2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Daniels, Phillips, Roosevelt & Valley Counties, Montana

Sponsored by

FRANCES MAHON DEACONESS HOSPITAL

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Prepared by
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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the Total Service Area, the service area of Frances Mahon Deaconess Hospital. A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

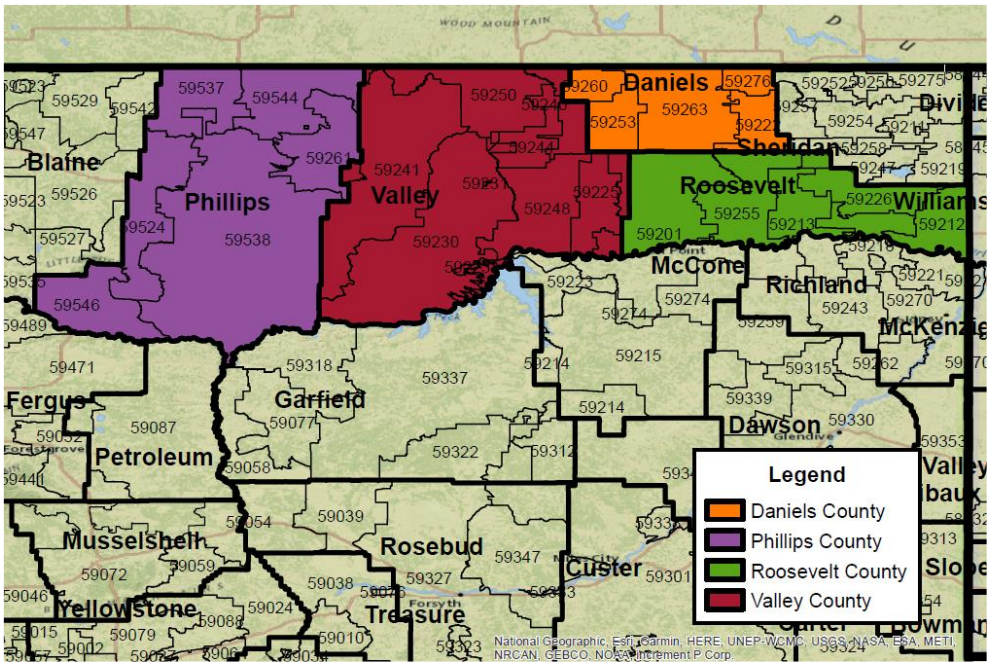
This assessment was conducted on behalf of Frances Mahon Deaconess Hospital by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States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

Methodology

Quantitative data input for this assessment includes secondary research (vital statistics and other existing health-related data) that allows for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research among community leaders gathered through an Online Key Informant Survey.

Community Defined for This Assessment

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



Online Key Informant Survey

To solicit input from community key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Frances Mahon Deaconess Hospital; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 45 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	2
Public Health Representatives	1
Other Health Providers	17
Social Services Providers	3
Other Community Leaders	22

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- Daniels Memorial Healthcare System
- Eastern Montana Community Mental Health Center
- Frances Mahon Deaconess Hospital
- Glasgow City Council
- Glasgow Police Department
- Glasgow Public Schools
- Hi-Line Clogging and Gymnastics
- Lustre Christian Schools
- Mental Health with Melanie Burner
- Milk River
- Prairie Ridge Village
- Roosevelt Medical Center
- Saco School District
- The Mama Coach (Lactation Consulting)
- Valley County Health Department
- Valley County Sheriff Department
- Valley View Home

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.

Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

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

Benchmark Data

Montana and National Data

Where possible, state and national data are provided as an additional benchmark against which to compare local findings.

Healthy People 2030

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

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 US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

For the purpose of this report, "significance" of secondary data indicators (which might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs. In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

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

IRS FORM 990, SCHEDULE H COMPLIANCE

For nonprofit 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 (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	23
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	88
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	11
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	12
Part V Section B Line 3h The process for consulting with persons representing the community's interests	7
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	93

SUMMARY OF FINDINGS

Significant Health Needs of the Community

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

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

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Lack of Health Insurance ▪ Access to Primary Care Physicians
CANCER	▪ Cancer Incidence ○ Prostate Cancer, Colorectal Cancer
DIABETES	▪ Key Informants: *Diabetes* ranked as a top concern.
DISABLING CONDITIONS	▪ Disability Prevalence
HEART DISEASE & STROKE	▪ Heart Disease Deaths
INFANT HEALTH & FAMILY PLANNING	▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ○ Motor Vehicle Crash Deaths ▪ Violent Crime Rate
MENTAL HEALTH	▪ Suicide Deaths ▪ Mental Health Provider Ratio ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Access to Recreation/Fitness Facilities

—continued on the following page—

AREAS OF OPPORTUNITY (continued)	
ORAL HEALTH	▪ Access to Dentists
RESPIRATORY DISEASE	▪ Lung Disease Deaths ▪ Asthma Prevalence ▪ COPD Prevalence
SEXUAL HEALTH	▪ Gonorrhea Incidence ▪ Chlamydia Incidence
SUBSTANCE USE	▪ Key Informants: *Substance Use* ranked as a top concern.
TOBACCO USE	▪ Cigarette Smoking ▪ Key Informants: *Tobacco Use* ranked as a top concern.

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 providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part 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 Use
3. Tobacco Use
4. Diabetes
5. Cancer
6. Nutrition, Physical Activity & Weight
7. Oral Health
8. Disabling Conditions
9. Heart Disease & Stroke
10. Sexual Health
11. Infant Health & Family Planning
12. Access to Health Care