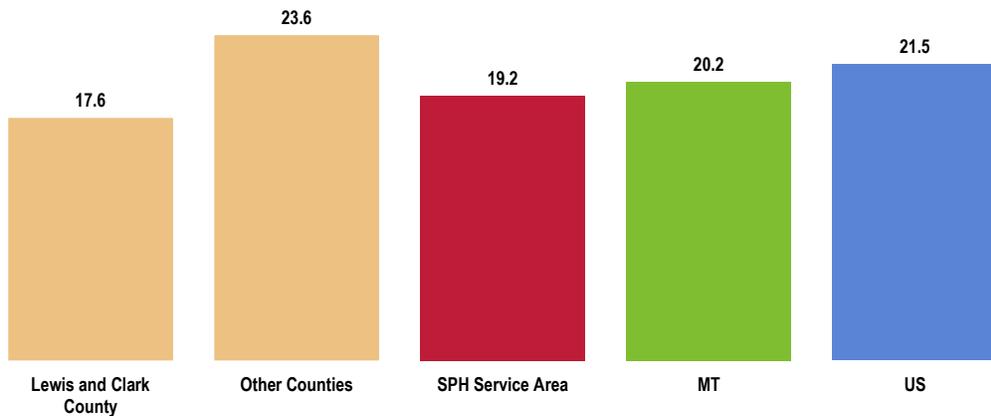
## Age-Adjusted Diabetes Deaths

**Between 2017 and 2019, there was an annual average age-adjusted diabetes mortality rate of 19.2 deaths per 100,000 population in the SPH Service Area.**

**TREND** ▶ Increasing in recent years.

**DISPARITY** ▶ Higher outside Lewis and Clark County.

**Diabetes: Age-Adjusted Mortality**  
(2017-2019 Annual Average Deaths per 100,000 Population)

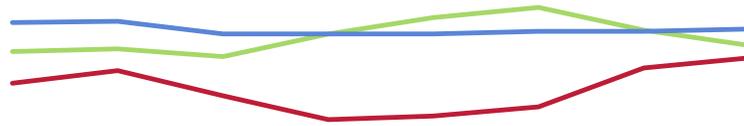


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.

Note: • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Diabetes: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SPH Service Area	17.2	18.2	16.2	14.3	14.6	15.3	18.4	19.2
MT	19.7	19.9	19.3	21.1	22.4	23.2	21.4	20.2
US	22	22.1	21.1	21.1	21.1	21.3	21.3	21.5

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.

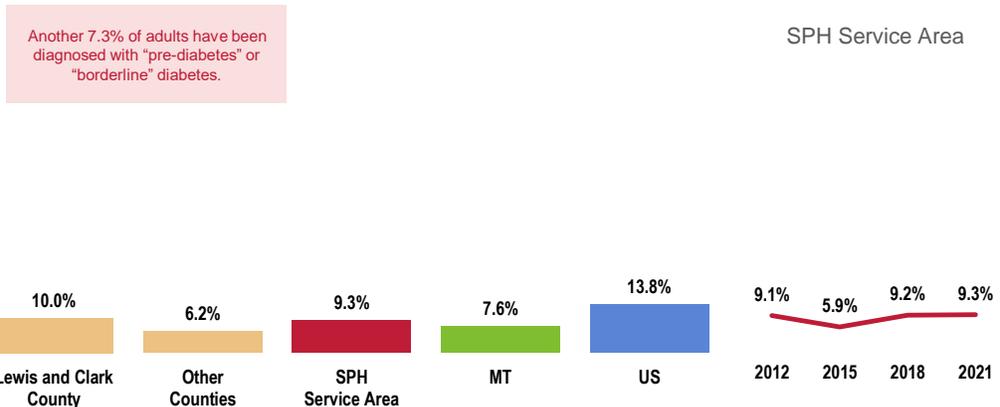
## Prevalence of Diabetes

**A total of 9.3% of SPH Service Area adults report having been diagnosed with diabetes.**

**BENCHMARK** ▶ Lower than the US figure.

**DISPARITY** ▶ Prevalence of diabetes among survey respondents was reported solely among those age 45 and older.

## Prevalence of Diabetes



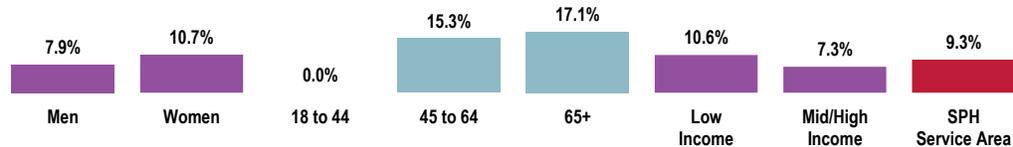
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 121]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.  
 • 2020 PRC National Health Survey, PRC, Inc.

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



## Prevalence of Diabetes (SPH Service Area, 2021)

Note that among adults who have not been diagnosed with diabetes, 44.3% report having had their blood sugar level tested within the past three years.

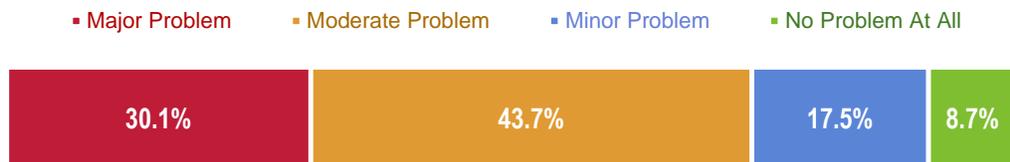


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 33, 121]  
 Notes: • Asked of all respondents.  
 • Excludes gestational diabetes (occurring only during pregnancy).

## Key Informant Input: Diabetes

A high percentage 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, 2021)



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

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

### Contributing Factors

The diabetes and obesity epidemic somewhat speaks for itself. The community is fatter and less healthy. There are few programs to help and those programs have limited capacity. Many insurance providers do not cover nutrition education or weight loss programs. – Physician

Prevention of diabetes is the biggest problem. Lifestyle issues and diet lead to an epidemic of diabetes leading to shorter lives with less quality. The proliferation of cheap, good tasting poor quality food and lack of exercise made worse by screen addiction (TV, video games, and devices) contribute to this. – Physician

Fitness can be an issue, unless you are able to handle a lot of hills. In addition, we can have some deep dark winters here. There isn't a facility that is free to community members for fitness. We are a bit behind the times with our nutrition information. While we have a pre-diabetes and diabetes prevention program, it really doesn't touch a lot of people. We need more. – Community Leader

Diabetes seems to be a health issue in our community that contributes to other health conditions. – Social Services Provider



Prevention and continuous management when there's an overall lack of nutrition education in K-12 schools, and lack of support and promotion for healthy eating and physical activity. – Social Services Provider

Lifestyle and behavioral change. Diet, healthy food, and exercise. – Physician

Healthy food and too many fast food/junk food options. – Community Leader

Diet, obesity, exercise, and medical compliance. – Physician

Being able to afford healthy food choices. No programs for exercise in the community nor an inside exercise facility. Getting adequate medical services. – Public Health Representative

Low cost exercise facilities. No cooking classes or programs to foster healthy eating. Individual dietary counseling for those at risk; no insurance coverage for seeing dietician. Need more programs to support general health and well being (ie free exercise classes, cooking classes, education) to focus on healthy lifestyle and disease prevention. – Physician

## Awareness/Education

Lack of education and community health outreach. – Other Health Provider

(Not necessarily in order) 1. Education about the diseases and how to self-monitor/treat/cope with consequences. 2. Access to affordable care and necessary interventions (insulin, monitors, etc.) 3. Preventive care and intervention.....working with young people and families to affect behavioral changes that may prevent disease development. – Community Leader

Lack of understanding and awareness of the disease. – Community Leader

Access to education and support for healthy diet and lifestyle choices. – Social Services Provider

Lack of systemic support around lifestyle changes needed to successfully manage diabetes or to promote health/wellness to prevent diabetes in the first place. – Other Health Provider

Diabetes education and awareness, helping patients understand why diabetes is a big deal to keep well controlled to prevent long term sequelae, coaching to help with lifestyle modification. Primary care does a good job with teaching and medications, but they need more resources for the social/lifestyle aspects of diabetes management. – Physician

Education and change in lifestyle habits. – Other Health Provider

Knowing how to or agreeing to correctly care for their diabetes when they really don't want to. – Social Services Provider

## Affordable Medications/Supplies

Medication is the biggest challenge---Insulin for Insulin dependent diabetics is not a "want", it is a necessity to survive. Insurances choose which medications/insulin brands they will approve. Some other brands may work for people, and prevent complications/hospitalizations, but they can't afford them because they aren't approved by their health insurance. – Public Health Representative

Cost of medication. – Physician

Access to affordable insulin support programs for changing dietary habits. – Public Health Representative

## Prevention/Screenings

Diabetes is often preventable. Obesity is often a precursor to diabetes. Poor diet is often a precursor to obesity. People with limited financial resources will buy food that gives them the most calories for the buck, which normally does not meet the range of nutritional requirements for optimum health. Again, diabetes and obesity are symptoms of greater social issues that must be considered. these issues must be tackled from various social perspectives. Education is always a good thing, however, a medical focus on prevention is key - especially for folks insured through any kind of universal healthcare system. Also, offering low-income people with nutritious alternatives to food pantry staples should be a priority. Healthy foods should be accessible for all members of the community - Community Leader

## Access to Care/Services

Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also, the quality of support seems to be reduced for medical services due to COVID concerns. – Social Services Provider

Access to medical and dental care, educational opportunities to learn about the damaging effects of chronic inflammation and the ability to control diabetes. – Other Health Provider



# KIDNEY DISEASE

## ABOUT KIDNEY DISEASE

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

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

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

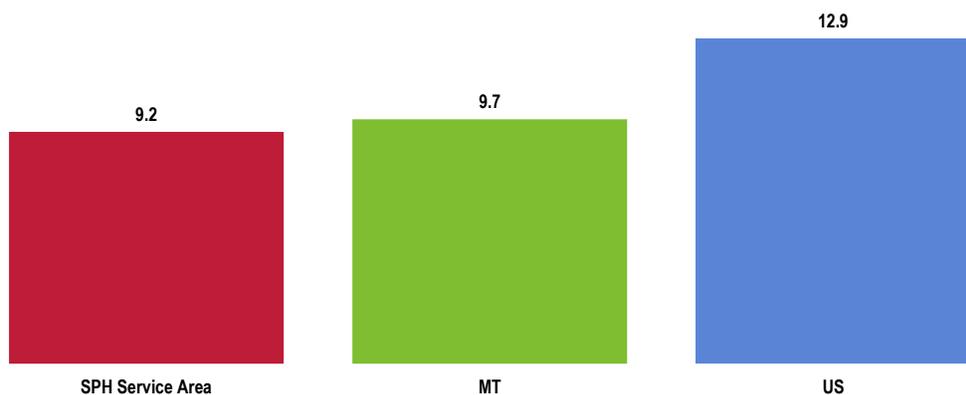
## Age-Adjusted Kidney Disease Deaths

**Between 2017 and 2019, there was an annual average age-adjusted kidney disease mortality rate of 9.2 deaths per 100,000 population in the SPH Service Area.**

**BENCHMARK** ▶ Lower than the US rate.

**TREND** ▶ Kidney disease mortality is increasing in the service area.

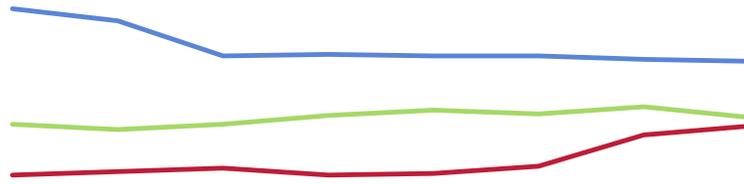
**Kidney Disease: Age-Adjusted Mortality**  
(2017-2019 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.



## Kidney Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SPH Service Area	6.4		6.8	6.4	6.5	6.9	8.7	9.2
MT	9.3	9.0	9.3	9.8	10.1	9.9	10.3	9.7
US	15.9	15.2	13.2	13.3	13.2	13.2	13.0	12.9

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.

## Key Informant Input: Kidney Disease

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, 2021)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



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

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

#### Access to Care/Services

Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also, the quality of support seems to be reduced for medical services due to COVID concerns. – Social Services Provider

Lack of local care. – Social Services Provider

#### Impact on Caregivers/Families

It impacts my family. My spouse has had two transplants. – Other Health Provider



# POTENTIALLY DISABLING CONDITIONS

## Multiple Chronic Conditions

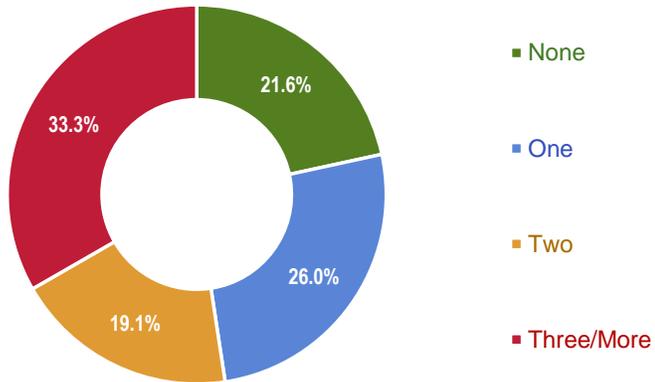
For the purposes of this assessment, chronic conditions include:

- Arthritis
- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Osteoporosis
- Sciatica
- Stroke

Multiple chronic conditions are concurrent conditions.

Among SPH Service Area survey respondents, most report currently having at least one chronic health condition.

Number of Current Chronic Conditions  
(SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 123]

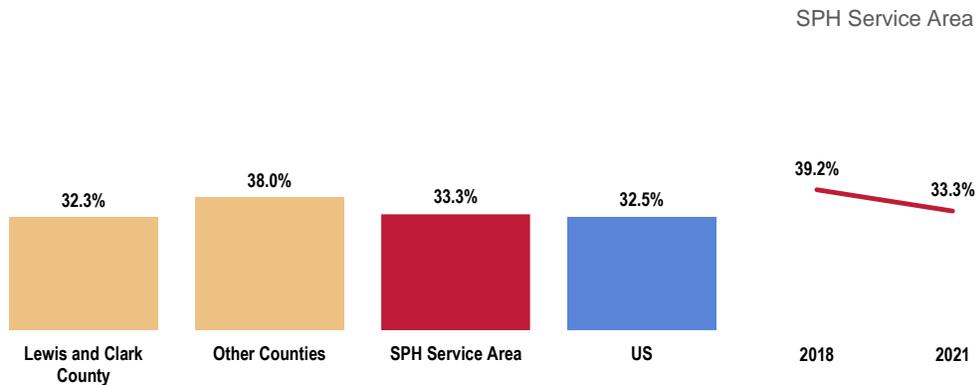
Notes: • Asked of all respondents.

• In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

In fact, one in three (33.3%) area adults reports having three or more chronic conditions.

**DISPARITY** ► Reported more often among women, adults age 45 and older, and respondents in low-income households.

## Currently Have Three or More Chronic Conditions



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 123]

• 2020 PRC National Health Survey, PRC, Inc.

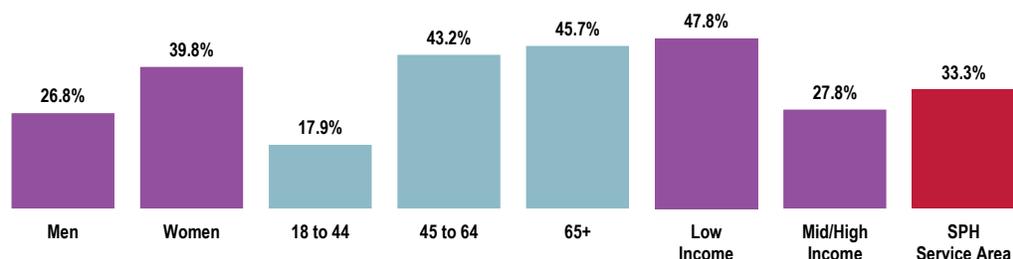
Notes: • Asked of all respondents.

• In this case, chronic conditions include lung disease, cancer, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, chronic pain, and/or diagnosed depression.

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



## Currently Have Three or More Chronic Conditions (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 123]  
 Notes: • Asked of all respondents.  
 • In this case, chronic conditions include lung disease, cancer, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, chronic pain, and/or diagnosed depression.

## Activity Limitations

### ABOUT DISABILITY & HEALTH

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

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

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

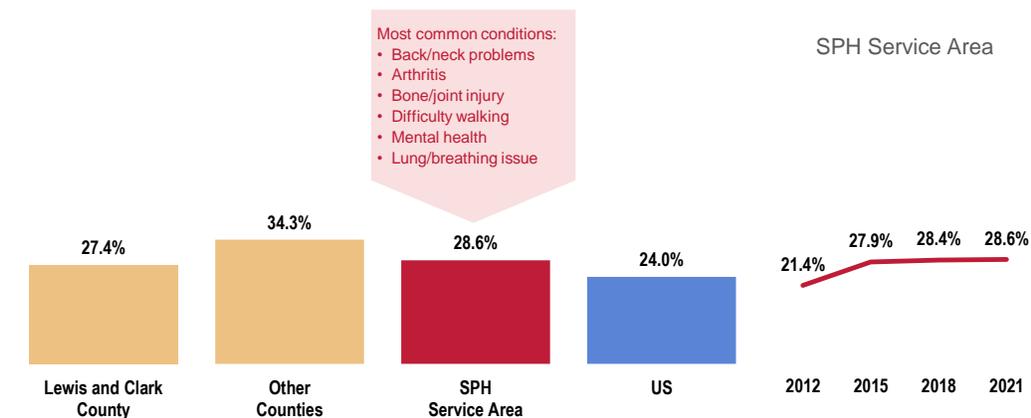
**A total of 28.6% of SPH Service Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.**

**TREND** ► Higher than 2012 survey findings but similar to subsequent administrations.

**DISPARITY** ► Reported more often among women, adults age 45+, and low-income residents.

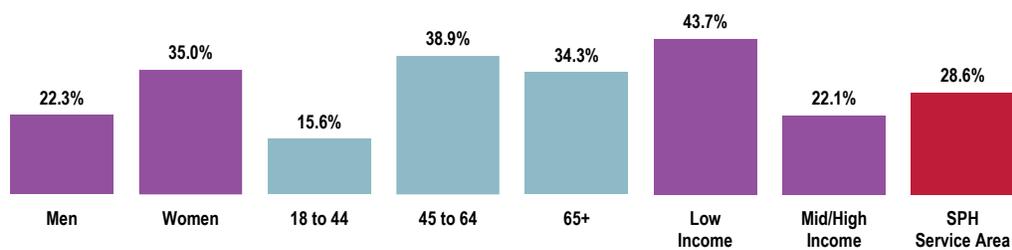


## Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 96-97]  
 ● 2020 PRC National Health Survey, PRC, Inc.  
 Notes: ● Asked of all respondents.  
 : ● "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (SPH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 96]  
 Notes: ● Asked of all respondents.



# Chronic Pain

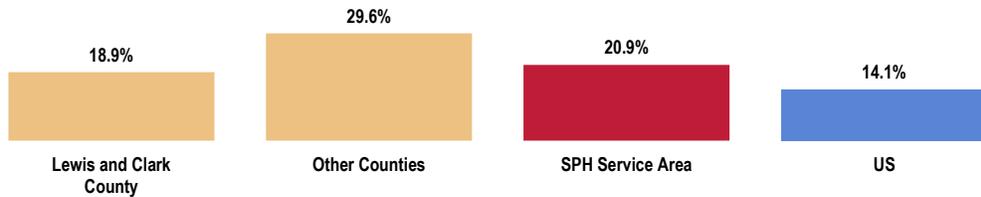
A total of 20.9% of SPH Service Area adults experience high-impact chronic pain, meaning physical pain that has limited their life or work activities “every day” or “most days” during the past six months.

**BENCHMARK** ▶ Much higher than the US prevalence and three times the Healthy People 2030 objective.

**DISPARITY** ▶ Much higher outside Lewis and Clark County. Higher among women, adults age 45 to 64, and those in low-income households.

## Experience High-Impact Chronic Pain

Healthy People 2030 = 7.0% or Lower



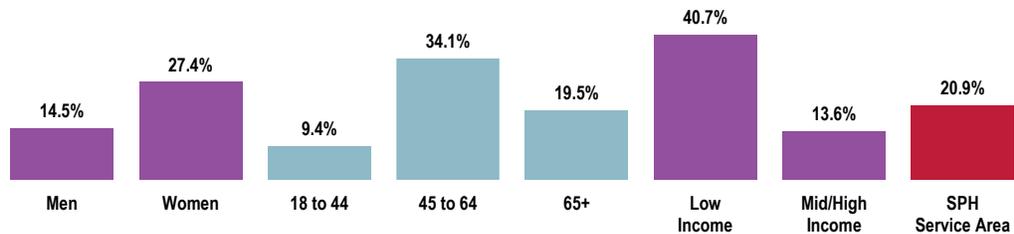
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 37]  
 ● 2020 PRC National Health Survey, PRC, Inc.  
 ● US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: ● Asked of all respondents.  
 ● High-impact chronic pain includes physical pain that limits life or work activities on “most days” or “every day” of the past six months.  
 ● “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Experience High-Impact Chronic Pain

(SPH Service Area, 2021)

Healthy People 2030 = 7.0% or Lower



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 37]  
 ● 2020 PRC National Health Survey, PRC, Inc.  
 ● US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

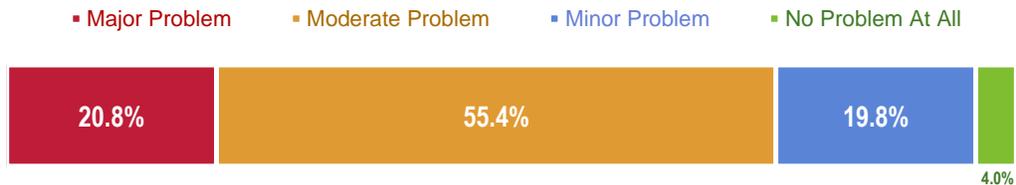
Notes: ● Asked of all respondents.  
 ● High-impact chronic pain includes physical pain that limits life or work activities on “most days” or “every day” of the past six months.



## Key Informant Input: Disability & Chronic Pain

Over half of key informants taking part in an online survey characterized *Disability & Chronic Pain* as a “moderate problem” in the community.

### Perceptions of Disability & Chronic Pain as a Problem in the Community (Key Informants, 2021)



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

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

#### Access to Care/Services

We have limited resources or access to specialty providers for pain and occupational medicine. – Physician

We do not have a chronic pain team or access to a wheelchair team. Finding a person to do seating for wheelchairs is difficult. Our city is not well equipped for people who use wheelchairs. – Physician

No comprehensive pain management program. Physical therapy is expensive and copays prevent barriers to getting proven care. Expensive to go to health club or pool. No insurance coverage for acupuncture, massage, or alternative methods for chronic pain reduction. Not enough counselors providing cognitive behavioral therapy for pain management or lack of training in this area. – Physician

Insufficient avenues of care for management of chronic pain. These patients need continuity of care and for the more complex patients, they need a pain management specialist in addition to primary care. There simply are not enough chronic pain providers in town, and turnover in care causes these individuals to seek care elsewhere (ie the ER and with new PCP’s), creating a disjointed care plan and in general, furthering opioid prescribing. – Physician

Few good strategies for supporting people with chronic pain. – Other Health Provider

#### Diagnosis/Treatment

Again I hear people with chronic pain say the only options they are offered is pills. They would like to receive and learn other ways to deal with chronic pain. – Other Health Provider

Chronic pain leading to substance misuse. – Social Services Provider

Difficulty to get adequate pain management due to the fear of addiction. – Public Health Representative

A substantial number of clients we serve complain of chronic pain and the inability to treat it consistently. – Social Services Provider

#### Lack of Providers

Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also, the quality of support seems to be reduced for medical services due to COVID concerns. – Social Services Provider

Lack of providers within the state. – Other Health Provider

There are not enough doctors to go around. – Social Services Provider

#### Built Environment

As we turn more into an aging community, our built environment and systems are not as equipped to handle disability and chronic pain. There is more that we can do in our community to support these groups and increase livability. – Public Health Representative



## Awareness/Education

I think overall health promotion could go a long way here. I feel that people are not empowered to live their fullest life with disability and chronic pain, and then have more disability. Related or chronic pain impacted diminished functioning as they age. – Other Health Provider

## Contributing Factors

Our community is not very accessible; our public transit system is not rider friendly; our school district's special education program is not inclusive; and we have an opioid crisis partially due to over prescribing of pain medications instead of alternative ways of living with pain - Social Services Provider

# Arthritis, Osteoporosis & Chronic Back Conditions

**A total of 39.5% of SPH Service Area adults age 50 and older report suffering from arthritis or rheumatism.**

**TREND** ▶ Increasing significantly from 2012 survey findings (similar to subsequent survey results).

**A total of 16.2% of SPH Service Area adults age 50 and older have osteoporosis.**

**BENCHMARK** ▶ Worse than the US prevalence and three times the Healthy People 2030 objective.

**TREND** ▶ Marks a statistically significant increase since 2012.

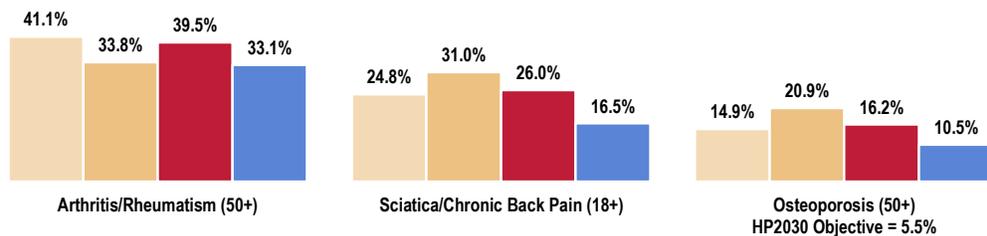
**A total of 26.0% of SPH Service Area adults (18 and older) suffer from chronic back pain or sciatica.**

**BENCHMARK** ▶ Well above the national percentage.

## Prevalence of Potentially Disabling Conditions

Healthy People 2030 = 5.5% or Lower (Osteoporosis)

■ Lewis and Clark County ■ Other Counties ■ SPH Service Area ■ US



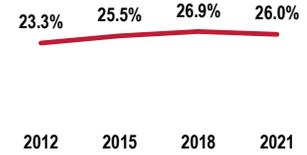
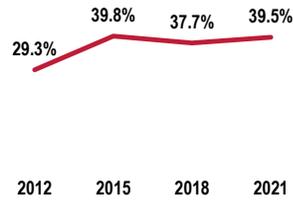
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 304, 347-348]  
● 2020 PRC National Health Survey, PRC, Inc.  
● US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>  
Notes: ● The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.  
: ● "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



**Arthritis/Rheumatism**  
(Adults Age 50+)

**Osteoporosis**  
(Adults Age 50+)  
Healthy People 2030 = 5.5% or Lower

**Sciatica/Chronic Back Pain**  
(All Adults Age 18+)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 302-304]  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>  
Notes: • Each indicator is shown among the age group specified.



# Alzheimer's Disease

## ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.<sup>1</sup> Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

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

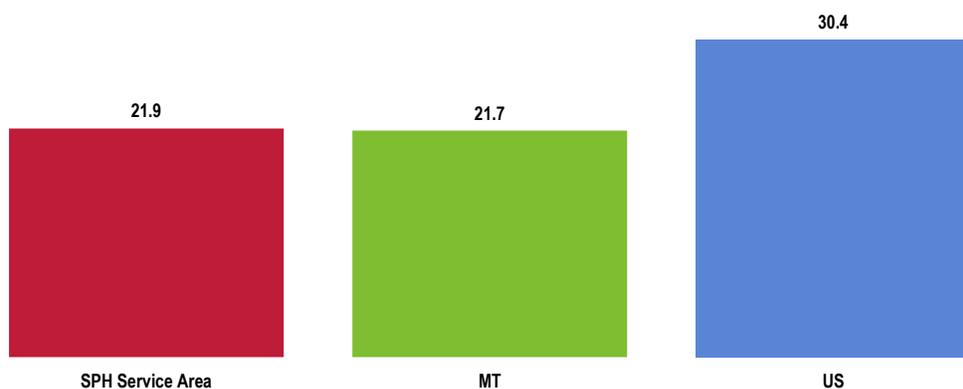
## Age-Adjusted Alzheimer's Disease Deaths

**Between 2017 and 2019, there was an annual average age-adjusted Alzheimer's disease mortality rate of 21.9 deaths per 100,000 population in the SPH Service Area.**

**BENCHMARK** ▶ Lower than the US mortality rate.

**TREND** ▶ The local rate has leveled off after increasing for years, echoing the national trend.

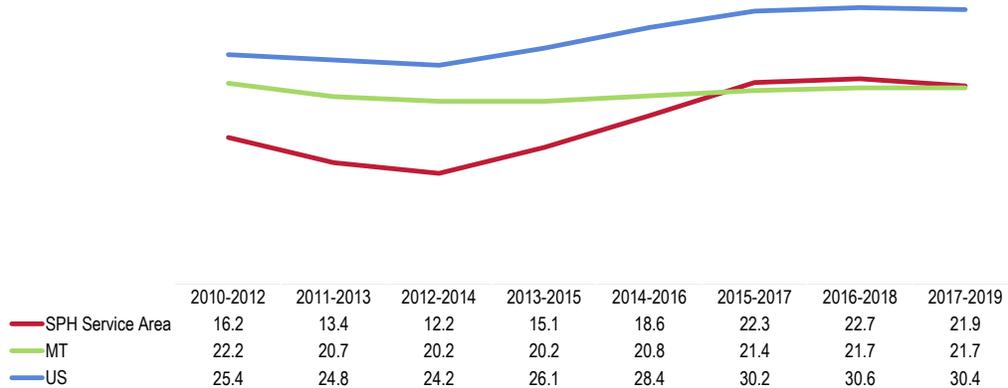
**Alzheimer's Disease: Age-Adjusted Mortality**  
(2017-2019 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.



## Alzheimer's Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

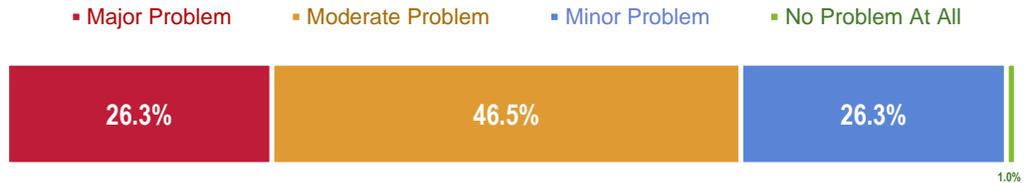


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.

## Key Informant Input: Dementia/Alzheimer's Disease

Key informants taking part in an online survey are most likely to consider *Dementia/Alzheimer's Disease* as a “moderate problem” in the community.

## Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community (Key Informants, 2021)



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

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

### Contributing Factors

The diabetes and obesity epidemic somewhat speaks for itself. The community is fatter and less healthy. There are few programs to help and those programs have limited capacity. Many insurance providers do not cover nutrition education or weight loss programs. – Physician

Prevention of diabetes is the biggest problem. Lifestyle issues and diet lead to an epidemic of diabetes leading to shorter lives with less quality. The proliferation of cheap, good tasting poor quality food and lack of exercise made worse by screen addiction (TV, video games, and devices) contribute to this. – Physician

Fitness can be an issue, unless you are able to handle a lot of hills. In addition, we can have some deep dark winters here. There isn't a facility that is free to community members for fitness. We are a bit behind the times with our nutrition information. While we have a pre-diabetes and diabetes prevention program, it really doesn't touch a lot of people. We need more. – Community Leader

Diabetes seems to be a health issue in our community that contributes to other health conditions. – Social Services Provider

Prevention and continuous management when there's an overall lack of nutrition education in K-12 schools, and lack of support and promotion for healthy eating and physical activity. – Social Services Provider



Lifestyle and behavioral change. Diet, healthy food, and exercise. – Physician  
 Healthy food and too many fast food/junk food options. – Community Leader  
 Diet, obesity, exercise, and medical compliance. – Physician  
 Being able to afford healthy food choices. No programs for exercise in the community nor an inside exercise facility. Getting adequate medical services. – Public Health Representative  
 Low cost exercise facilities. No cooking classes or programs to foster healthy eating. Individual dietary counseling for those at risk; no insurance coverage for seeing dietician. Need more programs to support general health and well being (i.e., free exercise classes, cooking classes, education) to focus on healthy lifestyle and disease prevention. – Physician

## Awareness/Education

Lack of education and community health outreach. – Other Health Provider  
 (Not necessarily in order) 1. Education about the diseases and how to self-monitor/treat/cope with consequences. 2. Access to affordable care and necessary interventions (insulin, monitors, etc.) 3. Preventive care and intervention.....working with young people and families to affect behavioral changes that may prevent disease development. – Community Leader  
 Lack of understanding and awareness of the disease. – Community Leader  
 Access to education and support for healthy diet and lifestyle choices. – Social Services Provider  
 Lack of systemic support around lifestyle changes needed to successfully manage diabetes or to promote health/wellness to prevent diabetes in the first place. – Other Health Provider  
 Diabetes education and awareness, helping patients understand why diabetes is a big deal to keep well controlled to prevent long term sequelae, coaching to help with lifestyle modification. Primary care does a good job with teaching and medications, but they need more resources for the social/lifestyle aspects of diabetes management. – Physician  
 Education and change in lifestyle habits. – Other Health Provider  
 Knowing how to or agreeing to correctly care for their diabetes when they really don't want to. – Social Services Provider

## Affordable Medications/Supplies

Medication is the biggest challenge---Insulin for Insulin dependent diabetics is not a "want", it is a necessity to survive. Insurances choose which medications/insulin brands they will approve. Some other brands may work for people, and prevent complications/hospitalizations, but they can't afford them because they aren't approved by their health insurance. – Public Health Representative  
 Cost of medication. – Physician  
 Access to affordable insulin support programs for changing dietary habits. – Public Health Representative

## Access to Care/Services

Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also, the quality of support seems to be reduced for medical services due to COVID concerns. – Social Services Provider  
 Access to medical and dental care, educational opportunities to learn about the damaging effects of chronic inflammation and the ability to control diabetes. – Other Health Provider

## Access to Care/Services

Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also, the quality of support seems to be reduced for medical services due to COVID concerns. – Social Services Provider  
 Access to medical and dental care, educational opportunities to learn about the damaging effects of chronic inflammation and the ability to control diabetes. – Other Health Provider

## Prevention/Screenings

Diabetes is often preventable. Obesity is often a precursor to diabetes. Poor diet is often a precursor to obesity. People with limited financial resources will buy food that gives them the most calories for the buck, which normally does not meet the range of nutritional requirements for optimum health. Again, diabetes and obesity are symptoms of greater social issues that must be considered. these issues must be tackled from various social perspectives. Education is always a good thing, however, a medical focus on prevention is key—especially for folks insured through any kind of universal healthcare system. Also, offering low-income people with nutritious alternatives to food pantry staples should be a priority. Healthy foods should be accessible for all members of the community. – Community Leader





# BIRTHS

# BIRTH OUTCOMES & RISKS

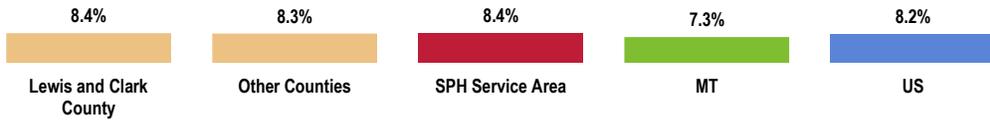
## Low-Weight Births

A total of 8.4% of 2006-2012 SPH Service Area births were low-weight.

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.

Low-Weight Births  
(Percent of Live Births, 2006-2012)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted May 2021.  
 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.

Low-Weight Births  
(Percent of Live Births)



	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: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted May 2021.  
 Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

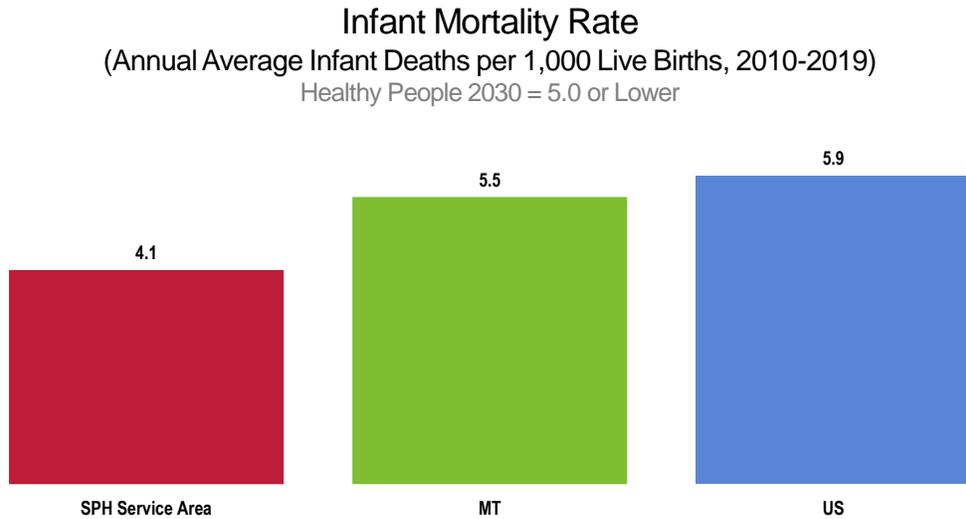


## Infant Mortality

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

Between 2010 and 2019, there was an annual average of 4.1 infant deaths per 1,000 live births.

**BENCHMARK** ▶ Lower than the state and national mortality rates. Satisfies the Healthy People 2030 objective.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted May 2021.

• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

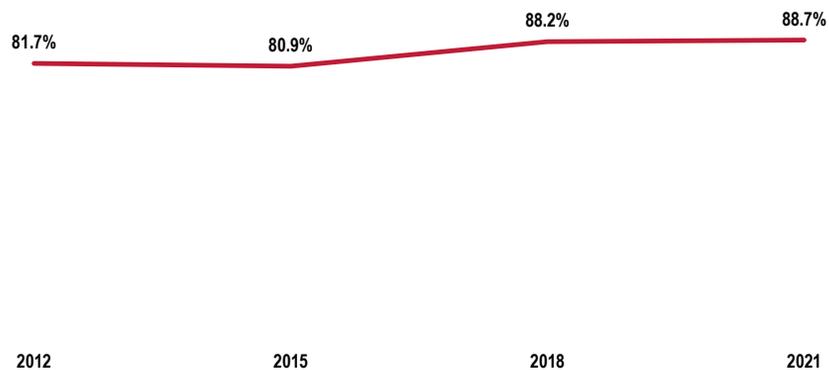
Notes: • Infant deaths include deaths of children under 1 year old.

• 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.

## Breastfeeding

The vast majority (88.7%) of surveyed parents reported that their child was breastfed or fed breastmilk as an infant.

### Child Was Breastfed or Fed Breastmilk as an Infant (SPH Service Area Parents)



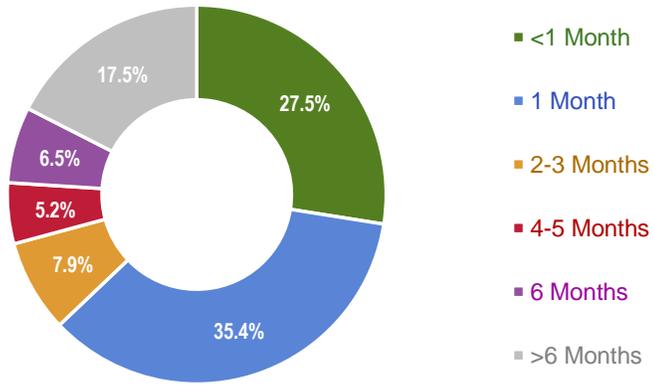
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 338]

Notes: • Asked of all respondents with a child under 18 at home.



Among those parents who breastfed their child, 24.0% 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 (Parents Whose Child Was Fed Breastmilk, 2021)



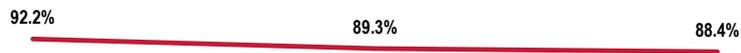
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 339]  
 Notes: • Asked of all parents whose child was fed breastmilk as an infant.

## Childhood Vaccinations

Nearly 9 in 10 surveyed parents (88.4%) would want a newborn to receive all recommended vaccinations.

- ▶ Parents who would not want a newborn to receive all recommended vaccinations cited concerns about the safety of vaccinations and/or a distrust of doctors, as well as references to family history and a feeling of low risk regarding childhood diseases.

### Would Want a Newborn to Receive All Recommended Vaccines (SPH Service Area Parents)



2015

2018

2021

Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 340]  
 Notes: • Asked of all respondents with a child under 18 at home.



# FAMILY PLANNING

## ABOUT FAMILY PLANNING

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

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

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

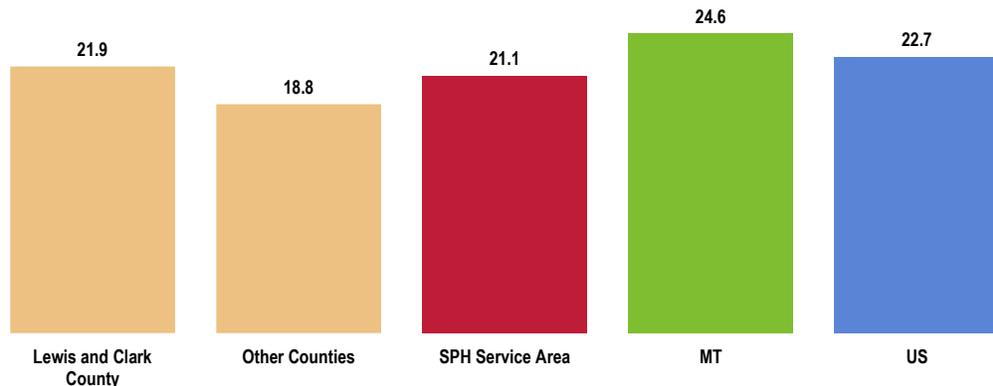
## Births to Adolescent Mothers

**Between 2012 and 2018, there were 21.1 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the SPH Service Area.**

**BENCHMARK** ▶ Lower than the Montana rate and satisfying the Healthy People 2030 objective.

**DISPARITY** ▶ Lower outside Lewis and Clark County.

**Teen Birth Rate**  
(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2012-2018)  
Healthy People 2030 = 31.4 or Lower



- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
  - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap ([sparkmap.org](http://sparkmap.org)).
  - US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
- 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: Infant Health & Family Planning

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

## Perceptions of Infant Health and Family Planning as a Problem in the Community (Key Informants, 2021)



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

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

### Access to Care/Services

Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also the quality of support seems to be reduced for medical services due to COVID concerns. – Social Services Provider

No NICU services. – Community Leader

Lack of access to health care for people who do not qualify for Medicaid and cannot afford insurance. Reproductive rights being politicalized. – Social Services Provider

Very little but intuition and knowing that the U.S has poor record for infant care and family planning. Presumably Montana has even worse statistics considering the rural distribution of much of our population and the regressive state policies with respect to family planning. Barriers are constantly being created and built higher to make it harder for people to get access to family program consultation and care. – Community Leader

Accessibility for infant care. If someone has Medicaid, they can get services. What about transportation that is easy to access with an infant. In all weather, anywhere in our city. If you don't have insurance, less options for infant care. – Public Health Representative

### Affordable Care/Services

Family planning/prenatal health/infant health should be a service provided to everyone, regardless of income. Family planning should help individuals/couples decide on all family planning issues: if/when to start a family; women's health services; birth control alternatives; assistance with genetic risk testing; abortion counseling; adoption counseling. Very often these kinds of services are left to religious organizations. Many people are not affiliated with a church. These services should be available to all members of the community. And all members of the community should be encouraged to be make these decisions responsibly. – Community Leader

Many of the families with lower incomes do not have great access to health care and the ability to pay. In addition, the amount of child and infant abuse in the community is largely underestimated. – Community Leader

### Follow-Up/Support

New parents need greater health care post and prenatal support from caregivers. The nonprofit sector is picking up the slack where healthcare leaves off. – Social Services Provider

### Funding

In 2017, the contracts with regional providers who did comprehensive assessments for infants was defunded. I think this is a critical weakness to lose. – Social Services Provider

### Continuity of Care

Lack of coordinated care. – Community Leader





# MODIFIABLE HEALTH RISKS

# NUTRITION

## ABOUT NUTRITION & HEALTHY EATING

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

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

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

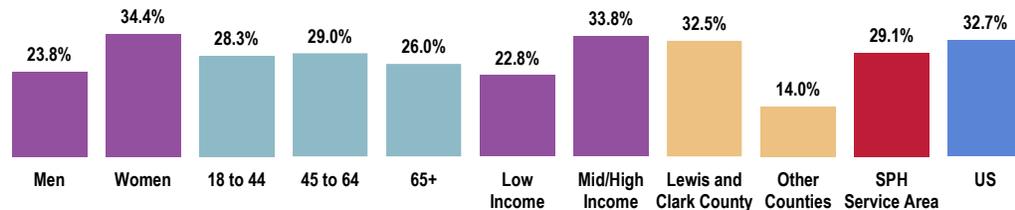
## Daily Recommendation of Fruits/Vegetables

**A total of 29.1% of SPH Service Area adults report eating five or more servings of fruits and/or vegetables per day.**

**DISPARITY** ► Much higher among Lewis and Clark County respondents. Reported less often among service area men.

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

Consume Five or More Servings of Fruits/Vegetables Per Day  
(SPH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 125]  
 Notes: ● Asked of all respondents.  
 ● For this issue, respondents were asked to recall their food intake on the previous day.  
 ● "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



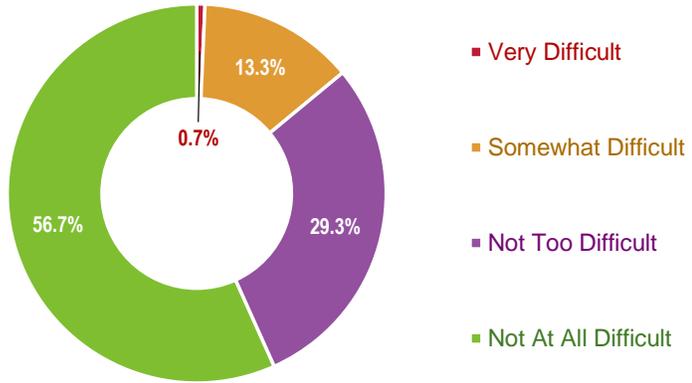
# Difficulty Accessing Fresh Produce

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?"

**RELATED ISSUE**  
See also *Food Access* in the **Social Determinants of Health** section of this report.

**Most SPH Service Area adults report little or no difficulty buying fresh produce at a price they can afford.**

**Level of Difficulty Finding Fresh Produce at an Affordable Price (SPH Service Area, 2021)**



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 79]  
Notes: • Asked of all respondents.

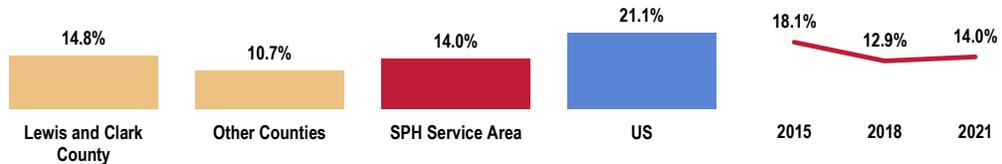
**However, 14.0% of SPH Service Area adults find it “very” or “somewhat” difficult to access affordable fresh fruits and vegetables.**

**BENCHMARK** ► Well below the US prevalence.

**DISPARITY** ► Considerably higher among women, adults age 45+, and low-income residents especially.

## Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce

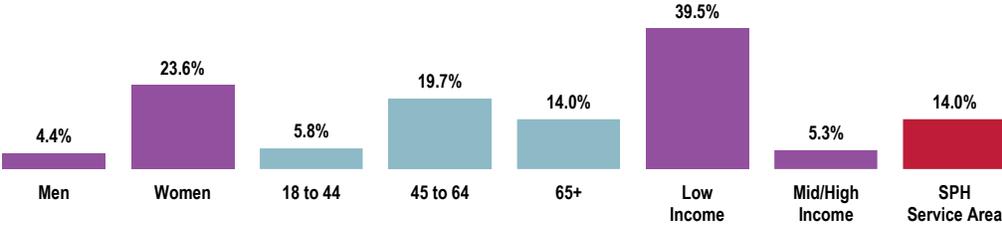
SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 79]  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.  
: • “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



# Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 79]  
Notes: • Asked of all respondents.



# PHYSICAL ACTIVITY

## ABOUT PHYSICAL ACTIVITY

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

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

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

## Leisure-Time Physical Activity

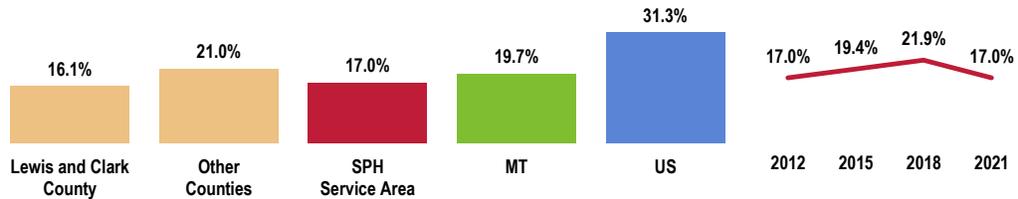
A total of 17.0% of SPH Service Area adults report no leisure-time physical activity in the past month.

**BENCHMARK** ▶ Well below the US prevalence. Satisfies the Healthy People 2030 objective.

### No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.2% or Lower

SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 82]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Montana data.  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

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

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.



# Activity Levels

## Adults

### ADULTS: 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.

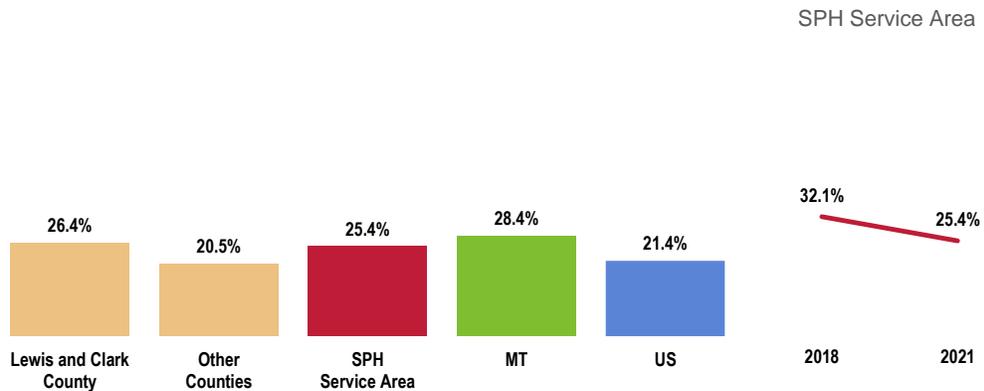
– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. [www.cdc.gov/physicalactivity](http://www.cdc.gov/physicalactivity)

**A total of 25.4% of SPH Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).**

**TREND** ▶ Decreasing from 2018 survey findings.

### Meets Physical Activity Recommendations

Healthy People 2030 = 28.4% or Higher

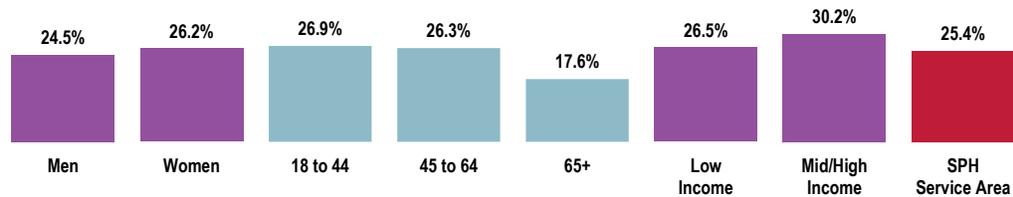


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 126]  
 • Behavioral Risk Factor Surveillance System Survey Data, Atlanta, Georgia, United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Montana data.  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>  
 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.



## Meets Physical Activity Recommendations (SPH Service Area, 2021)

Healthy People 2030 = 28.4% or Higher



- Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 126]
  - US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
- 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.

## Children

### CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

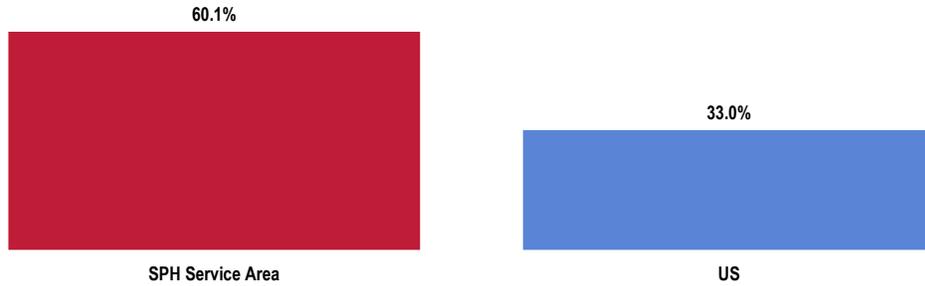
- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. [www.cdc.gov/physicalactivity](http://www.cdc.gov/physicalactivity)

**Among SPH Service Area children age 2 to 17, 60.1% are reported to have had 60 minutes of physical activity on each of the seven days preceding the interview (1+ hours per day).**

**BENCHMARK** ► Considerably higher than the US prevalence.



## Child Is Physically Active for One or More Hours per Day (Parents of Children Age 2-17)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 109]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents with children age 2-17 at home.  
 • Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.  
 • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

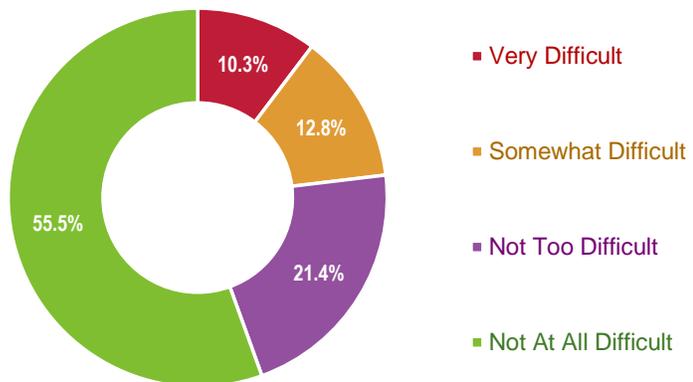
## Access to Physical Activity

### Access Difficulty

While most survey respondents do not experience difficulty accessing safe and affordable places for exercise (such as parks, gyms, YMCAs, recreational centers, etc.), a total of 23.1% gave "very difficult" or "somewhat difficult" responses to the inquiry.

DISPARITY ► Difficulty is reported more often among women, adults age 45 to 64, and low-income respondents.

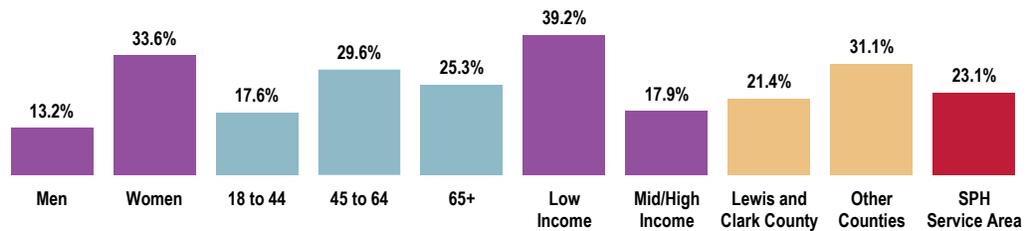
### Level of Difficulty Accessing Safe and Affordable Places for Physical Activity (Parks, Gyms, YMCAs, or Rec Centers) (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 326]  
 Notes: • Asked of all respondents.



## Find It “Very” or “Somewhat” Difficult to Access Safe, Affordable Places for Fitness (SPH Service Area, 2021)



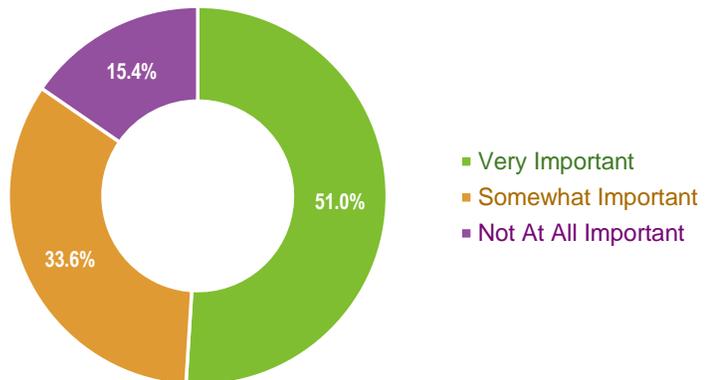
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 326]  
 Notes: • Asked of all respondents.  
 : • “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

### Importance of Improving Access

Asked to gauge the importance of improving access to the community’s trails, parks, and greenways, just over half (51.0%) of survey respondents gave “very important” ratings and another one-third (33.6%) gave “somewhat important” responses.

**DISPARITY** ▶ Lewis and Clark County residents gave overall higher “very/somewhat important” responses.

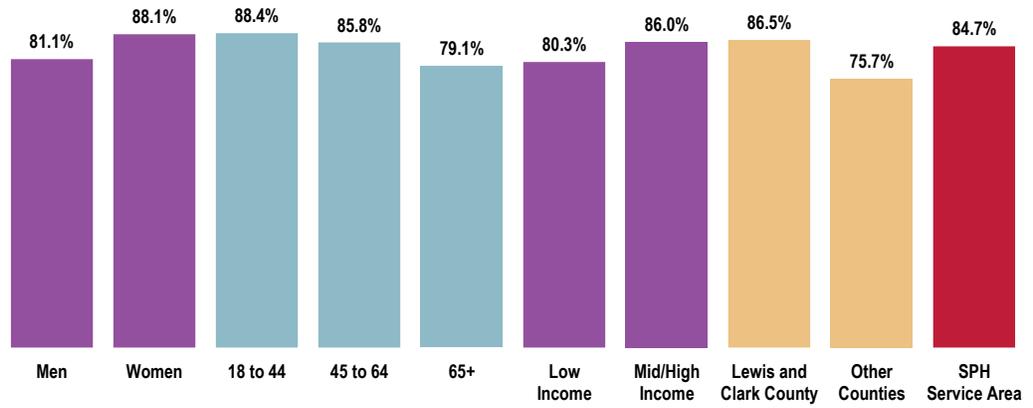
## Importance of Improving Access to Trails, Parks, and Greenways in the Community (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 327]  
 Notes: • Asked of all respondents.



## “Very” or “Somewhat” Important for Community to Improve Access to Trails, Parks, and Greenways (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 327]  
 Notes: • Asked of all respondents.  
 : • “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



# WEIGHT STATUS

## ABOUT OVERWEIGHT & OBESITY

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

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

- Healthy People 2030 (<https://health.gov/healthypeople>)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared ( $m^2$ ). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches<sup>2</sup>)] 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  $\geq 30 kg/m^2$ . 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  $\geq 30 kg/m^2$ , 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	$\geq 30.0$

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.



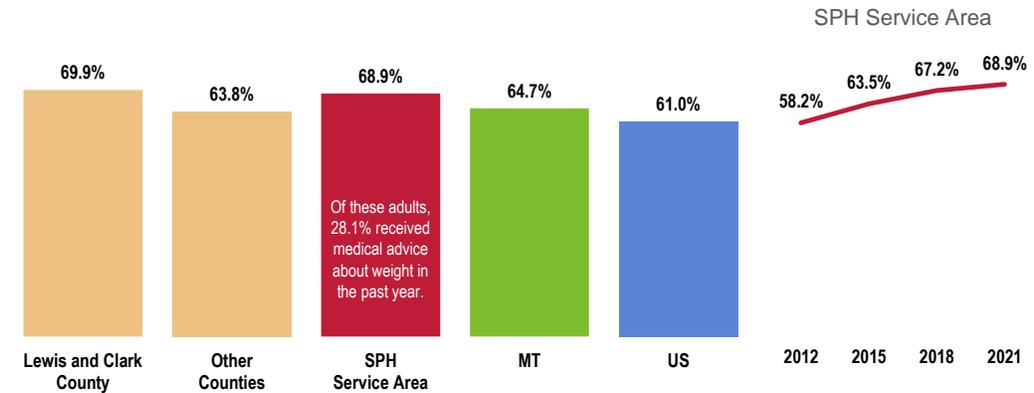
## Overweight Status

Over two in three (68.9%) SPH Service Area adults are **overweight**.

**BENCHMARK** ▶ Higher than the US prevalence of overweight.

**TREND** ▶ Denotes a statistically significant increase since 2012.

### Prevalence of Total Overweight (Overweight and Obese)



- Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 128, 325]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Montana data.
  - 2020 PRC National Health Survey, PRC, 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.

Note that 28.1% of overweight adults have been given advice about their weight by a health professional in the past year (while most have not).

The overweight prevalence above includes 32.8% of SPH Service Area adults who are **obese**.

**TREND** ▶ Higher than the 2012 response but similar to subsequent survey findings.

**DISPARITY** ▶ Reported more often among adults age 45 and older as well as low-income adults.

Here, "overweight" includes those respondents with a BMI value  $\geq 25$ .

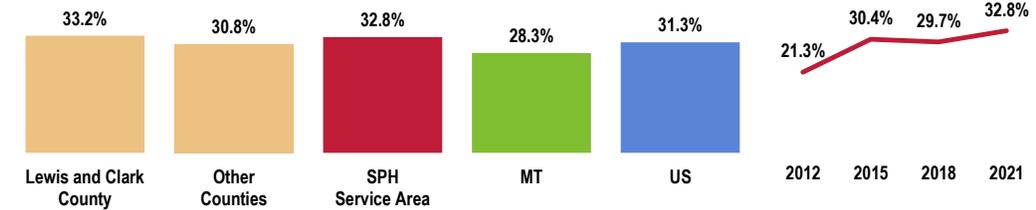
"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value  $\geq 30$ .



## Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower

SPH Service Area



Sources:

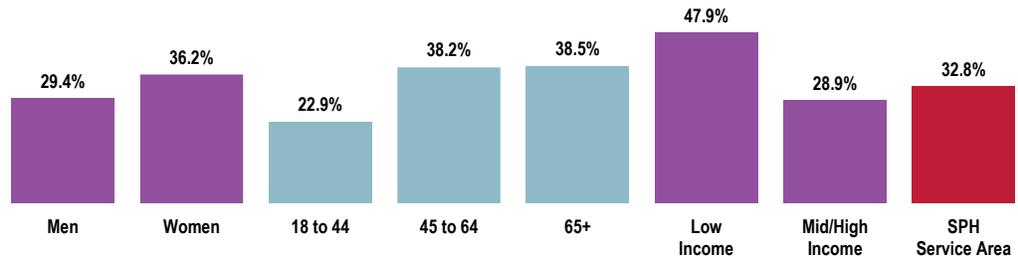
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Montana data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

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.

## Prevalence of Obesity (SPH Service Area, 2021)

Healthy People 2030 = 36.0% or Lower



Sources:

- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

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.

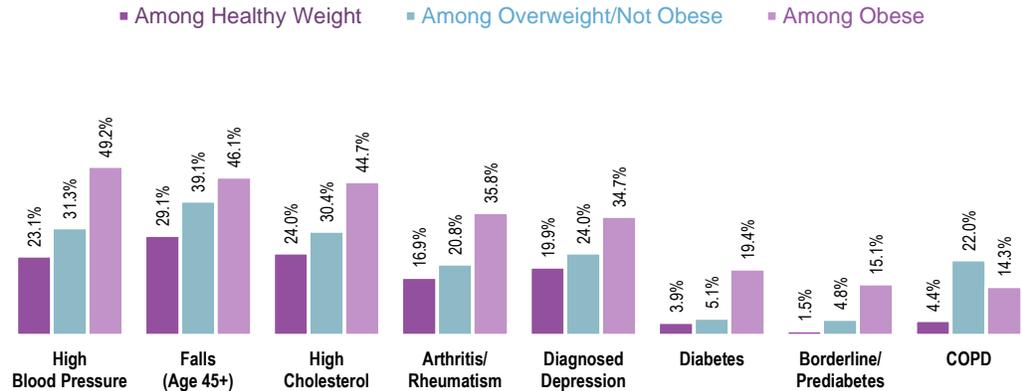


## Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions, as outlined in the following chart.

The correlation between overweight and various health issues cannot be disputed.

### Relationship of Overweight With Other Health Issues (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 128]  
Notes: • Based on reported heights and weights, asked of all respondents.

## Children's Weight Status

### ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5<sup>th</sup> percentile
- Healthy Weight ≥5<sup>th</sup> and <85<sup>th</sup> percentile
- Overweight ≥85<sup>th</sup> and <95<sup>th</sup> percentile
- Obese ≥95<sup>th</sup> percentile

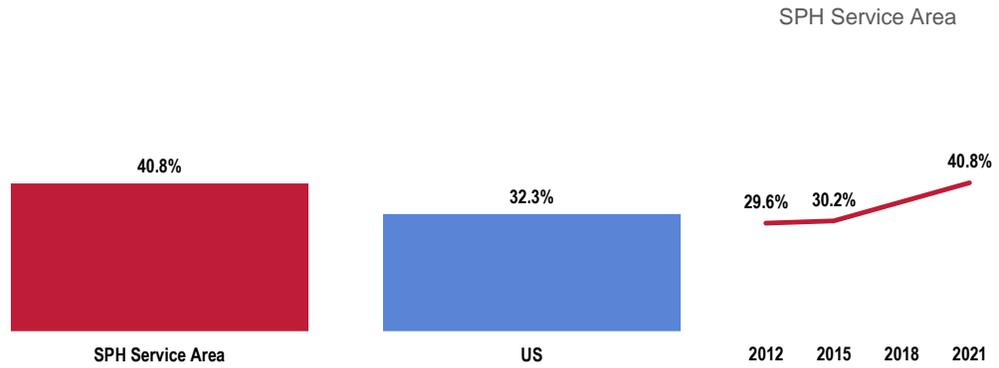
– Centers for Disease Control and Prevention



Based on the heights/weights reported by surveyed parents, 40.8% of SPH Service Area children age 5 to 17 are overweight or obese (≥85th percentile).

TREND ► The increase over time is not yet statistically significant.

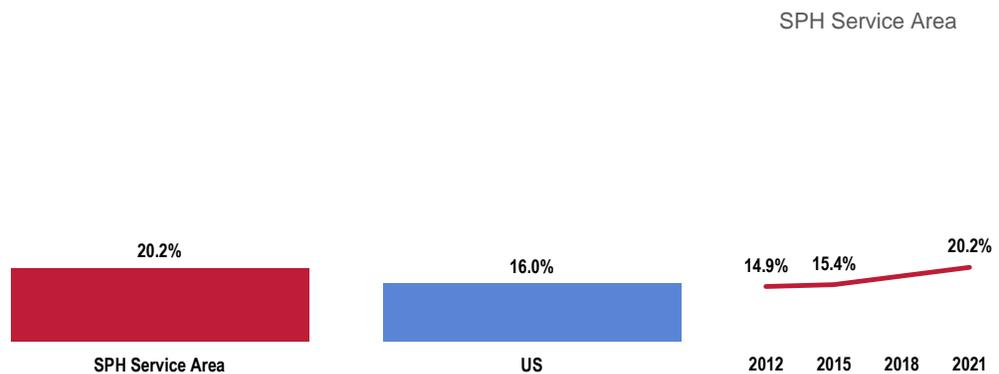
### Prevalence of Overweight in Children (Parents of Children Age 5-17)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 131]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents with children age 5-17 at home.  
 • Overweight among children is determined by children's Body Mass Index status at or above the 85<sup>th</sup> percentile of US growth charts by gender and age.

The childhood overweight prevalence above includes 20.2% of area children age 5 to 17 who are obese (≥95th percentile).

### Prevalence of Obesity in Children (Children Age 5-17 Who Are Obese; BMI in the 95<sup>th</sup> Percentile or Higher) Healthy People 2030 = 15.5% or Lower



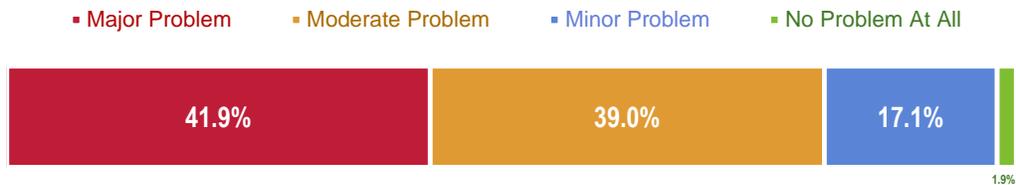
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 131]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>  
 Notes: • Asked of all respondents with children age 5-17 at home.  
 • Obesity among children is determined by children's Body Mass Index status equal to or above the 95<sup>th</sup> percentile of US growth charts by gender and age.



# Key Informant Input: Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a “major problem” in the community.

## Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community (Key Informants, 2021)



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

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

### Contributing Factors

Lack of nutrition education/counseling in K-12 schools to influence kids at an early age. Teaching kids where food comes from and the many careers around this area. Overall lack of value for food, nutrition, and physical activity (an overall healthy environment). Need for more accessibility and affordability of healthy and culturally appropriate foods. Need for healthy foods served in K-12 schools through school meal program (highly processed foods). Major need for a new kitchen at the local high school, which is the satellite kitchen that serves thousands of meals to students daily and during the summer months. A teaching kitchen can be built in for high school students interested in culinary careers. Healthy food promotion is desperately needed in schools and in the community to help influence consumer decisions. Hiring a Registered Dietitian to work in the Helena schools would pay for itself by prevent diet related health issues, including obesity and eating disorders. – Social Services Provider

Overeating, inactivity, and personal choice. – Physician

Quick and easy solutions to meals can be less nutritious and higher in calories. It is a difficult journey to increase physical activity and lose weight. – Public Health Representative

Public awareness and motivation. Lack of facilities although the community is always working on this issue. – Community Leader

Most of the food that is donated is highly processed food, high in sodium, sugar, and carbohydrates. All of this contributes to poor eating habits simply due to availability of health fresh foods, places to make meals also contributes. Not having a facility to store homeless property causes ongoing theft, and ties homeless to packing around their property, which contributes to inability to get employment. – Social Services Provider

In terms of nutrition, we are a bit of a food desert. Can't grow much here. Not a lot of awareness about proper nutrition. – Community Leader

Easy access to poor quality, good tasting, high calorie food with limited nutritional content is a big part of the problem. People do not prioritize physical activity thinking of screens and food as comfort. Supplements and "diets" take the place of healthy eating. – Physician

Nutritious food is more expensive than junk food. People don't really understand how to eat in a healthy manner - calories in, calories out - eating for fuel, not always for pleasure. People do not get nearly enough physical activity. All of this leads to most of the population being overweight. Being overweight leads to a host of other medical issues that might not sure up until down the road when it is too late to try to fix them. People don't ever say they died from being overweight but they do. They may die of kidney failure but it was diet and weight over the years. – Social Services Provider

Low-income folks tend to buy foods that give them the most caloric bang for the buck. Eating high-quality nutritious foods are often more expensive than lesser-quality foods. Higher quality foods are not often available at food pantries (including high-quality fruits and vegetable). We could help low-income folks attain higher nutritional goals by increasing the minimum wage, offering low-income folks the opportunity to buy higher quality foods through creative initiatives. Again, focus should be on prevention. Education is important, but should be reinforced by initiating incentives. – Community Leader



Our community is no different from most in that need except that many families are lower income. For the past two generations families have gotten away from providing nutritious family meals together. Younger people have relied on fast food, super-sized drinks, fried foods that arguably taste pretty good but nutrition should be taught early so the at families can make the better food decisions. Less physical activity for our young people is a major problem; we need more supervised physical activity resources to keep our young people occupied; baseball programs, skating, etc. We all snack more than generations in the past and consume far more calories than is needed for healthy nutrition. – Community Leader

All of this plays an overall role in the health of our community. I think that workplaces need to be more invested in the health of their employees. I feel like we do a good job of getting children out and active, but options drop off for organized physical activities for adults of all ages. It's also really easy to go through a fast food drive through, but there are not any quick, easy, affordable healthier options. – Other Health Provider

U.S. and, I think, Montana residents are continuing to see increases in population percentage obesity. Particularly concerned about youth and decreased physical activity caused by numerous factors, including: Lack of living wage for many jobs and resulting increase in two working parent families, so reduced supervision and contact with children. Availability of and access to other types of "entertainment" such as video games. Insufficient access to supervised outside activities such as baseball, dance, biking, hiking, etc. Increased fear of allowing children to explore and wander and create their own outdoor lifestyles. Poor eating habits also associated with changes in family supervision and connection, ongoing advertising bombarding residents with poor food choices. – Community Leader

Alcohol abuse, lack of indoor activities in winter, and culture around food and nutrition. – Community Leader

## Awareness/Education

I feel that this is a on-going issue in middle and high schools. Children need to be taught proper nutrition and have access to physical activity. Get them off of screens. – Social Services Provider

Education. Need to understand the relationship between obesity and diabetes, as well as joint and spine deterioration, and predisposition to heart attack and stroke. – Other Health Provider

Education on healthy eating, cooking and cost savings of preparing your own food. Helena has a lot of mediocre fast food restaurants. – Community Leader

Knowledge/awareness, commitment to behavioral change, access to resources. – Physician

Doctors and health providers not being honest with folks about this very basic first step to good health. All levels of health care providers need to get very serious about this issue. – Social Services Provider

General lack of understanding that sugar, flour and high glycemic foods cause obesity, not fat consumption. Lifestyle choices affect nutrition. Fast food and processed food are not healthy. – Public Health Representative

Health and nutrition is overlooked in our society as a whole. As a diabetic, I stumbled across the value of a plant based diet, and it made all the difference. Folks need more information and more options when considering their health. – Social Services Provider

## Access to Care/Services

Easily accessible and affordable programs supporting healthy physical activity programs throughout the community. Limited education and access to healthy dietary choices. Higher associated costs of healthy foods, compared to the prevalence, easy-access and relatively low-cost food options. – Social Services Provider

No good medical weight loss programs. People have a hard time figuring out how to get started and what to do when they are at a program. – Physician

## Built Environment

Access to sidewalks in certain neighborhoods. Access to healthy, fresh food in certain parts of the county. During COVID, PE is only one day per week at Helena Schools. – Public Health Representative

Issue effecting the country in general. In Helena there is limited bike and walking paths/lanes for commuting. – Physician

## Insufficient Physical Activity

People are not physically active. Walking and biking are not commonplace activities for most people. We drive everywhere. – Community Leader

We need to make the healthy choices the easy choices. We have a severe lack of physical activity in our community, both for youth and adults. Plus, lack of access to nutritious foods in the schools. – Public Health Representative

## Policy

Legislation has created a Local Food Choice Act that allows home prepared, high risk foods and raw milk to be sold. This is an opportunity for potentially serious foodborne illnesses to significantly increase in our community. – Public Health Representative



# SLEEP

## SLEEP

According to professional sleep societies, adults aged 18 to 60 years should sleep at least 7 hours each night for the best health and wellness.

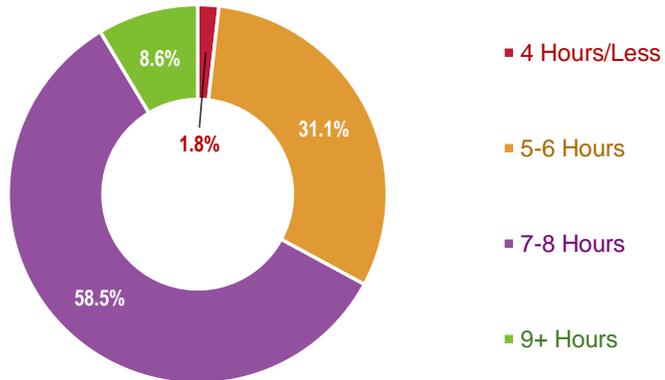
Sleeping less than 7 hours per night is linked to increased risk of chronic diseases such as diabetes, stroke, high blood pressure, heart disease, obesity, and poor mental health, as well as early death. Not getting the recommended amount of sleep can affect one's ability to make good decisions and increases the chances of motor vehicle crashes.

- Institute of Medicine (US) Committee on Sleep Medicine and Research; 2014 Behavioral Risk Factor Surveillance System (BRFSS), CDC

**A total of 32.9% of SPH Service Area adults reporting getting an average of less than seven hours of sleep per night.**

**DISPARITY** ► Reported more often among adults age 45 to 64.

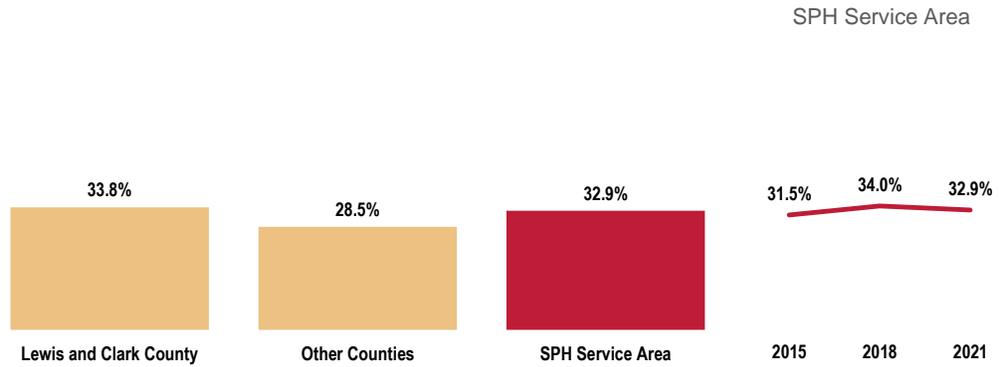
**Average Hours of Sleep Per Night**  
(SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 333]  
Notes: • Asked of all respondents.

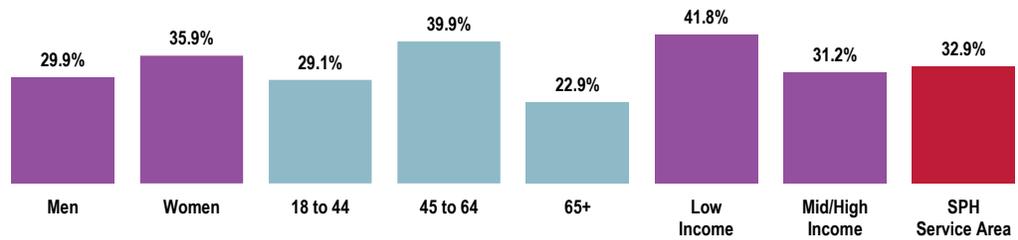


## Generally Sleep Less Than Seven Hours Per Night



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 349]  
 Notes: • Asked of all respondents.  
 : • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Generally Sleep Less Than Seven Hours Per Night (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 349]  
 Notes: • Asked of all respondents.



# SUBSTANCE ABUSE

## ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. ...Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

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

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

## Age-Adjusted Cirrhosis/Liver Disease Deaths

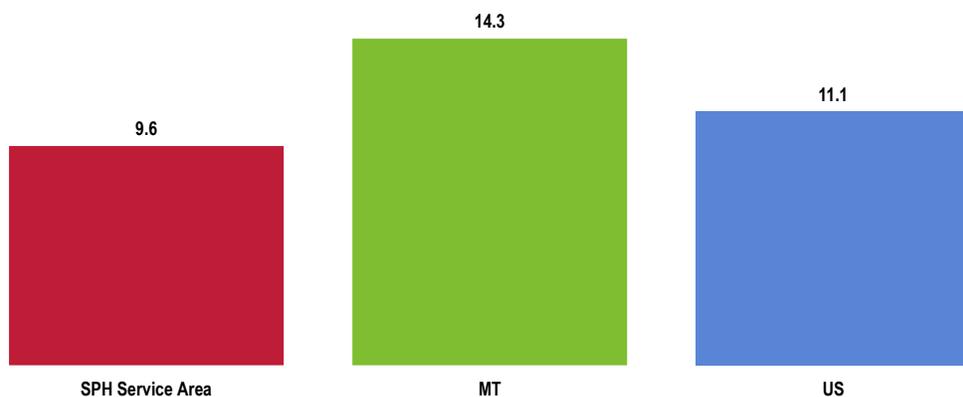
**Between 2017 and 2019, the SPH Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 9.6 deaths per 100,000 population.**

**BENCHMARK** ▶ Lower than the Montana and US mortality rates.

**TREND** ▶ Stable in recent years.

### Cirrhosis/Liver Disease: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower

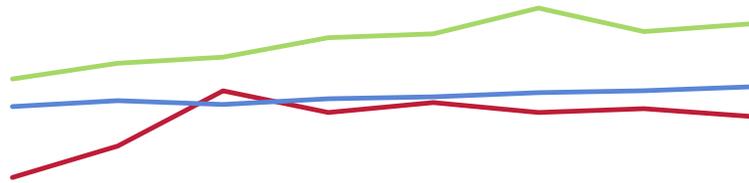


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>



## Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
— SPH Service Area	6.5	8.1	10.9	9.8	10.3	9.8	10.0	9.6
— MT	11.5	12.3	12.6	13.6	13.8	15.1	13.9	14.3
— US	10.1	10.4	10.2	10.5	10.6	10.8	10.9	11.1

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

## Alcohol Use

### Excessive Drinking

**Excessive drinking** includes heavy and/or binge drinkers:

- **HEAVY DRINKERS** ▶ men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- **BINGE DRINKERS** ▶ men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

**A total of 20.9% of area adults are excessive drinkers (heavy and/or binge drinkers).**

**BENCHMARK** ▶ Well below the national prevalence.

**DISPARITY** ▶ Correlates with age in the service area and reported more often among men and higher-income residents.



# Excessive Drinkers

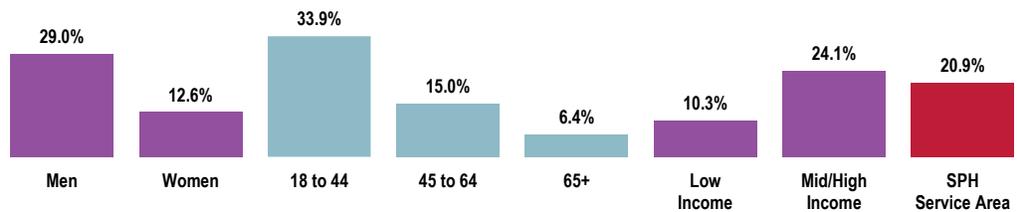
SPH Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 136]  
 ● 2020 PRC National Health Survey, PRC, 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); 2019 Montana data.

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 Drinkers (SPH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 136]  
 ● 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.



## Drinking & Driving

A total of 3.9% of SPH Service Area adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.

### Have Driven in the Past Month After Perhaps Having Too Much to Drink

SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 317]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Montana data.

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

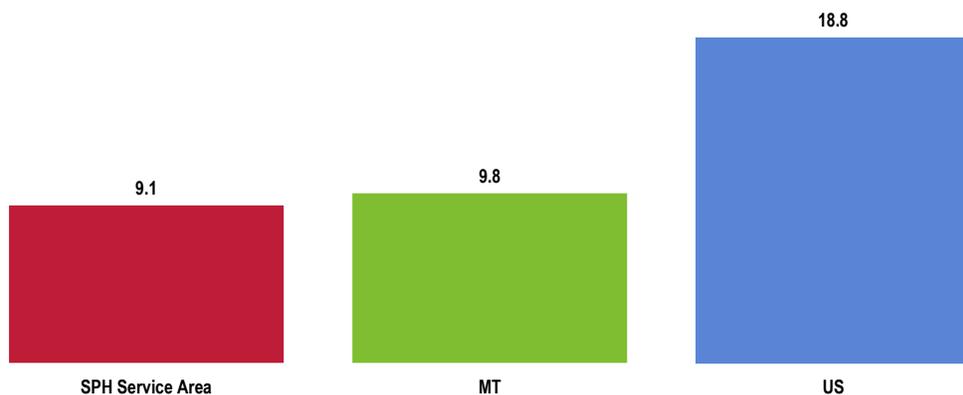
## Age-Adjusted Unintentional Drug-Related Deaths

Between 2017 and 2019, there was an annual average age-adjusted unintentional drug-related mortality rate of 9.1 deaths per 100,000 population in the SPH Service Area.

**BENCHMARK** ▶ Half the national mortality rate.

**TREND** ▶ Rates have been fairly stable over time, in contrast to the increasing US trend.

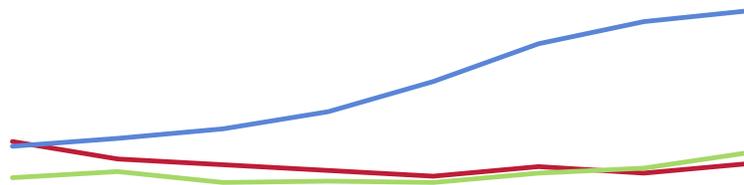
### Unintentional Drug-Related Deaths: Age-Adjusted Mortality (2017-2019 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.



## Unintentional Drug-Related Deaths: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SPH Service Area	10.5	9.4			8.3	8.9	8.5	9.1
MT	8.2	8.6	7.9	8.0	7.9	8.5	8.8	9.8
US	10.2	10.7	11.3	12.4	14.3	16.7	18.1	18.8

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2021.

## Illicit Drug Use

**Almost none of the surveyed respondents (0.3%) acknowledge using an illicit drug in the past month.**

**BENCHMARK** ► Below the US prevalence and easily satisfying the Healthy People 2030 objective.

### Illicit Drug Use in the Past Month

Healthy People 2030 = 12.0% or Lower

SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 49]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

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

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.

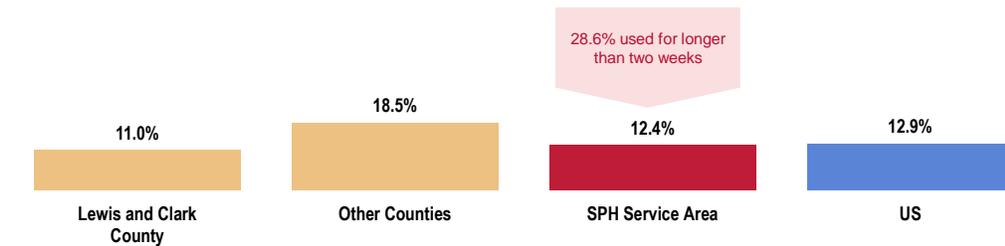


## Use of Prescription Opioids

A total of 12.4% of SPH Service Area adults report using a prescription opioid drug in the past year; of these adults, 28.6% took the drugs for longer than two weeks.

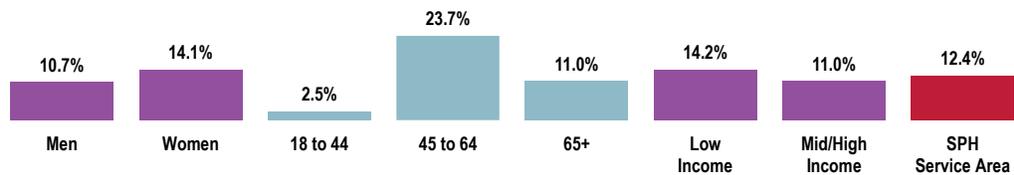
DISPARITY ► The prevalence is much higher among adults over age 44.

### Used a Prescription Opioid in the Past Year



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 50, 321]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 : • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

### Used a Prescription Opioid in the Past Year (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 50]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.



## Personal Use of Prescription Medication

When asked, 2.8% of survey respondents reported using a prescription drug “on their own” (without a prescription, more than prescribed, and/or longer than prescribed) in the past year.

DISPARITY ► Considerably higher outside Lewis and Clark County. Reported more often among adults age 18 to 44 and seniors (age 65+).

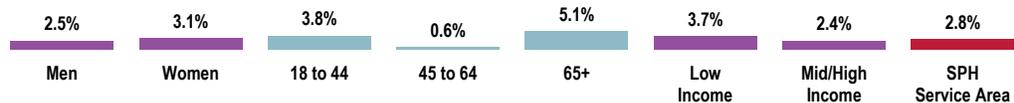
### Took Prescription Drugs On Own in the Past Year (Without Rx or More/Longer Than Prescribed; SPH Service Area)

SPH Service Area



- Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 320]  
 Notes: • Asked of all respondents.  
 • Examples include sedatives (sleeping pills, barbiturates, Seconal, or Quaaludes), tranquilizers/anti-anxiety drugs (Valium, Librium, muscle relaxants, or Xanax), opiates/painkillers (Codeine, Darvon, Percocet, Dilaudid, Demerol, morphine, Vicodin, or Oxycontin), and/or stimulants (Preludin, Benzadrine, Methadrine, uppers, speed, amphetamines, or Ritalin).  
 : • “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

### Took Prescription Drugs On Own in the Past Year (Without Rx or More/Longer Than Prescribed; SPH Service Area)



- Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 320]  
 Notes: • Asked of all respondents.  
 • Examples include sedatives (sleeping pills, barbiturates, Seconal, or Quaaludes), tranquilizers/anti-anxiety drugs (Valium, Librium, muscle relaxants, or Xanax), opiates/painkillers (Codeine, Darvon, Percocet, Dilaudid, Demerol, morphine, Vicodin, or Oxycontin), and/or stimulants (Preludin, Benzadrine, Methadrine, uppers, speed, amphetamines, or Ritalin).

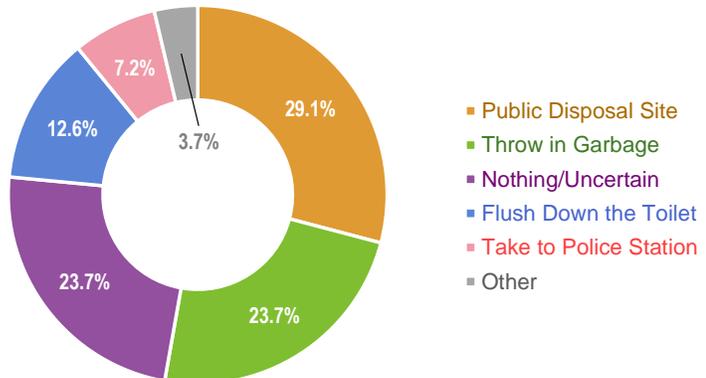


## Expired Prescriptions

Asked how they dispose of expired prescriptions, 29.1% of survey respondents mentioned taking the medication to some type of public disposal site, such as a drugstore/pharmacy, a physician's office, or a designated drop box.

Note that nearly one-fourth of adults throw expired prescriptions into the garbage, while 12.6% flush them.

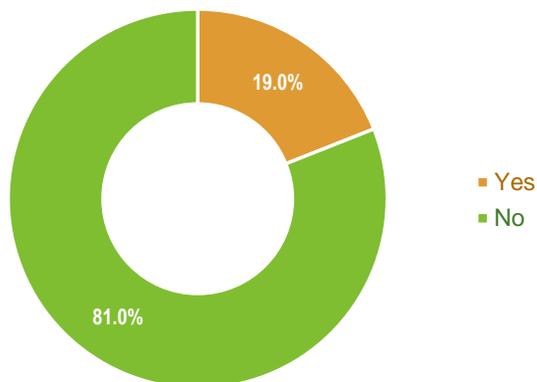
Method of Disposal for Expired Prescriptions  
(SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 319]  
Notes: • Asked of all respondents.  
• In this case, a public disposal site might be a drugstore/pharmacy, a physician's office, a drop box, and a bin at the VA.

Among surveyed adults in the SPH Service Area, 19.0% have prescription medications in the home that are expired or should no longer be taken.

Have Prescriptions in the Home  
That Are Expired or Should No Longer Be Taken  
(SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 318]  
Notes: • Asked of all respondents.



## Alcohol & Drug Treatment

Nearly no survey respondents (0.3%) reported difficulty finding professional help for an alcohol or drug problem in the past year.

### Difficulty Finding Professional Help for an Alcohol-/Drug-Related Problem in the Past 12 Months

SPH Service Area



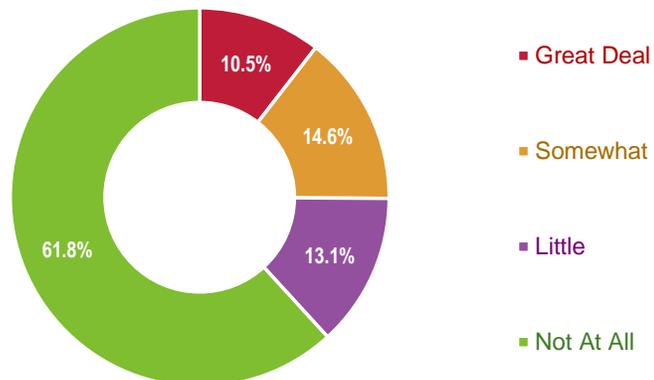
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 322]  
 Notes: • Asked of all respondents.  
 : • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Personal Impact From Substance Abuse

Most SPH Service Area residents' lives have not been negatively affected by substance abuse (either their own or someone else's).

Area adults were also asked to what degree their lives have been impacted by substance abuse (whether their own abuse or that of another).

### Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's) (SPH Service Area, 2021)



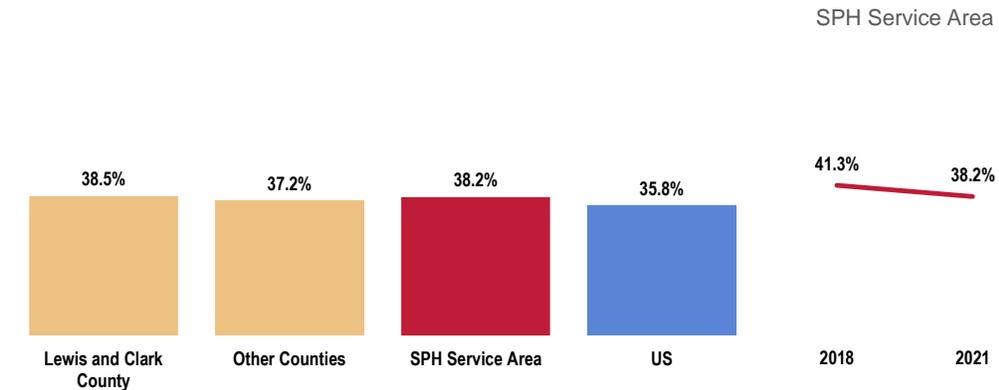
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 52]  
 Notes: • Asked of all respondents.



However, 38.2% have felt a personal impact to some degree (“a little,” “somewhat,” or “a great deal”).

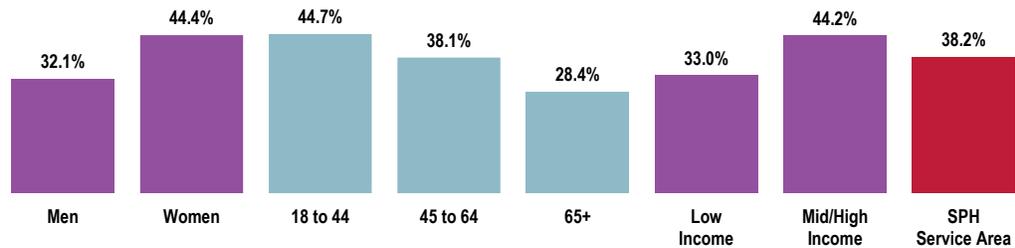
DISPARITY ► Decreases with age and reported more often among women in the service area.

### Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 52]  
 • 2020 PRC National Health Survey, PRC, 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.

### Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else) (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 52]  
 Notes: • Asked of all respondents.  
 • Includes response of “a great deal,” “somewhat,” and “a little.”



# Key Informant Input: Substance Abuse

The greatest share of key informants taking part in an online survey characterized *Substance Abuse* as a “major problem” in the community.

## Perceptions of Substance Abuse as a Problem in the Community (Key Informants, 2021)



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

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

### Access to Care/Services

- A bias toward inpatient treatment statewide. Many can have success with outpatient, but it is not built or promoted. That is changing a bit after undoing a state law that basically created a few monopolies. We need to continue to expand access. – Community Leader
- Limited treatment centers. – Public Health Representative
- People whom are actively using need acute crisis care, and there is a lack of ability to refer quickly to inpatient treatment. – Social Services Provider
- Timely access to services; services specific to an individual’s need. – Social Services Provider
- Any medical condition is a challenge in this community and the surrounding community due to a lack of health professionals with available time. Also, the quality of support seems to be reduced for medical services due to COVID concerns. – Social Services Provider
- Limited resources and the limited amount of time that they have individuals stay in the programs. – Other Health Provider
- Available resources and the person’s desire to be treated. – Social Services Provider
- Getting people to treatment. – Community Leader
- The distance in getting those in need of treatment to services and returned so they are not coming back homeless or without follow-up while stabilizing back to the community. Possibly as case manager to follow up. – Social Services Provider
- Accessibility. When someone is ready for inpatient, to find a place that they can afford and is open to take someone. Then the follow-through once they are released into the community again. – Public Health Representative
- Limited resources. – Physician
- Limited resources to getting people the long-term treatment they need to get clean and stay clean. Medicaid only stays for short stays in facilities but will send a person several times. If the person could be there long-term right from the start, they might have a chance at getting healthy. Substance abuse is a misunderstood issue. It starts with experimenting or self-medicating and becomes an addiction that is nearly impossible to control. – Social Services Provider
- Access. – Other Health Provider
- Skilled Substance Abuse providers meeting clients where they are. More are needed to prevent and treat those suffering. Not enabling habits, but actually helping them out of path. – Community Leader
- Treatment facilities. – Social Services Provider
- Now we have two addiction specialists at St. Peter’s Health so there are providers covered by most insurance. Unfortunately there is no inpatient program for detox and outpatient counseling is limited. – Physician
- Access to services, proper identification of problems and referral, ongoing behavioral/lifestyle change support. – Physician



There are very few Addiction Treatment Centers in the Helena or Montana area. Many people with addiction problems have no insurance and can't afford care. There are very few addiction specialists. – Physician  
We have a lack of inpatient treatment options in Helena and Montana. People have to wait months often for a bed at MCDC. Many people are looking for something other than Boyd Andrews or AA as an outpatient as well and we don't have a lot of options for them. We need an inpatient treatment center in Helena. – Physician

## Contributing Factors

Prevention is huge but getting past the stigma of substance abuse and treating it as a disease will go a long way to improved treatment in our community. – Social Services Provider

Isolation, poverty, and pain lead to drug abuse. – Community Leader

Housing stability, then access to programs. – Social Services Provider

Stigma, the number of providers who are available and the timing of getting into support. – Other Health Provider

The addiction itself is powerful. Cost can be an issue for extended stay programs. – Physician

Access to treatment. Many clients identify the need for rehab but have been sober for a couple of weeks and are told they no longer qualify because they are "too stable". Clients often then relapse as a way to be access services. The wait times for treatment is incredibly long and usually provides short notice making it hard to coordinate housing, childcare, employment, etc. needs. Similar to mental health, there are too few providers for the need in the community and clients either can't get in with a provider or don't feel like they are able to see their provider often enough. Substance use and access to treatment is frequently used as a method of control in abusive relationships. People are also often terrified to reach out for support when they want/need it because they are afraid of community judgment, losing kids, losing employment, losing housing, etc. The silence and the shame often work to perpetuate and escalate the issue, in addition to the demand outpacing capacity. – Social Services Provider

Stigma, high quality treatment programs, no local detox option, and no local in-patient option. – Public Health Representative

Personal motivation, housing, and peer support. – Social Services Provider

The stigma to accessing substance use services, especially for parents. There is also a lack of crisis intervention services that don't involve putting someone in jail or the ER for substance use that has hit a critical point for a person. There is a lack of comprehensive services and SUD treatment facilities that go beyond 30-day treatment. – Social Services Provider

## Lack of Providers

Lack of providers, counselors, and treatment programs locally. – Community Leader

Not enough substance abuse counselors. Not enough substance abuse facilities, both inpatient and outpatient. Expensive and rarely covered by insurance. – Physician

There are not enough counselors and funding. – Social Services Provider

Treatment centers are away from the community and we have no substance abuse therapists nearby. – Public Health Representative

Not enough beds for youth. Not enough therapists/counselors. Too long of a waiting list. – Social Services Provider

## Affordable Care/Services

We need more resources and those resources must be affordable. – Other Health Provider

The lack of readily available free effective quality treatment. We spend too many resources treating the crime of drugs without addressing the underlying addiction-creates an endless cycle. Some treatment programs are not effective-need to be more intensive and longer. – Social Services Provider

Lack of money to pay for it and lack of quality treatment options. – Social Services Provider

Availability and affordability, lack of insurance or funding. – Social Services Provider

Lack of resources, money and insurance. Denial of problem. – Public Health Representative

## Denial/Stigma

Like mental health: stigma. Most don't want to admit they have a problem; others see it as a weakness/deficiency so there is stigma and shame. For that reason, people don't access available services as much as they should. Also, Montana has a culture of drinking socially so it's difficult to avoid for those that perhaps would want to limit their exposure to alcohol. Drugs are a bit different. – Community Leader

The individual with the substance abuse problem not wanting the help. – Social Services Provider

Lack of recognition as to when drinking levels are unhealthy. – Other Health Provider

The greatest barrier to accessing needed substance abuse treatment is getting addicts to realize that they need treatment. – Community Leader



## Personal Choice

Desire to access services based on inability to imagine a fun life without substances. My response was related to alcohol specifically. Drinking is so closely tied into the social scene in Montana, I've watched people who think they might have a problem try to quit and fail because they are unable to find a way to continue to be social in the ways they are accustomed to. – Public Health Representative

Clients willingness to get help. – Social Services Provider

Personal choice, many options. Soft entry by access to marijuana and alcohol, especially for preteens and teens. – Physician

The number of youth that are abusing substances. – Social Services Provider

## Incidence/Prevalence

Substance abuse in our community is a lot more prevalent than many would believe. It also affects many age groups and income levels. – Community Leader

## Lack of Recreational Activities

Lack of high school and middle school activities leads to higher instances of substance use. – Social Services Provider

## Awareness/Education

Training. – Public Health Representative

## Most Problematic Substances

Key informants (who rated this as a “major problem”) clearly identified **alcohol** as causing the most problems in the community, followed by **methamphetamine/other amphetamines and heroin/other opioids**.

### SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Abuse as a “Major Problem”)

Alcohol	61.4%
Methamphetamines or Other Amphetamines	24.6%
Heroin or Other Opioids	8.8%
Prescription Medications	1.8%
Marijuana	1.8%
Cocaine or Crack	1.8%



# TOBACCO USE

## ABOUT TOBACCO USE

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

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

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

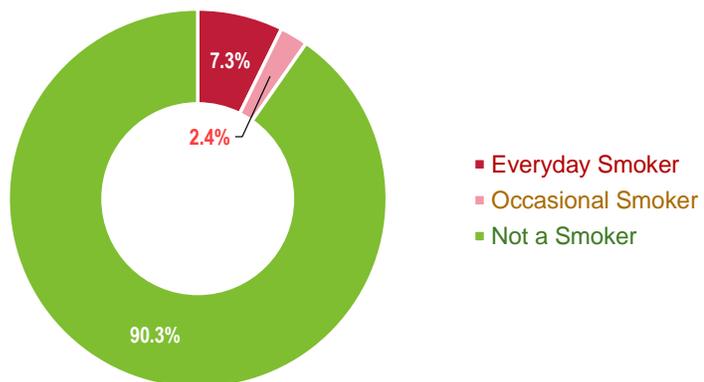
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Cigarette Smoking

### Cigarette Smoking Prevalence

**A total of 9.7% of SPH Service Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).**

Cigarette Smoking Prevalence  
(SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 40]  
Notes: • Asked of all respondents.



Note the following findings related to cigarette smoking prevalence in the SPH Service Area.

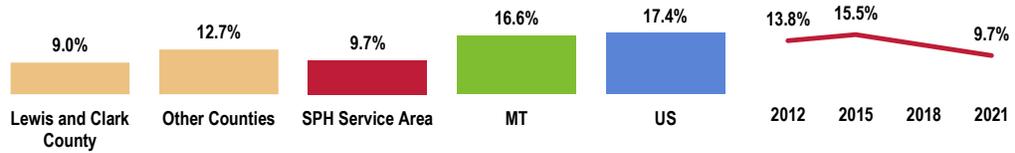
**BENCHMARK** ► Well below the state and national prevalence but failing to satisfy the Healthy People 2030 objective.

**DISPARITY** ► Higher among women, adults under 65, and those in lower-income households.

## Current Smokers

Healthy People 2030 = 5.0% or Lower

SPH Service Area



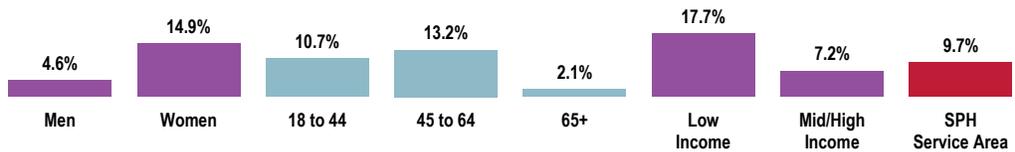
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 40]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); Montana 2019 data.  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.  
 • Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

## Current Smokers

(SPH Service Area, 2021)

Healthy People 2030 = 5.0% or Lower



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 40]  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.  
 • Includes regular and occasion smokers (every day and some days).



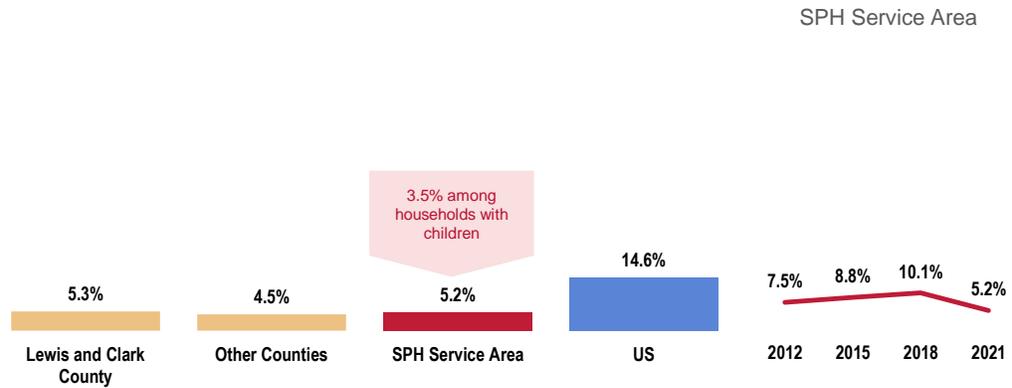
## Environmental Tobacco Smoke

Among all surveyed households in the service area, 5.2% report that someone has smoked cigarettes in their home on an average of four or more times per week over the past month.

**BENCHMARK** ▶ Well below the national prevalence.

**TREND** ▶ Similar to earliest findings but decreasing significantly since 2018.

### Member of Household Smokes at Home



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 43, 134]  
• 2020 PRC National Health Survey, PRC, Inc.

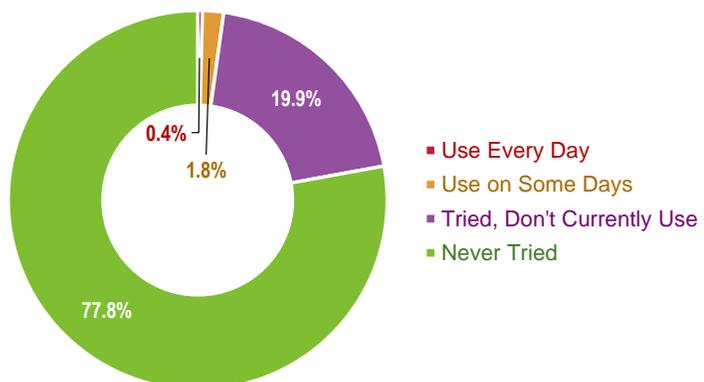
Notes: • Asked of all respondents.  
• "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.  
• "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Other Tobacco Use

### Use of Vaping Products

Most SPH Service Area adults have never tried electronic cigarettes (e-cigarettes) or other electronic vaping products.

#### Use of Vaping Products (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 135]  
Notes: • Asked of all respondents.



However, 2.2% currently use vaping products either regularly (every day) or occasionally (on some days).

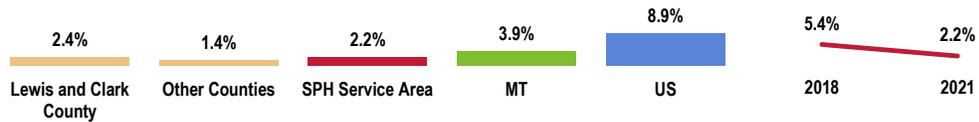
**BENCHMARK** ▶ Below the state figure and especially the national figure.

**TREND** ▶ Marks a significant decrease from 2018 survey findings.

**DISPARITY** ▶ Reported more often among men, young adults, and upper-income residents.

### Currently Use Vaping Products (Every Day or on Some Days)

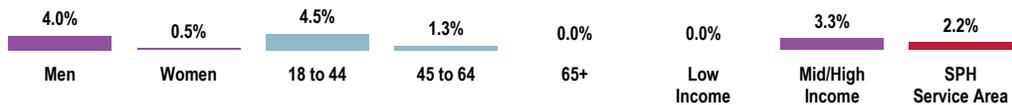
SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 135]  
 • 2020 PRC National Health Survey, PRC, 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): 2019 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.

### Currently Use Vaping Products (SPH Service Area, 2021)



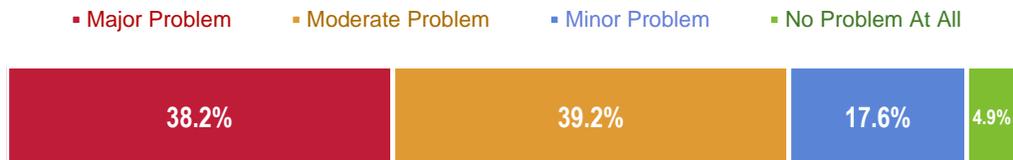
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 135]  
 Notes: • Asked of all respondents.  
 • Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).



# Key Informant Input: Tobacco Use

The greatest share of key informants taking part in an online survey characterized *Tobacco Use* as a “moderate problem” in the community, followed closely by “major problem” responses.

## Perceptions of Tobacco Use as a Problem in the Community (Key Informants, 2021)



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

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

### Youth

- Vaping has become a very big thing in the teenager demographic. – Social Services Provider
- Young using it and vaping. – Community Leader
- Number of youth taking up vaping. – Social Services Provider
- Too many kids are vaping because they think it is safe. – Physician
- It is beyond me that young people still continue to get involved with tobacco, especially with all the information available for the health issues. Older people know better for sure but addiction is a strong pull and so many are just not successful in their efforts to quit. I really doubt that the young people look upon smoking as “cool.” So what is the attraction? I have never been a smoker so I do not have a good answer. – Community Leader
- Tobacco and vaping use among youth is epidemic. – Public Health Representative
- Youth and adults have just converted to tobacco delivery systems other than cigarettes, vapes and E-cigs. Also, flavored cigs. A shame, we were doing well and the current state administration is going to move us backwards. – Community Leader
- Montana and Helena have higher than average tobacco use and the high uptick in youth tobacco rates via vaping is concerning. – Other Health Provider
- Vaping is an epidemic with youth. It’s also touted as a way to stop smoking cigarettes. There is a culture around rodeo that tobacco is a norm. – Social Services Provider

### Incidence/Prevalence

- Montana has a traditionally high use of tobacco, and it seems to be everywhere. – Social Services Provider
- E-cigarettes and flavored nicotine products are being marketed to our children, getting them addicted to nicotine early in life and continuing that addiction. Many of my patients smoke and chew tobacco despite knowing the medical problems this has caused them. Nicotine is so addictive. The amount of money spent treating people due to the detrimental effects of tobacco is huge. – Physician
- I see a lot of people smoking in front of bars, in their vehicles, and in public areas. – Public Health Representative
- It is in every community. – Other Health Provider
- The community health needs assessment and the county health rankings continue to show our county to have higher smoking rates than the national smoking rate. – Public Health Representative
- I still see/smell so many smokers. – Social Services Provider
- I honestly don’t know why so many Montanans smoke. – Physician



## Co-Occurrences

We are still seeing lots of patients with COPD. Now with vaping, and flavored vaping choices, younger people are starting to vape or smoke. – Physician

It causes lung cancer. – Social Services Provider

I believe the use of vape and tobacco causes significant increase in other health related problems. The single worst problem is with the children using vape. – Social Services Provider

## Easy Access

Access by minors. – Other Health Provider

Easy access. Usage beginning at younger ages. – Social Services Provider

## Impact on Quality of Life

Far too many lives are damaged through tobacco use and it is a struggle to let it go. – Social Services Provider

Addictive, expensive, causes cancer and heart disease. Leads to more personal medical problems, need for medical care and drains medical resources. – Physician

## Addiction

Nicotine is addictive and tobacco products are easily accessible. – Physician

It is so addictive: hard to quit. People have access to resources (“Quit line,” medications, etc.) but often it is a habit: have a cigarette before bed, or a social activity, or a stress reliever. For as addictive as it is, if unable to cope in other ways, they will have a hard time quitting. – Public Health Representative

## Contributing Factors

Many people who live in poverty use tobacco as a coping strategy, and it often leads to health and financial struggles. It is an unhealthy coping mechanism that often does not help the person to address the underlying issues they are struggling with and instead add additional issues and barriers. There are resources to help people try and quit, but our clients often struggle with accessing those resources consistently because of the trauma and crisis they are often experiencing. Additionally many programs aimed at helping people quit address the nicotine addiction but not the other issues they help drive the need for tobacco use. – Social Services Provider

## Parental Influence

Lots of adult modeling to youth, including chewing tobacco and nicotine vape products. – Social Services Provider



# SEXUAL HEALTH

## ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

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

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

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

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

## HIV

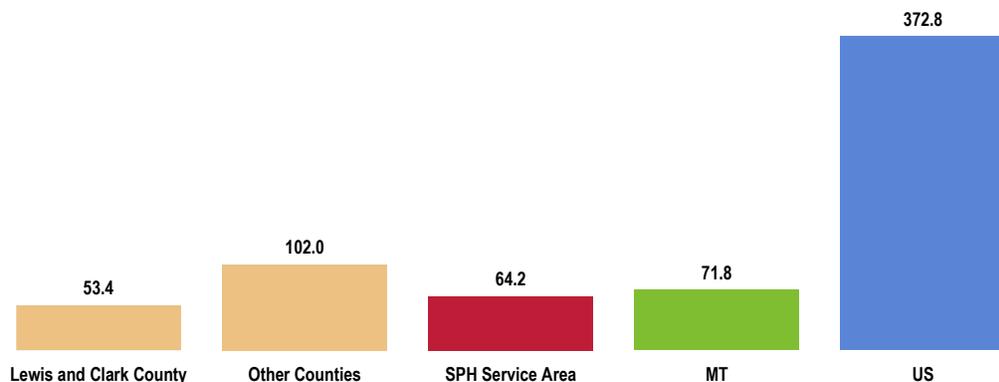
### HIV Prevalence

**In 2018, there was a prevalence of 64.2 HIV cases per 100,000 population in the SPH Service Area.**

**BENCHMARK** ▶ Well below the national prevalence rate.

**DISPARITY** ▶ Higher in the Other Counties than in Lewis and Clark County.

**HIV Prevalence**  
(Prevalence Rate of HIV per 100,000 Population, 2018)



Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.  
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap ([sparkmap.org](http://sparkmap.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.



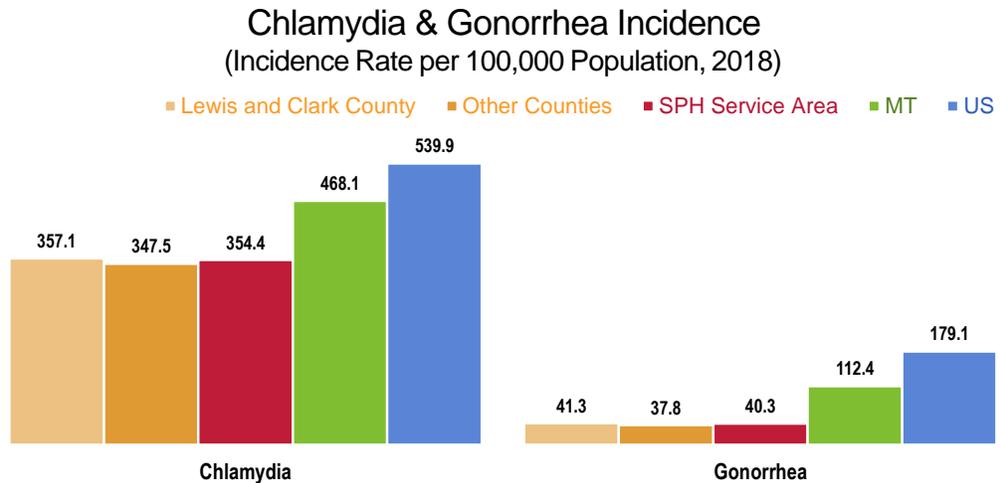
# Sexually Transmitted Infections (STIs)

## Chlamydia & Gonorrhea

In 2018, the chlamydia incidence rate in the SPH Service Area was 354.4 cases per 100,000 population.

The SPH Service Area gonorrhea incidence rate in 2018 was 40.3 cases per 100,000 population.

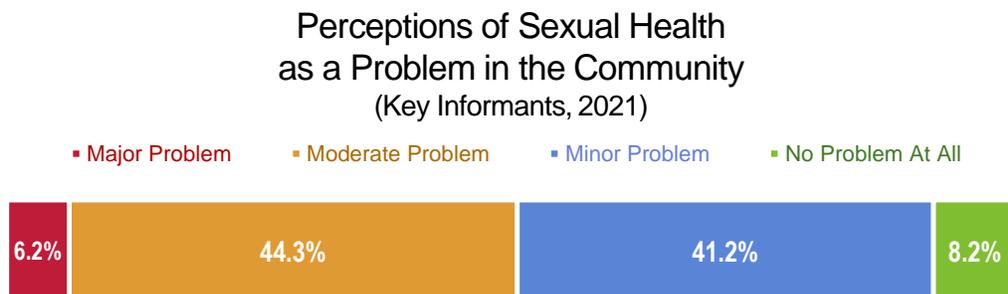
**BENCHMARK** ▶ Both rates are well below the related state and national rates.



Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.  
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap (sparkmap.org).  
 Notes: • This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.  
 • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Key Informant Input: Sexual Health

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



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

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

### Awareness/Education

Teens receive very little info about healthy sexuality. Most learn about sex from their computers, porn, or from their friends. – Other Health Provider





# ACCESS TO HEALTH CARE

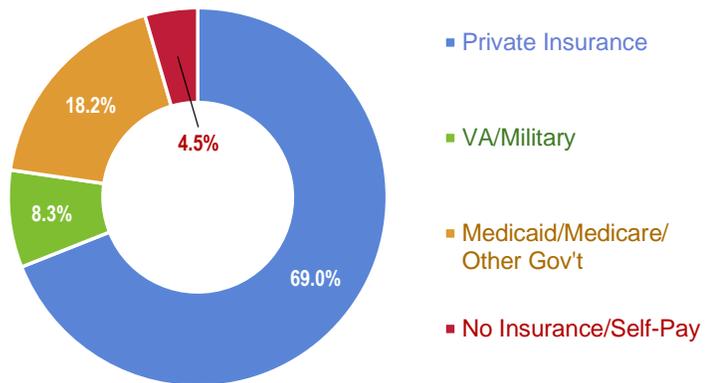
# HEALTH INSURANCE COVERAGE

## Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 69.0% of SPH Service Area adults age 18 to 64 report having health care coverage through private insurance. Another 26.5% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Health Care Insurance Coverage  
(Adults Age 18-64; SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 137]  
Notes: • Reflects respondents age 18 to 64.

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

## Lack of Health Insurance Coverage

Among adults age 18 to 64, 4.5% report having no insurance coverage for health care expenses.

**BENCHMARK** ▶ Well below the Montana and US percentages.

**TREND** ▶ Marks a steady, significant decrease in lack of insurance since 2012.

**DISPARITY** ▶ Notably higher in the low-income population.



## Lack of Health Care Insurance Coverage (Adults Age 18-64)

Healthy People 2030 = 7.9% or Lower

SPH Service Area

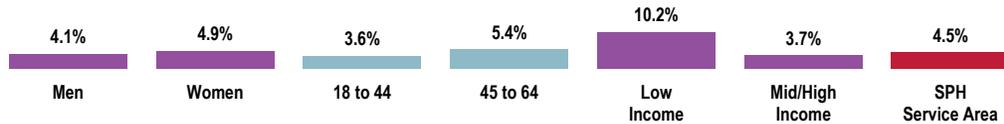


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 137]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents under the age of 65.  
 • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Lack of Health Care Insurance Coverage (Adults Age 18-64; SPH Service Area, 2021)

Healthy People 2030 = 7.9% or Lower



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 137]  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • Asked of all respondents under the age of 65.



# DIFFICULTIES ACCESSING HEALTH CARE

## ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. ...About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

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

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

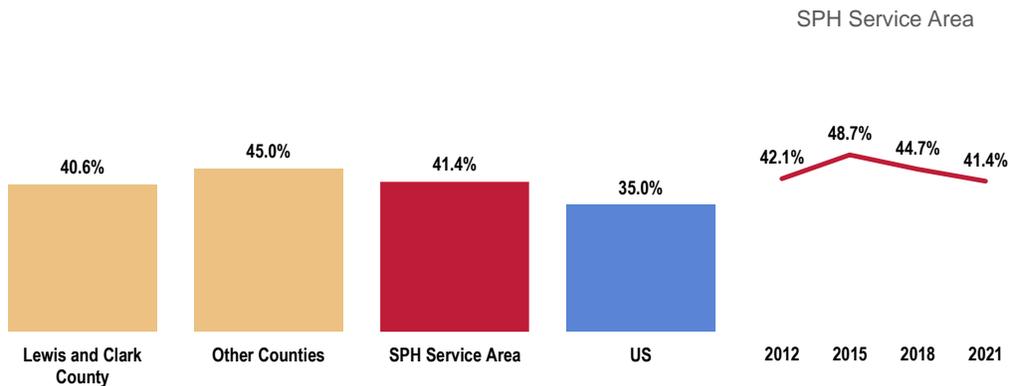
## Difficulties Accessing Services

**A total of 41.4% of SPH Service Area adults report some type of difficulty or delay in obtaining health care services in the past year.**

**BENCHMARK** ▶ Worse than the national percentage.

**DISPARITY** ▶ Highest among adults age 45 to 64.

### Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year

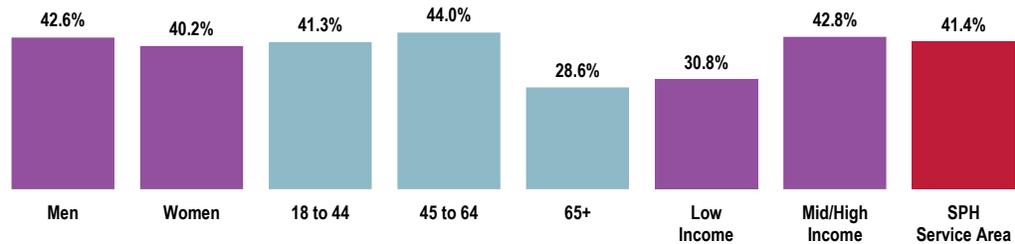


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 140]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 • Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.  
 • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.



## Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year (SPH Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 140]  
 Notes: ● Asked of all respondents.  
 ● Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

## Barriers to Health Care Access

Of the tested barriers, appointment availability and finding a physician impacted the greatest shares of SPH Service Area adults.

**BENCHMARK** ► Worse than US findings for appointment availability and finding a physician; better than US findings for cost of a physician visit, cost of prescription medications, and transportation.

**TREND** ► The barrier of cost (for both physician visits and prescription medications) has improved for service area residents since 2012.

**DISPARITY** ► Residents outside Lewis and Clark County are much more likely to report that a lack of transportation was a barrier to medical care in the past year.

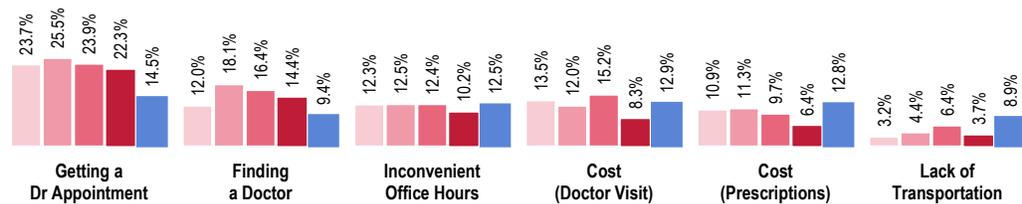
To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

## Barriers to Access Have Prevented Medical Care in the Past Year (SPH Service Area)

■ 2012 ■ 2015 ■ 2018 ■ 2021 ■ US

In addition, 7.4% of adults have skipped doses or stretched a needed prescription in the past year in order to save costs.



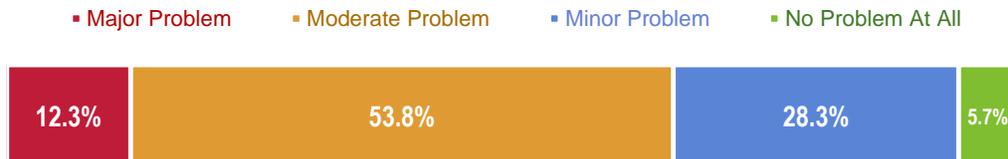
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 7-14]  
 ● 2020 PRC National Health Survey, PRC, Inc.  
 Notes: ● Asked of all respondents.



# Key Informant Input: Access to Health Care Services

Over half of key informants taking part in an online survey characterized *Access to Health Care Services* as a “moderate problem” in the community.

## Perceptions of Access to Health Care Services as a Problem in the Community (Key Informants, 2021)



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

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

### Access to Care/Services

It takes over a month to get a new patient in to a primary care doctor for their first visit. Often, primary care doctors don't have available appointment to see their panel of patients with acute illnesses. We still have deficits in specialty care such as Oncology, Neurology. – Physician

Families need to go out of state for specialized medical care. – Social Services Provider

Specific to mental health, professionals are booked, and limited amount of session frequency allowed by insurance is not helpful. As far as general health care, the care is so terribly expensive that often bypassed. Even when insurance is available, the out of pocket and deductibles make access to care troubling. Basically care is available to those who have. – Community Leader

There are no internal medicine physicians in our community. – Physician

People cannot afford medical care of any kind, especially mental health and dental health. – Social Services Provider

St. Peter's Health and Hospital have lots of turnover and seem to have trouble recruiting and retaining specialists. – Community Leader

For Augusta, Montana, access to health services in Lewis and Clark County is one of the biggest challenges. Distance and road conditions are a huge barrier. Lack of transportation for some folks so having to rely on family/friends. Augusta has me as a public health nurse but no clinic and no pharmacy so folks have to travel far to get medical care. – Public Health Representative

### Insurance Issues

People who do not have access to any affordable health insurance often do not have the same options for health care as do people who have insurance provided by an employer or through other means. The State Legislature seems to want to continue to limit those who can receive Medicaid and that also creates some challenges. In addition, there are some specialities that have one or no specific provider in town and that may limit people's options or force them to go out of town. – Community Leader

Cost for uninsured or under-insured people. – Other Health Provider

### Contributing Factors

Cost, people don't understand need for screening and treatment, transportation. – Other Health Provider

Lack of coordinated care. Too many gaps and cracks. – Community Leader



# PRIMARY CARE SERVICES

## ABOUT PREVENTIVE CARE

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

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

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

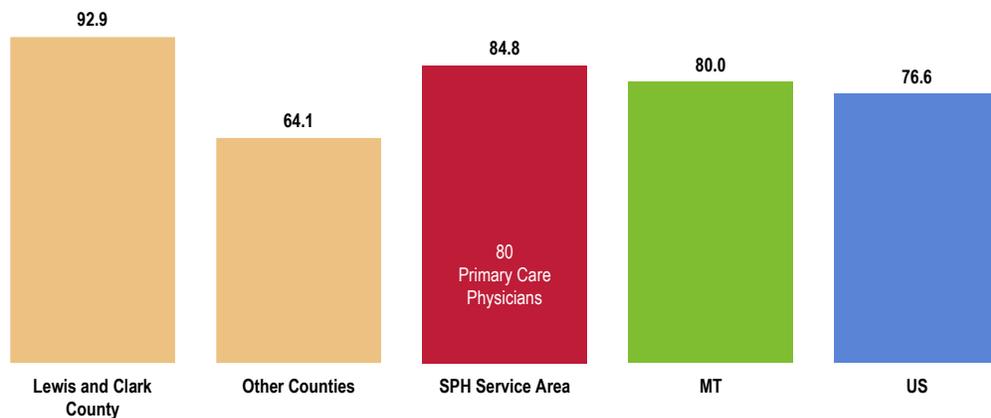
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Access to Primary Care

In 2017, there were 80 primary care physicians in the SPH Service Area, translating to a rate of 84.8 primary care physicians per 100,000 population.

DISPARITY ► Considerably lower outside Lewis and Clark County.

Access to Primary Care  
(Number of Primary Care Physicians per 100,000 Population, 2017)



Sources: 

- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2021 via SparkMap ([sparkmap.org](http://sparkmap.org)).

Notes: 

- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.
- "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Specific Source of Ongoing Care

A total of 79.2% of SPH Service Area adults were determined to have a specific source of ongoing medical care.

**BENCHMARK** ▶ Higher than the US prevalence but failing to satisfy the Healthy People 2030 objective.

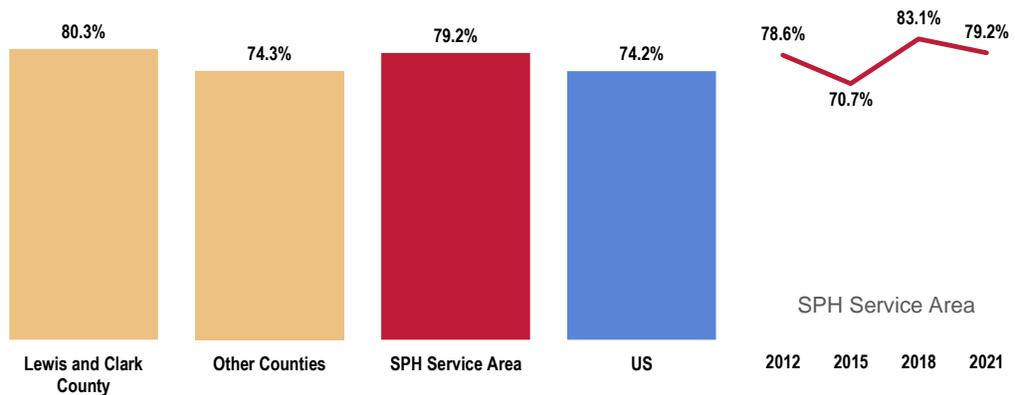
**TREND** ▶ Fluctuating over time (higher than the 2015 survey findings).

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.

### Have a Specific Source of Ongoing Medical Care

Healthy People 2030 = 84.0% or Higher



- Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 139]
  - 2020 PRC National Health Survey, PRC, Inc.
  - US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>
- Notes:
- Asked of all respondents.
  - "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Utilization of Primary Care Services

### Adults

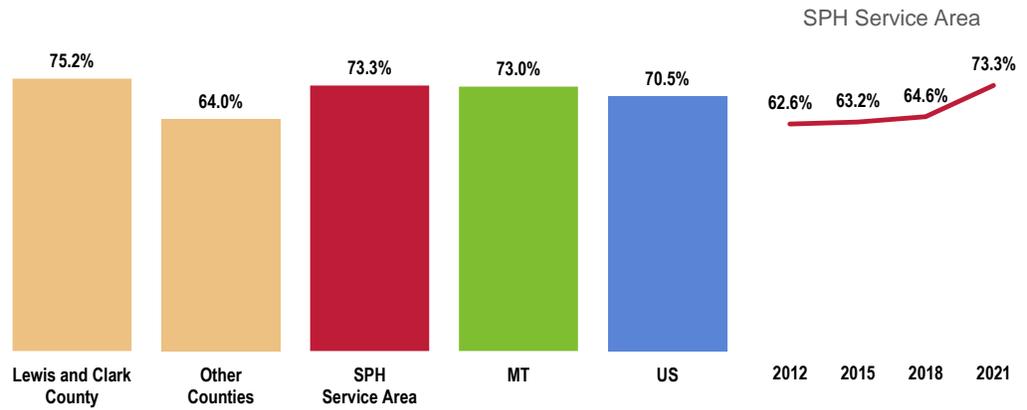
Nearly three in four adults (73.3%) visited a physician for a routine checkup in the past year.

**TREND** ▶ Marks a statistically significant increase from the previous years' survey findings.

**DISPARITY** ▶ Much lower outside Lewis and Clark County. Correlates with age and is lower among men than women in the service area.



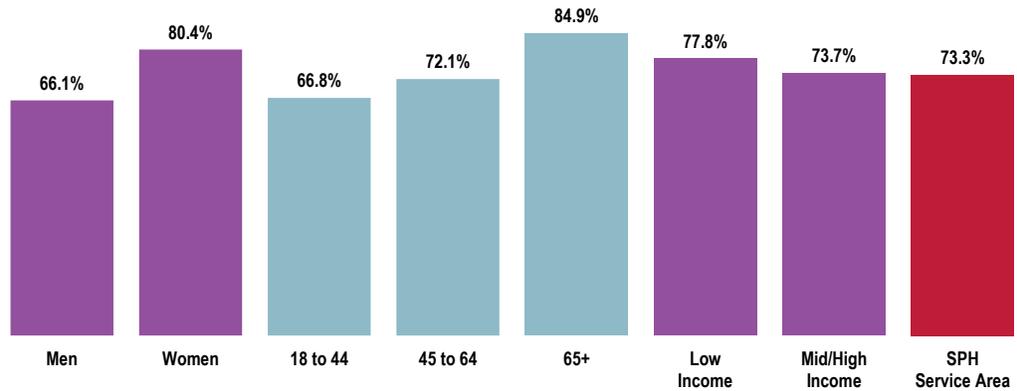
## Have Visited a Physician for a Checkup in the Past Year



Sources: • 2021 PRC Community Health Survey, PRC, 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); 2019 Montana data.  
 • 2020 PRC National Health Survey, PRC, Inc.

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

## Have Visited a Physician for a Checkup in the Past Year (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 18]  
 Notes: • Asked of all respondents.

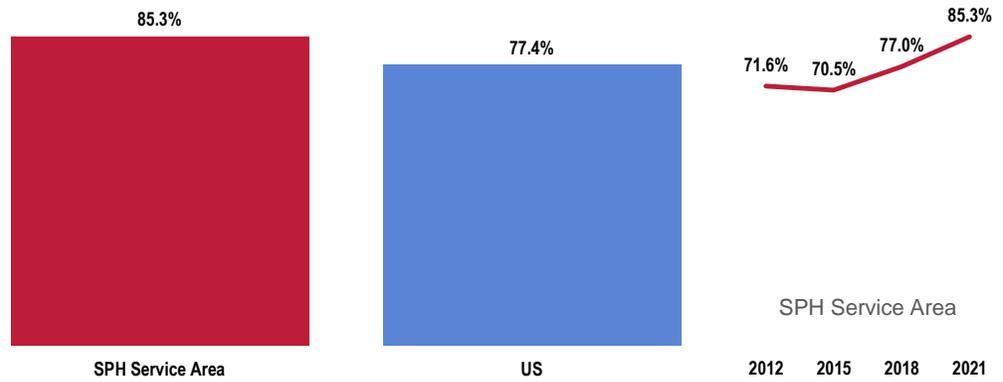


## Children

Among surveyed parents, 85.3% report that their child has had a routine checkup in the past year.

TREND ► Marks a statistically significant increase since 2012.

### Child Has Visited a Physician for a Routine Checkup in the Past Year (Parents of Children 0-17)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 105]  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents with children 0 to 17 in the household.



# EMERGENCY ROOM UTILIZATION

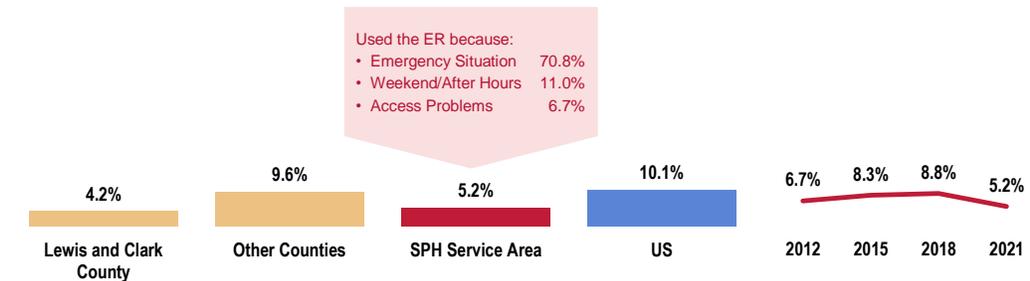
A total of 5.2% of SPH Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

**BENCHMARK** ▶ Well below the national prevalence.

**DISPARITY** ▶ Reported more often among adults age 45 to 64.

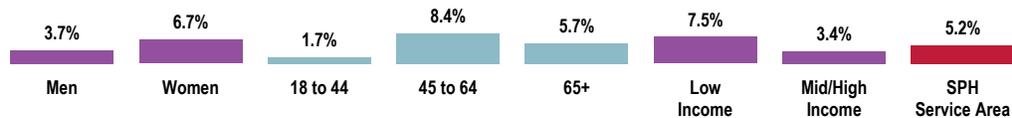
## Have Used a Hospital Emergency Room More Than Once in the Past Year

SPH Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 22, 300]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 : • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.

## Have Used a Hospital Emergency Room More Than Once in the Past Year (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 22]  
 Notes: • Asked of all respondents.

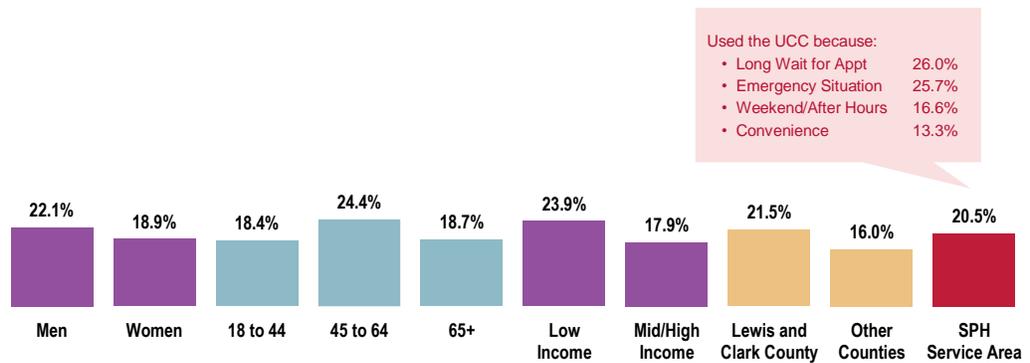


# URGENT CARE CENTER UTILIZATION

A total of 20.5% of SPH Service Area adults have been treated in an urgent care center in the past year.

DISPARITY ► Higher among Lewis and Clark County respondents.

## Have Been Treated at an Urgent Care Center in the Past Year (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 301-302]  
 Notes: • Asked of all respondents.  
 : • "Other Counties" include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



# ORAL HEALTH

## ABOUT ORAL HEALTH

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

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

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

## Dental Insurance

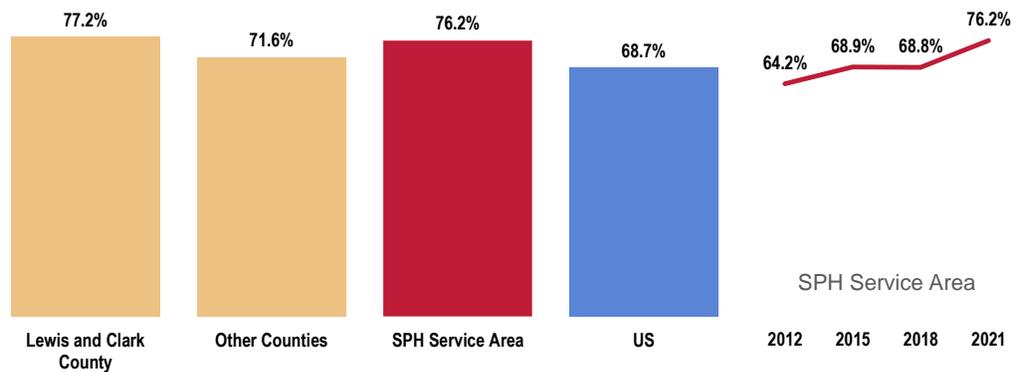
**Over three in four SPH Service Area adults (76.2%) have dental insurance that covers all or part of their dental care costs.**

**BENCHMARK** ▶ Higher than the national prevalence and satisfies the Healthy People 2030 objective.

**TREND** ▶ Denotes a statistically significant increase from 2012 survey findings.

### Have Insurance Coverage That Pays All or Part of Dental Care Costs

Healthy People 2030 = 59.8% or Higher



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 21]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

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



# Dental Care

## Adults

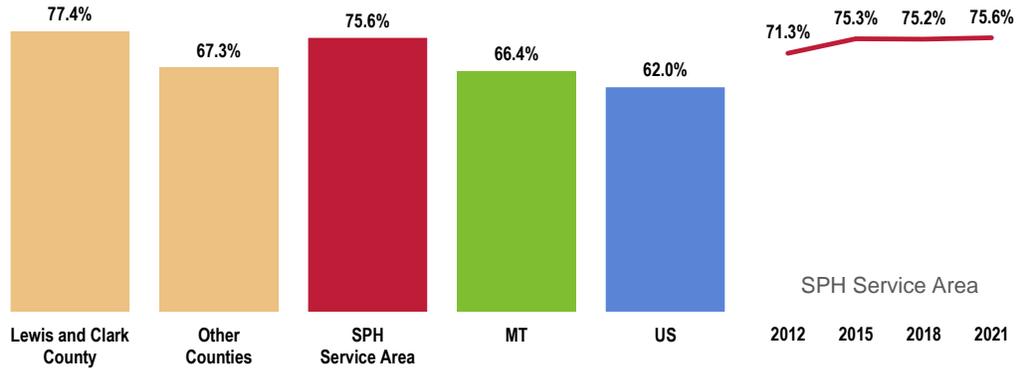
**A total of 75.6% of SPH Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.**

**BENCHMARK** ▶ Well above the state and national percentages. Easily satisfies the Healthy People 2030 objective.

**DISPARITY** ▶ Reported less often among women and low-income respondents.

### Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



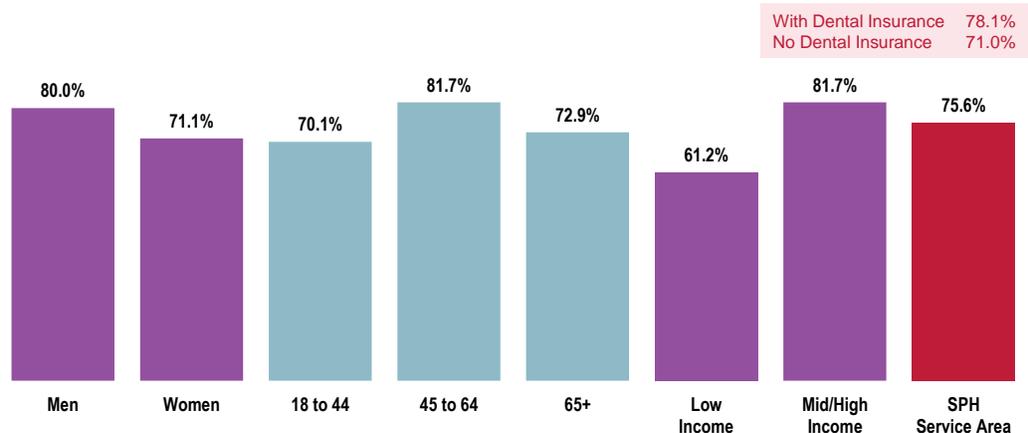
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 20]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.  
• 2020 PRC National Health Survey, PRC, Inc.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

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



## Have Visited a Dentist or Dental Clinic Within the Past Year (SPH Service Area, 2021)

Healthy People 2030 = 45.0% or Higher



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 20]  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>  
 Notes: • Asked of all respondents.

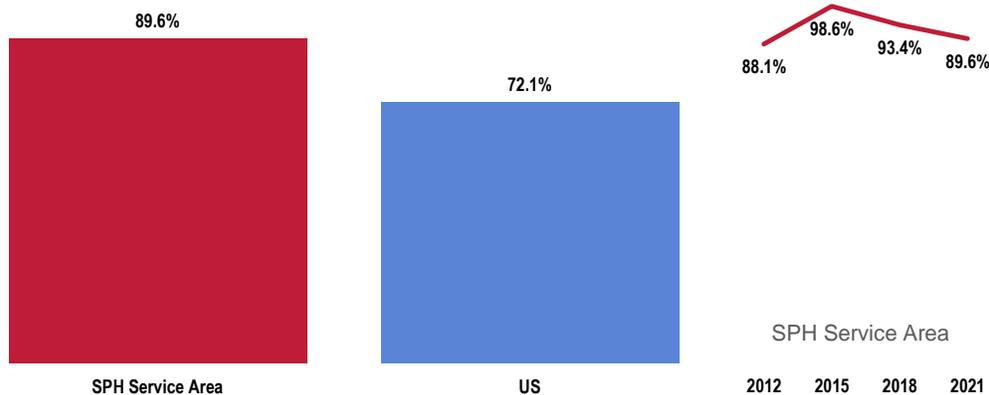
## Children

A total of 89.6% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

**BENCHMARK** ► Higher than the US figure and satisfying the related Healthy People 2030 goal.

## Child Has Visited a Dentist or Dental Clinic Within the Past Year (Parents of Children Age 2-17)

Healthy People 2030 = 45.0% or Higher



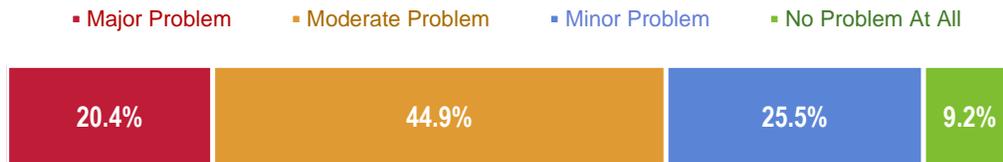
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 108]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>  
 Notes: • Asked of all respondents with children age 2 through 17.



# Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a “moderate problem” in the community.

## Perceptions of Oral Health as a Problem in the Community (Key Informants, 2021)



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

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

### Access to Care/Services

- Most dentists don't take Medicaid. – Social Services Provider
- Almost no dental providers for Medicaid beneficiaries. – Physician
- Lack of available dentists that accept Medicaid. – Social Services Provider
- Not many providers who accept Medicaid. Our scope of practice issues are huge. Big turf protection by hygienists around varnish. – Community Leader
- Issue for the uninsured. – Physician
- Lack of access to dental health care for those who can't afford insurance or are unemployed and are not currently insured. – Community Leader
- Minimal insurance coverage including Medicaid for routine dental visits and screenings. Minimal providers accepting Medicaid. – Physician
- Lack of insurance coverage for dental care, and lack of access for many individuals. – Public Health Representative
- There are no dental services offered in our community. It was tried a few years ago to have a dentist available at our medical clinic but it went away. Not sure what was involved in cancelling those services. There are plenty of dental providers in Helena but again travel may prevent challenges. – Community Leader

### Contributing Factors

- Many of our clients struggle with oral health. They often use the dental clinic at Pureview but often only after their oral health has deteriorated to the point of needing dentures. Many people struggle to get in to dentists to engage in preventative care and maintenance. Payment is also hard for many of our clients and there are sometimes remedies other than pulling teeth that are too expensive for our clients to afford. Clients with substance use history often complain of judgment and inappropriate care from dental providers and neglect that part of their health to avoid the shame and judgment that often comes with seeking services. – Social Services Provider
- I have noticed that many adults in our community have unaddressed dental issues-missing teeth, rotting teeth. Some of these situations are related to other related causes such as substance abuse (meth use), or mental illness where teeth are neglected. Persons with low incomes simply do not have access to regular preventative dental care that those with higher incomes and dental health coverage are able to access. – Social Services Provider

### Affordable Care/Services

- There are lots of folks that cannot afford dental care. – Community Leader
- Costs and access to services. – Social Services Provider
- People can't afford it. – Social Services Provider

### Incidence/Prevalence

- I see folks all over Helena with extremely poor dental hygiene and serious oral decay. – Social Services Provider



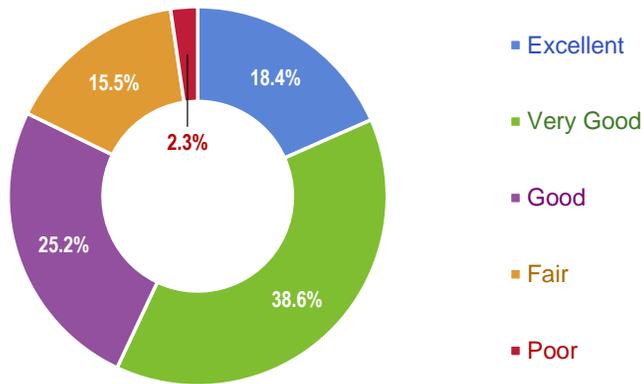


# LOCAL RESOURCES

# PERCEPTIONS OF LOCAL HEALTH CARE SERVICES

Most SPH Service Area adults rate the overall health care services available in their community as “excellent” or “very good.”

Rating of Overall Health Care Services Available in the Community (SPH Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 6]  
Notes: • Asked of all respondents.

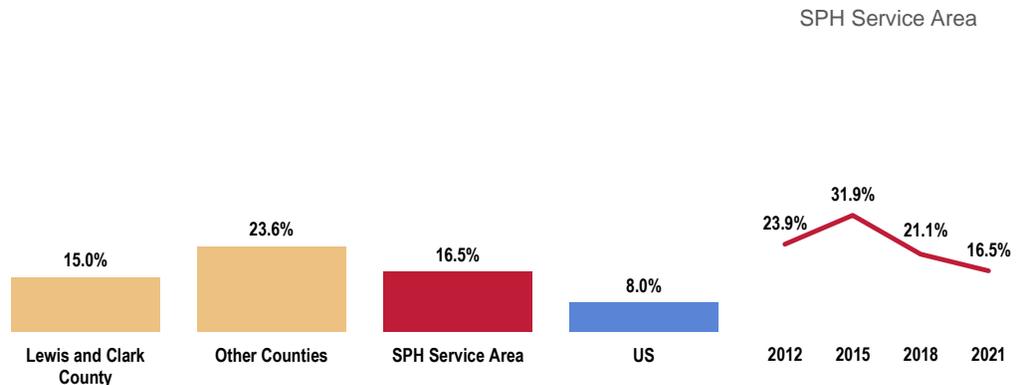
However, 16.5% of residents characterize local health care services as “fair” or “poor.”

**BENCHMARK** ▶ Twice the US percentage.

**TREND** ▶ Marks a significant decrease from 2012 and 2015 survey findings.

**DISPARITY** ▶ Highest among adults age 45 to 64 and those with access difficulties in the past year.

## Perceive Local Health Care Services as “Fair/Poor”

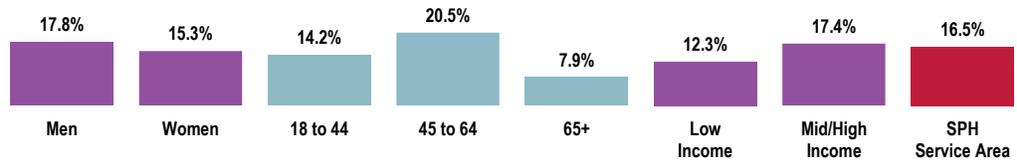


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 6]  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.  
• “Other Counties” include Broadwater, Jefferson, Meagher, and Powell counties in Montana.



## Perceive Local Health Care Services as “Fair/Poor” (SPH Service Area, 2021)

With Access Difficulty 27.7%  
No Access Difficulty 8.4%



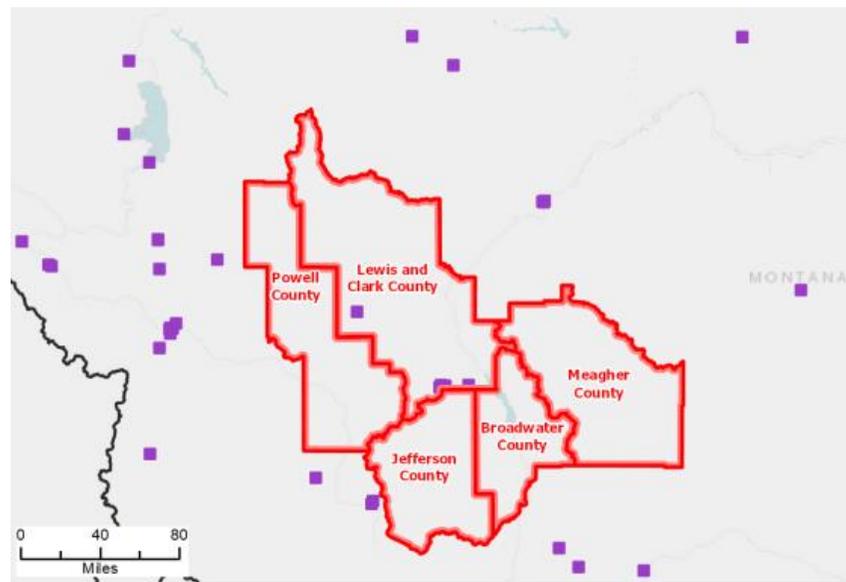
Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 6]  
Notes: • Asked of all respondents.



# HEALTH CARE RESOURCES & FACILITIES

## Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within the SPH Service Area as of September 2020.



Map Legend

Federally Qualified Health Centers, POS  
September 2020



Report Location, County



SparkMap



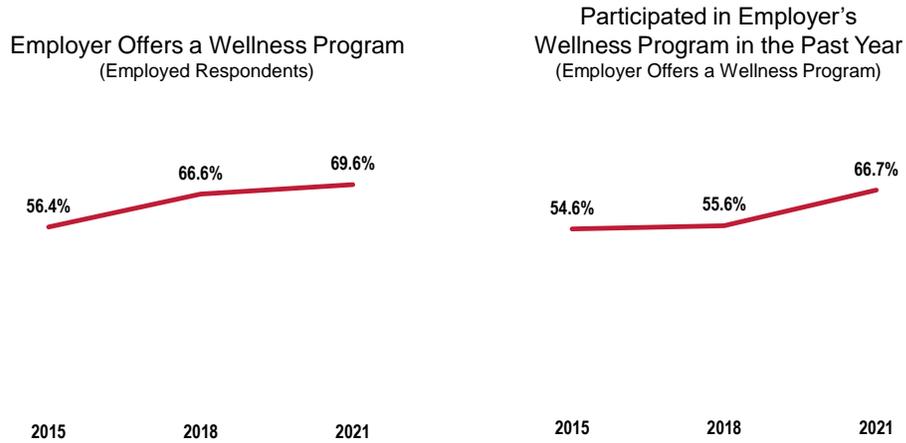
# Workplace Wellness Programs/Events

Among employed survey respondents, 69.6% report that their employer offers a workplace wellness program.

TREND ► Denotes a significant increase since 2015.

Of those employed respondents whose employer offers a workplace wellness program, two in three (66.7%) participated in such an event at least once in the past year.

TREND ► Increasing from previous survey findings.



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 336-337]  
Notes: • Asked of all employed respondents.



# Resources Available to Address the Significant Health Needs

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

## Access to Health Care Services

- Benefis Health Care
- Center for Mental Health
- Children's Special Health Services
- God's Love Inc.
- Health Department
- Helena Indian Alliance
- Help 406-438-6978
- Hospitals
- Instar
- Insurance
- Lewis and Clark Health Department
- Library
- MAPP-Net
- Montana Family to Family Health Information Center
- Montana School for the Deaf and Blind
- Our Place
- PureView Health Center
- Rocky Mountain Development Council
- Shodair Children's Hospital
- St. Peter's Health
- St. Peter's Hospital

## Cancer

- American Cancer Society
- Huntsman Cancer Institute
- County/State Cancer Screening Programs
- CTC Care Managers
- Doctor's Offices
- Huntsman Cancer Institute
- Last Chance Gulch
- Lewis and Clark Public Health
- PureView Health Center
- St. Peter's Cancer Center
- St. Peter's Health
- St. Peter's Hospital
- Support Group
- Veteran's Administration

## Coronavirus

- Child Care Connections
- Communication Strategies for Vaccine Hesitancy
- CVS
- Doctor's Offices
- DPHHS
- Family Planning Clinic
- Ft. Harrison Veteran's Healthcare Center
- Health Department
- Helena Indian Alliance–Leo Pocha Clinic
- Hospitals
- Independent Record
- Lewis and Clark Board of Health
- Lewis and Clark Health Department
- Lewis and Clark Public Health
- Local Business Leaders
- Pharmacies
- Public Health
- PureView Health Center
- School System
- St. Peter's Health
- St. Peter's Hospital
- Television

## Dementia/Alzheimer's Disease

- AARP
- Alzheimer's Association
- Area Agency on Aging
- Assisted Care Facilities
- Benefis Health Care
- Big Sky
- Big Sky Nursing Home
- Caregiver Support Groups
- Community Center on Aging
- Cooney Home
- Doctor's Offices
- DPHHS
- Dynamic Health Technologies
- Edgewood
- Fitness Centers/Gyms
- Friends/Family
- Home Helpers of Helena
- Masonic Home



- Memory Care Units
- Montana State Plan
- Natural Grocers
- PureView Health Center
- Real Food Store
- Renaissance
- Rocky Mountain Development Council
- Senior Programs
- Shodair Children's Hospital
- St. Patrick/Providence Hospital
- St. Peter's Health
- St. Peter's Health Medical Group
- St. Peter's Hospital
- State of Montana
- Touchmark
- United Way
- Visiting Angels

**Diabetes**

- American Diabetes Association
- Association of Diabetes Care and Education Specialist
- Diabetes Education
- Doctor's Offices
- Family Planning Clinic
- Federally Qualified Health Centers
- Fitness Centers/Gyms
- Food Share
- Grocery Stores
- Helena Food Share
- Helena Indian Alliance
- Hospitals
- Inch by Inch Program
- Lewis and Clark Health Department
- Lewis and Clark Public Health
- Montana Diabetes Control Project
- Montana Diabetes Program
- Nutrition Services
- Planet Fitness
- PureView Health Center
- School System
- St. Peter's Health
- St. Peter's Health Medical Group
- St. Peter's Hospital
- Touchmark
- Veteran's Administration
- Weight Watchers
- Youth Sports Programs

**Disabilities**

- Area 4 Agency on Aging
- Chronic Disease Self-Management Education Programs
- Doctor's Offices
- Group Homes

- Healthy Communities Coalition
- Helena Indian Alliance–Leo Pocha Clinic
- Helena Orthopedics
- Montana Independent Living Project
- Physical Therapy
- PureView Health Center
- Social Security Administration
- Spring Meadow Resources
- St. Peter's Health
- St. Peter's Hospital
- Stepping On
- Veteran's Administration
- Walk With Ease
- West Mont

**Family Planning**

- Benefis Health Care
- Children's Hospital of Montana
- Community Health
- Criminal Justice System
- Deaconess
- DPHHS
- Early Childhood Coalition
- Faith-Based Resources
- Headstart
- Healthy Mothers/Healthy Babies
- Helena Indian Alliance
- Helena Pediatrics
- Options Clinic
- Partners in Pediatrics
- Planned Parenthood
- Public Health
- PureView Health Center
- Rocky Mountain Development Council
- St. Peter's Health
- WIC

**Heart Disease**

- American Heart Association
- Doctor's Offices
- Freedom From Smoking
- Health Coaches for Hypertension
- Health Department
- Lewis and Clark Public Health
- Parks and Recreation
- PureView Health Center
- Senior Programs
- St. Peter's Health
- Veteran's Administration
- Wellness Programs
- YMCA



## **Injury and Violence**

Augusta Ambulance  
Behavioral Health Services  
Child Protection Team  
Doctor's Offices  
Domestic Violence Center  
DPHHS  
Faith-Based Resources  
Friendship Center  
Good Samaritan Ministries  
Helena Police Department  
Helena Resource Advocates  
Law Enforcement  
Lewis and Clark Suicide Prevention Coalition  
Lewis and Clark Health Department  
Lewis and Clark Public Health  
Lewis and Clark Sheriff's Department  
Montana Coalition Against Domestic Violence  
Outpatient Treatment Center  
Private Therapists  
Probation and Parole  
PureView Health Center  
School System  
St. Peter's Health  
VAWA Law Enforcement  
Victim Services  
Youth Connections  
YWCA

## **Kidney Disease**

PureView Health Center  
St. Peter's Health

## **Mental Health**

AA/NA  
AWARE  
Behavioral Health Leadership Team  
Big Sky Psychiatry  
Boyd Andrew Center  
Center for Mental Health  
Community Mental Health Center  
CTR  
Doctor's Offices  
DPHHS  
Early Childhood Education  
Florence Crittenton  
God's Love Inc.  
Good Samaritan Ministries  
Health Department  
Helena Indian Alliance  
Helena Indian Alliance - Leo Pocha Clinic  
Helena Valley Addiction Services  
Helena Young Professionals  
Homeless Service Providers

Indian Health Clinic  
Instar  
Intermountain  
Intermountain Child and Adolescent Psychiatry Clinic  
Intermountain Children's Home  
Intermountain Hope and Healing  
Journey Home  
Lewis and Clark Public Health  
Local Advisory Council  
Medicaid  
Mental Health Providers  
MHAT Trainings  
Mobile Crisis Response Team  
Montana Telepsych Solutions  
NAMI  
Our Place  
PACT Teams  
Pre-Trial Services  
Private Therapists  
Providence  
Public Health  
PureView Health Center  
Rocky Mountain Development Council  
School System  
Shodair Children's Hospital  
Small Business Development  
Social Groups/Clubs  
Social Workers  
St. Peter's Health  
St. Peter's Hospital  
State of Montana Employee Assistance Program  
Suicide Prevention Coalition  
Telehealth  
Training for Suicide Prevention  
Veteran's Administration  
Wells Wellness  
Western Montana Community Mental Health Center  
YWCA

## **Nutrition, Physical Activity, and Weight**

AARP  
Child and Adult Care Food Program  
Capital City Health Club  
Chronic Disease Self-Management Education Programs  
City of Helena  
District Wellness Committee  
Doctor's Offices  
Employee Wellness Programs  
Evolve Nutrition  
Fitness Centers/Gyms  
Food Share



- Girls Thrive
- God's Love Inc.
- Good Samaritan Ministries
- Healthy Communities Coalition
- Helena Community Gardens
- Helena Farmer's Market
- Helena Food Share
- Hospitals
- Inch by Inch Program
- Jennifer Colegrove
- Kids Hunger Coalition
- Lewis and Clark Health Department
- Lewis and Clark Public Health
- Montana CSAs
- No Kid Hungry
- Nutrition Services
- Online Weight Loss Programs
- Parks and Recreation
- Prickly Pear Land Trust
- Public Health
- PureView Health Center
- Real Food Store
- Rocky Mountain Development Council
- School System
- Self-Help Resources
- SNAP Education
- St. Peter's Health
- Veteran's Administration
- Weight Watchers
- YMCA
- Youth Sports Programs

**Oral Health**

- Caldwell Dental
- Calmor Dental
- Community Health Dental Services
- Dentist's Offices
- Doctor's Offices
- Health Department
- Lewis and Clark Public Health
- Local Dental Association
- Montana Roots Dental
- PureView Health Center
- School System

**Respiratory Disease**

- American Lung Association
- County Air Programs
- Doctor's Offices
- DPHHS
- Fort Harrison VA
- Helena Indian Alliance–Leo Pocha Clinic
- Local/State Restrictions on Indoor Smoking
- PureView Health Center
- St. Peter's Health

**Sexual Health**

- Doctor's Offices
- Medicaid
- Options Clinic
- Planned Parenthood
- PureView Health Center
- School System
- St. Peter's Health

**Substance Abuse**

- AA/NA
- Addiction Valley Resources
- After Court Services
- Agencies
- Boyd Andrew Center
- Celebrate Recovery
- Center for Mental Health
- Doctor's Offices
- Drug Court
- Florence Crittenton
- Friendship Center
- God's Love Inc.
- Good Samaritan Ministries
- Health Department
- Helena Housing Authority
- Helena Indian Alliance
- Helena Indian Alliance–Leo Pocha Clinic
- Helena Valley Addiction Services
- Helena Valley Treatment Services
- Hope House
- Hospitals
- Ideal Option
- Inpatient Substance Abuse Treatment
- Instar
- Intermountain
- Intermountain Hope and Healing
- Law Enforcement
- Licensed Addiction Counselors
- MAT Programs
- Montana Council on Problem Gambling
- Outpatient Substance Abuse Treatment
- Private Therapists
- Public Health



- PureView Health Center
- Salvation Army
- School System
- Shodair Children's Hospital
- St. Peter's Health
- St. Peter's Health Medical Group
- St. Peter's Hospital
- Valley Addiction Services
- Veteran's Administration
- Western Montana Community Mental Health Center
- Youth Connections

### **Tobacco Use**

- Doctor's Offices
- Employers
- God's Love Inc.
- Insurance
- Lewis and Clark County Cessation Program
- Lewis and Clark Health Department
- Lewis and Clark Public Health
- Licensed Addiction Counselors
- Mental Health Providers
- OPI-Tobacco Prevention
- Private Therapists
- PureView Health Center
- Quit Line
- Salvation Army
- School System
- St. Peter's Health
- State of Montana
- State of Montana Cessation Program
- Substance Abuse Providers
- Television
- Tobacco Cessation Resources





# APPENDICES

# EVALUATION OF PAST ACTIVITIES

St. Peter's Health (SPH) is committed to making a positive impact on the health of the community it serves. Upon review of the Community Health Needs Assessment, they develop strategies to focus on areas of greatest needs, taking into account the total available resources to effectively address those issues. From 2019-2021 SPH has approached the priority areas in the following ways:

## ACCESS TO HEALTHCARE SERVICES

Goal 1: Decrease barriers to care access	
Strategy	Activity/Accomplishment
<b>Improve virtual care availability</b>	<ul style="list-style-type: none"> <li>• Implemented telehealth platform                             <ul style="list-style-type: none"> <li>○ Connected 91 employed providers</li> <li>○ Over 14,000 virtual clinic visits</li> </ul> </li> <li>• 12 assisted living and skilled nursing facilities connected to virtual visit/virtual visit facilitation device</li> <li>• Partnered with University of Utah Health for Tele-stroke services, tele-Intensive Care Unit and tele-neurology services                             <ul style="list-style-type: none"> <li>○ Utilized 100+ times each year in the ED</li> </ul> </li> </ul>
<b>Improve rural care availability</b>	<ul style="list-style-type: none"> <li>• Opened satellite clinic in Townsend</li> </ul>
<b>Mitigate transportation barrier to care</b>	<ul style="list-style-type: none"> <li>• Launched a Community Paramedicine program                             <ul style="list-style-type: none"> <li>○ Over 300 referrals and 700 visits</li> </ul> </li> </ul>
<b>Improve access to community health and social care services</b>	<ul style="list-style-type: none"> <li>• Active membership on CONNECT (closed-loop electronic referral system) advisory board                             <ul style="list-style-type: none"> <li>○ Expanded use of CONNECT within organization and advocated for wider community use</li> </ul> </li> <li>• Provided free student sports physicals                             <ul style="list-style-type: none"> <li>○ Physicals provided covering 3 counties</li> </ul> </li> <li>• Provided free preventive health screenings (blood pressure)</li> </ul>
<b>Building/infrastructure</b>	<ul style="list-style-type: none"> <li>• Opened new Plastic Surgery &amp; Medical Aesthetics service line</li> <li>• Opened a new physical therapy and rehabilitation location</li> <li>• Partnered with local rural fire departments to re-station paramedic units to reduce response times.</li> <li>• Opened a dedicated Wound Care Center</li> </ul>



**Increase health profession training opportunities**

- Launched in-house Medical Assistant and Certified Nurse Assistant training program
  - Over 45 individuals newly trained
- Supported Health Occupations Students of America (HOSA) State Leadership conference
- Supported Carroll College Nursing-medical supplies
- Supported Great Divide Ski Patrol
- Provided ambulance Standby Event Support at a large variety of community events

**Goal 2: Improve ratings of local healthcare**

**Strategy**

**Activity/Accomplishment**

**Improve care experience for our community members**

- Hired a Patient Experience Partner
  - Improved 6 areas of communication challenges
- Implemented Patient & Family Advisory Council for primary care
- Implemented Community Advisory Council for hospital
- Supported local HIE (Big Sky Care Connect)
- Partnered with local organizations to provide holistic care to our patients

**Program Descriptions and Highlights**

- **Townsend Satellite Clinic:** This new clinic opened in 2020 in Townsend, MT, is located in Broadwater County, 30 miles away from our main SPH Campus. The St. Peter’s Health - Townsend Clinic provides comprehensive primary care services five days per week as well as rotating specialties including urology, general surgery and orthopedics to Townsend and the greater Broadwater County area. The clinic also houses laboratory services and diagnostic imaging services, like x-ray and ultrasound.
- **Outpatient Telehealth Access:** As a result of the Montana’s Shelter in Place during 2020 COVID-19 Pandemic, St. Peter’s Health had to rapidly implement telehealth options that were not previously in place within the medical group setting. Additionally, St. Peter’s Health partnered with the local assisted and skilled nursing facilities and provided a virtual device that captured vital signs and components of a digital physical assessment so that the patient was able to be assessed by an SPH employed provider, but within the safety of the facility to decrease the risk of COVID-19 exposure.
- **Community Paramedic Program:** The other area of focus was addressing limited transportation as a barrier to accessing care. To alleviate this we implemented a community paramedicine program aimed at treating individuals in their environment. This care delivery model allows paramedics to access services in their home with referral from their primary care team and connection via assisted telemedicine back to their PCP. The goal of the community paramedicine program is to provide public health and preventative care in the field to improve health outcomes and access to care. This program can provide many different types of care—blood draws, immunizations, chronic health condition education, facilitation of tele-health visits for those who have access challenges, vital signs monitoring, etc. Patients served through this program have verbalized some aspects of a social determinant of health barriers that prevents them from accessing care in a traditional environment – transportation challenges, COVID-19 diagnosis, and other socio-economic barriers.



# CANCER

Goal 1: Improve cancer education and community awareness	
Strategy	Activity/Accomplishment
<b>Educate the community on cancer prevention</b>	<ul style="list-style-type: none"> <li>• Sponsored local athletic programming with cancer awareness messaging</li> <li>• Delivered local media content (articles and interviews) focused on cancer awareness and promotion of screening and early detection</li> <li>• Supported American Cancer Society mission programs/patient support</li> <li>• Supported Susan Komen golf tournament</li> <li>• Supported Camp Mak-A-Dream for children with cancer</li> </ul>

Goal 2: Identify program and service enhancements	
Strategy	Activity/Accomplishment
<b>Clinical program development</b>	<ul style="list-style-type: none"> <li>• Affiliated Cancer Treatment Center with University of Utah's Huntsman Cancer Institute</li> </ul>

## Program Descriptions and Highlights:

- **Improving Community Awareness of Breast Cancer:** SPH sponsored Carroll College athletic programming to bring cancer awareness to local students and community members with a focus on breast cancer awareness. SPH also collaborated with key stakeholders to publish Health Matters Columns within the local newspaper, Helena Independent Record. Topic examples include:
  - Health Matters: Breast Cancer in Our Community
  - Health Matters: Screening, Early Detection Important Tools in Detecting Breast Cancer



## HEART DISEASE & STROKE

Goal 1: Increase blood pressure and cholesterol control	
Strategy	Activity/Accomplishment
<b>Standardize blood pressure measurement and hypertension care</b>	<ul style="list-style-type: none"> <li>• Implemented evidence-based Hypertension Care Pathway</li> <li>• Implemented measurement of standardized blood pressures</li> </ul>
<b>Increase community education and awareness</b>	<ul style="list-style-type: none"> <li>• Launched targeted proactive outreach efforts for patients with hypertension                             <ul style="list-style-type: none"> <li>○ 175+ individuals educated</li> </ul> </li> <li>• Provided free blood pressure screening                             <ul style="list-style-type: none"> <li>○ Hospital entrance monthly</li> <li>○ Capitol Square Farmers Market</li> </ul> </li> </ul>

Goal 2: Identify program and service enhancements	
Strategy	Activity/Accomplishment
<b>Clinical program development</b>	<ul style="list-style-type: none"> <li>• Launched group hypertension self-management class</li> <li>• Embedded clinical pharmacists &amp; clinical nutrition in team-based care                             <ul style="list-style-type: none"> <li>○ 2 clinical pharmacists</li> <li>○ 1 clinical nutritionist</li> <li>○ Over 420 clinical pharmacist visits in 2020</li> <li>○ Over 280 clinical nutritionist visits in 2020</li> </ul> </li> </ul>

### Program Descriptions & Highlights:

- **Hypertension self-management class:** St. Peter's Health invested in training two employees to become facilitators for the Health Coaches for Hypertension Control (HCHC) classes. These evidence-based classes target individuals who already have the diagnosis of hypertension and teach self-management strategies proven to help manage and improve high blood pressure, in addition to providing nutrition, activity, tobacco cessation and medication management education. Program implementation began in 2021 with both virtual and in-person format options.
- **Clinical Pharmacist & Clinical Nutrition addition to team-based care:** SPH was able to include wrap-around services for individuals via our embedded clinical pharmacists and the addition of an embedded clinical nutrition team member. During monthly rounding with primary care teams, Population Health team members encouraged referrals to these areas of expertise and support and in turn saw an increase in utilization of these resources for individuals with cardiovascular risk factors and/or current diagnoses. To help better understand the current state and to continue to monitor the success of these interventions, SPH implemented the use of a data dashboard via PowerBI for these populations.



## INJURY & VIOLENCE

Goal 1: Increase education and awareness of risk factors	
Strategy	Activity/Accomplishment
Offer screenings to identify individuals (age 65+) at-risk for falls	<ul style="list-style-type: none"> <li>Screening annually for all Medicare Annual Wellness Visits</li> </ul>
Educate the community on firearm related safety risks	<ul style="list-style-type: none"> <li>Hosted mental health awareness education</li> <li>Hosted suicide prevention training</li> <li>Active member of leadership team for community lethal means reduction group-Safer Communities Montana                             <ul style="list-style-type: none"> <li>Increased availability of lethal means reduction resources for distribution to patients/community</li> </ul> </li> </ul>
Promote community awareness of unintentional injury deaths	<ul style="list-style-type: none"> <li>Sponsor Friendship Center's Face the Violence campaign</li> <li>Sponsor Rocky Mountain Trauma Symposium</li> <li>HPD national child safety council-purchase of drug safety materials</li> <li>Continued to partner with certified child passenger safety technician for Child Car Seat Safety community class</li> </ul>

Goal 2: Identify program and service enhancements	
Strategy	Activity/Accomplishment
Clinical program development	<ul style="list-style-type: none"> <li>Fall prevention group workshop                             <ul style="list-style-type: none"> <li>20 individuals served in first 3 months</li> </ul> </li> </ul>

### Program Descriptions & Highlights:

- Fall Prevention Program:** SPH invested in training 5 staff members as Stepping On facilitators. This evidence based intervention is an upstream program to assist participants in gaining balance and strength while also learning to recognize their risk of falling and strategies to mitigate this risk. It has been shown to reduce falls 31%. While the implementation of the class was put on hold for a time, due to the COVID-19 pandemic, SPH was able to begin offering this class in 2021. Additionally, SPH continues to discuss community wide fall prevention efforts through participation in the Aging Well Workgroup whose mission is to ensure communities are livable for people of all ages, especially older adults and to educate and advocate for community changes and programs that serve this mission.
- Firearm-related death prevention efforts:** St. Peter's Health has hosted two annual "We Speak Mental Health Weeks" in September. This week focused on community and employee awareness, stigma reduction, and education regarding mental health resources, mental health crisis recognition and prevention of suicide deaths. For those in crisis, St. Peter's Health's Complex Care Team retains a stock of gun locks with accompanying tags listing the crisis hotline and Deterra drug deactivation systems for distribution to patients in outpatient clinic visits as needed. Furthermore, St. Peter's



Health became an active member of the Safer Communities Montana Leadership group, advocating for suicide prevention in through collaboration with firearm and pharmaceutical community to reduce lethal means access by people at-risk, by providing appropriate suicide prevention tools and training to pharmacies, firearm-related businesses, health providers and community members.

## MENTAL HEALTH

Goal 1: Improve community awareness of and engagement with mental health services	
Strategy	Activity/Accomplishment
<b>Increase depression screening rate to identify at-risk individuals</b>	<ul style="list-style-type: none"> <li>Implemented depression screening at least annually for all SPH primary care patients</li> </ul>
<b>Promote community awareness of mental health concerns/decrease stigma</b>	<ul style="list-style-type: none"> <li>Hosted awareness and education events               <ul style="list-style-type: none"> <li>Suicide prevention training</li> <li>Secondary trauma resiliency skills training</li> <li>Mental Health &amp; Youth Mental Health First Aid training</li> <li>Mental health mini-webinar</li> <li>Mental health focused local newspaper articles</li> </ul> </li> <li>Sponsored awareness events and activities: National Alliance on Mental Illness (NAMI) Walk team, Out of the Darkness Suicide Prevention Walk, Perinatal Mental Health conference, American Foundation for Suicide Prevention MT conference, CASA, Big Sky Council of Child and Adolescent Psychiatry webinar, 2020 MOM Conference webcast, Trauma Informed Advocates of Broadwater County, Intermountain mental and behavioral health, Big Brothers Big Sisters, Shodair, ChildWise Institute</li> <li>Partnered with Lewis &amp; Clark County Public Health to champion the Man Therapy campaign</li> <li>Participated in the Military Strong Campaign               <ul style="list-style-type: none"> <li>5 departments completed</li> </ul> </li> <li>Active member of the county Suicide Prevention Coalition and Mental &amp; Social Wellbeing Workgroup</li> <li>Active member of Elevate Montana Helena Affiliate-focused on adverse childhood event &amp; resilience awareness</li> </ul>



## Goal 2: Identify program and service enhancements

Strategy	Activity/Accomplishment
<b>Clinical program development</b>	<ul style="list-style-type: none"> <li>• Integrated behavioral health in to primary care team.               <ul style="list-style-type: none"> <li>○ 4 integrated behavioral health professionals</li> <li>○ 2,151 visits for 641 unique patients in 2020</li> </ul> </li> <li>• Developed a parental support program offering support from pregnancy through the first year postpartum</li> <li>• Added clinical psychologist to psychiatry clinic</li> <li>• Launched mobile crisis response team               <ul style="list-style-type: none"> <li>○ Helped 63 individuals avoid jail or ED in first 4 months</li> </ul> </li> <li>• Added art therapy program to inpatient Behavioral Health Unit in partnership with the Holter Art Museum and expanded art programming in Cancer Treatment Center and other inpatient units.               <ul style="list-style-type: none"> <li>○ Healing Arts exhibit at museum</li> </ul> </li> <li>• Added pet therapy program</li> <li>• Offered free Bereavement Education Support Group</li> <li>• Launched a new partnership with Frontier Psychiatry to offer on-demand psychiatry services for pediatric patients in crisis and all patients via mobile crisis response team.</li> <li>• Partnered with Intermountain to provide counseling to pediatric patients on the Women and Children's Unit</li> </ul>

### Program Descriptions & Highlights:

- **Mobile Crisis Response Team:** In 2020 St. Peter's Health implemented the Mobile Crisis Response Program. The goal of the Mobile Crisis Response Team program is to reduce emergency department and detention center admissions due to behavioral health crises because sometimes the best type of care is delivered right where the individual is – on the street, in their home. Individuals who are part of the Mobile Crisis Response Team are all mental health professionals with a wide variety of backgrounds – social work, law enforcement – who are committed to helping people in crisis. These individuals respond alongside law enforcement to reports of incidents where individuals are in behavioral health crisis – can be dispatched by officers or by 911. Once on scene, the Mobile Crisis Response Providers can provide de-escalation, safety planning and redirection to other resources for assistance in the community for individuals in which the emergency room or the detention center is not the right setting for care.
- **Integrated Behavioral Health within Primary Care:** Because St. Peter's Health is dedicated to caring for the whole person, they expanded team based care to include Integrated Behavioral Health. The growth of the team included 4 Behavioral Health Professionals (BHPs) and also expanded access by implementing virtual and telephonic visits in addition to face-to-face visits. The BHPs at St. Peter's Health Medical Group are Licensed Clinical Social Workers (LCSWs) and Licensed Clinical Professional Counselors (LCPCs) and work with the identified patient to provide brief counseling services in partnership with the employed primary providers. The BHPs work closely with the patient and primary care teams to provide services around the following areas: alcohol use, anxiety, depression, divorce/loss of relationship, substance use, grief, life transitions (such as children moving away or employment issues), postpartum depression and/or anxiety, and stress.



# NUTRITION, PHYSICAL ACTIVITY & WEIGHT

Goal 1: Education and awareness of healthy choices	
Strategy	Activity/Accomplishment
<b>Educate community on importance of healthy lifestyles</b>	<ul style="list-style-type: none"> <li>• Sponsored physical activity and healthy choice awareness focused events &amp; activities:               <ul style="list-style-type: none"> <li>○ Step-challenge</li> <li>○ Family Fun Fest</li> <li>○ SHAPE Montana-education for PE teachers in improving youth health</li> <li>○ Kiwanis club-ADA playground</li> <li>○ Prickly Pear Land Trust fun run</li> <li>○ YMCA Brand X</li> <li>○ Helena Dragon Boat Teams</li> <li>○ Home/virtual physical activity backpacks</li> <li>○ Youth bike riding-Helena Dynamos</li> <li>○ Helena Last Chance Tennis Club</li> <li>○ HHS softball</li> <li>○ Jefferson High Booster Club-weight room equipment</li> </ul> </li> </ul>
<b>Promote community awareness of and access to healthy food options</b>	<ul style="list-style-type: none"> <li>• Supported: Helena Food share Healthy Food Initiative, Salvation Army food pantry, Broadwater 4H Livestock Council support donation of local food to Broadwater food pantry</li> <li>• Partnered with Helena Food Share for distribution of Farmers to Families food boxes</li> <li>• Continued food box distribution partnership for individuals with chronic conditions and mobility or transportation challenges</li> <li>• Provided interviews and content to local news outlets on healthy lifestyle topics</li> </ul>

Goal 2: Identify program and service enhancements	
Strategy	Activity/Accomplishment
<b>Clinical program development</b>	<ul style="list-style-type: none"> <li>• Continued group diabetes prevention program</li> <li>• Invested in staff education for health coaching               <ul style="list-style-type: none"> <li>○ 4 staff trained and certified in health coaching</li> </ul> </li> </ul>

## Program Descriptions & Highlights:

- **Diabetes Prevention Program:** St. Peter's continues to offer the Inch by Inch as part of the National Diabetes Prevention Program and continued to achieve full recognition status with the Centers for Disease Control. This 12-month nutrition and physical activity course focuses on the prevention of diabetes and heart disease through lifestyle change. Classes are six months of weekly sessions and six months of monthly sessions. Eligible individuals include the following:



- Provider referral with cholesterol labs and glucose labs within a year
- Medical eligibility criteria: BMI >25, plus at least one of the following: Pre-diabetes, elevated blood pressure and/or elevated cholesterol with medication

During this class, the participants must commit to keeping a daily food and drink log plus regular moderate physical activity for >150 minutes/week. Additionally, a six-month YMCA membership is offered as part of the class fee. As a result of COVID-19 in 2020, the Inch by Inch team had to creatively design a virtual platform to ensure they were able to continue this service for our community members.

- **Health Coach Training:** St. Peter’s Health recognizes the importance of supporting patients and the community with quality resources to assist in meeting individuals where they are to support patient-centered, behavior-change goals related to health and weight management. To address this need, SPH invested in ensuring 4 staff members received the education and training necessary to become certified health coaches.

## POTENTIALLY DISABLING CONDITIONS

Goal 1: Identify program and service enhancements	
Strategy	Activity/Accomplishment
Clinical program development	<ul style="list-style-type: none"> <li>• Continued arthritis movement program</li> </ul>

### Program Descriptions & Highlights:

- **Arthritis Movement Program:** The Arthritis Movement Program designed specifically for people with arthritis and related diseases continued through 2019 and the first months of 2020. The program’s multiple components help reduce pain and stiffness, and help maintain or improve mobility, muscle strength and functional ability. Each class includes a variety of exercises that can be performed while sitting, standing or lying on the floor; endurance building routines; relationship exercises; and health education topics. Individuals from basic to advanced capabilities will benefit from the program. Unfortunately the program had to be put on temporary hold in March 2020 due to COVID-19.



## RESPIRATORY DISEASES

Goal 1: Increase education and awareness of risk factors	
Strategy	Activity/Accomplishment
Increase community education and awareness	<ul style="list-style-type: none"> <li>Partnered with the Montana Quitline to embed referrals in our EHR</li> <li>Active member in Montana Asthma Advisory Group</li> </ul>
Partner with the community to address the COVID -19 global pandemic	<ul style="list-style-type: none"> <li>Donated medical supplies to community nonprofits for precaution implementation</li> <li>Active member of local Community Organizations Active in Disasters</li> <li>Provided clinical experts to disseminate COVID-19 prevention information in local media</li> <li>Opened COVID-19 testing facility to the community</li> <li>Donated time and materials to community COVID response efforts</li> <li>Served as a key member of the local COVID-19 vaccination planning group</li> </ul>

### Program Descriptions & Highlights:

- Tobacco Cessation Program:** St. Peter's Health partners both with the Montana QuitLine and the American Lung Association to implement a community clinically-based program to help tobacco users quit for good. This program uses evidenced-based programming that combines the use of medication and behavioral counseling. This approach is widely regarded as the "Gold Standard" of tobacco cessation programming. The Freedom from Smoking was created by the experts at the American Lung Association – an organization with more than 50 years of experience helping those who use tobacco quit. This program is led by St. Peter's Health trained facilitators and is offered to anyone who uses tobacco through a primary care provider referral. Using evidence-based programming to encourage the use of medication and/or nicotine replacement therapy, this 7-week group program (8 classes total) helps individuals prepare for Quit Day, offer group support from others who are also wanting to quit, includes access to a free telephone support line, and class materials to be used in and outside of the sessions. Despite COVID-19 challenges 46 individuals completed the course in 2020 and the program experienced a 60% successful quit rate at 6 weeks after course completion.
- COVID-19 support:** During 2020, much of the organizational focus shifted to preparing for and addressing the COVID-19 Global Pandemic within the SPH service area. During this time SPH partnered with the community in the following ways: donation of medical supplies to local nonprofit organizations to ensure ability to implement COVID-19 precautions (e.g. thermometers), participation in the local Elkhorn Community Organizations Active in Disasters (COAD), a group of local nonprofits committed to assisting vulnerable populations during the pandemic and assisting with other community-based COVID-19 response efforts, provided clinical experts to share COVID-19 prevention information through media campaigns, opened up one of three COVID-19 testing facilities in the community, and provided workflow guidance and staff for community COVID-19 Vaccinations.



## SUBSTANCE ABUSE

Goal 1: Increase community awareness of and engagement with substance use disorder resources	
Strategy	Activity/Accomplishment
<b>Increase substance use screening rate to identify at-risk individuals</b>	<ul style="list-style-type: none"> <li>• Implemented substance use screening (AUDIT-C)</li> <li>• Implemented use of SBIRT pathway (screening , brief intervention, and referral to treatment)</li> <li>• Continue inpatient admission substance use screening</li> </ul>
<b>Promote awareness of mental health concerns and decrease stigma</b>	<ul style="list-style-type: none"> <li>• Supported awareness and education events               <ul style="list-style-type: none"> <li>○ Suicide prevention training</li> <li>○ Secondary trauma resiliency skills training</li> <li>○ Mental health first aid training</li> <li>○ Mental health mini-webinar</li> <li>○ Mental health focused local newspaper articles</li> </ul> </li> <li>• Sponsored substance use disorder resource community partners               <ul style="list-style-type: none"> <li>○ Florence Crittenton</li> <li>○ YWCA</li> <li>○ Hope Center</li> </ul> </li> </ul>

Goal 2: Identify program and service enhancements	
Strategy	Activity/Accomplishment
<b>Clinical program development</b>	<ul style="list-style-type: none"> <li>• Added new Addiction Medicine service line to the Broadway Clinic.</li> <li>• Launched and grew “Taking Care of You” parental support program, focused on the perinatal time period.</li> <li>• Integrated Social Workers/Social Service Coordinators into primary care team, inpatient case management team and ED.</li> <li>• Added clinical psychologist to psychiatry clinic</li> </ul>

### Program Descriptions & Highlights:

- **Parental Support Program:** SPH grew the focus on supporting postpartum patients and were able to build the SPH Taking Care of You: A Parental Support Program. This parental support program offers resources and professional help from caregivers for parents, guardians and families experiencing a variety of stressors including mental health or substance use challenges during pregnancy and through the first year postpartum. The team consists of specially trained registered nurse (RN) Care Managers, Behavioral Health Professionals and Social Workers who partner with the patient’s primary care/OB-GYN provider and work to connect patients to community resources. This program offers support for the following: depression, anxiety, tobacco and alcohol or drug use, stress, grief/loss, challenges with social needs (housing, transportation, food).



- **Addiction Medicine:** In 2020 St. Peter's Health added an addiction medicine service line to the Broadway Clinic site. The St. Peter's addiction medicine clinic is led by Dr. Kyle Moore, who is double board-certified in family medicine and addiction medicine. Dr. Moore completed a one-year addiction medicine fellowship and is licensed through the Food and Drug Administration (FDA) to prescribe medications to treat opioid use disorder including buprenorphine (Suboxone). The SPH Addiction Medicine Team works with patients and primary care providers to identify and treat addiction through comprehensive treatment plans that often involve care from a multi-disciplinary team and FDA approved medications.



# COLLABORATIVE COMMUNITY HEALTH IMPROVEMENT PLAN

In addition to the work St. Peter's does within their walls to support the community they serve, they also participate in greater community collaborative efforts. St. Peter's Health is a member of the Healthy Together Steering Committee, comprised of leaders across the county's health and social service landscape. In 2019 The Healthy Together Steering Committee spearheaded the formation of a collaborative Community Health Improvement Plan (CHIP) through a robust process involving a task force, comprised of 80 community stakeholders. The task force identified 3 key areas of focus for collective community-wide action and greatest impact: behavioral health, early childhood, and system access and referral.

Throughout the 2019-2021 time period, St. Peter's Health has remained an active member of the Healthy Together Steering Committee as well as actively involved in addressing these priority areas through community involvement and organization specific interventions. These are summarized below.

For further details on the strategies and progress of these collaborative CHIP areas as well as current activities of the Healthy Together Task Force, please visit: [www.lccountymt.gov/health/healthy-together](http://www.lccountymt.gov/health/healthy-together)

## PRIORITY AREA 1: BEHAVIORAL HEALTH

### **Goal 1: Increase awareness of behavioral health and suicide and normalize the conversation around these topics**

- SPH is an active member of the Lewis and Clark Suicide Prevention Coalition
  - Letter of support provided for the extension grant to continue the coordinator's position
- SPH partnered to hold trainings in QPR, Mental Health First Aid and Youth Mental Health First Aid for both the community and employees
  - SPH has one QPR trainer on staff
- SPH partnered to continue Man Therapy campaign in the community
- SPH is an active member of the Safer Communities Montana leadership group-a campaign focused on lethal means
  - In-kind donation of official group logo design
  - Assistance with the funding and development of group radio public service announcements
- Several SPH departments have received Military Strong campaign training
- SPH active membership in LOSS team feasibility group
- SPH active membership in Suicide Survivor Support Group planning

### **Goal 2: Provide access to behavioral health screening and adequate, effective and integrated mental health and substance abuse treatment for every resident of the county**

- SPH is a member of the Lewis and Clark Mental Health Advisory Council (LAC)



## PRIORITY AREA 2: EARLY CHILDHOOD

**Goal 1: Create a safe and compassionate community where we strengthen relationships, share our stories and support each other**

**Goal 2: Increase access to and knowledge of high-qualified childcare and early education options of all families in the county**

- SPH is an active member of the Elevate Montana Helena Affiliate
  - Assisted in planning and hosting a Coalition Gathering event
  - Areas of SPH received ACES training
- SPH leadership and other staff participated in resilience training using STAR-T: Secondary Trauma Resiliency Skills Training
- SPH is an active member of the Mental and Social Wellbeing Workgroup of the Healthy Communities Coalition of Lewis and Clark County
- SPH is an active member of the Early Childhood Coalition
- SPH is an active member of Zero to Five
- SPH is an active member of & currently co-facilitator of the Maternal Mental Health Taskforce

## PRIORITY AREA 3: IMPROVING ACCESS AND REFERRALS TO SERVICES

**Goal 1: Create a seamless system for referrals to all health and human-service programs in the county that support an intentional and strategic culture of collaboration**

- SPH is an active member of the CONNECT advisory board
- SPH continues to utilize the CONNECT system and promote use where possible in the system and community

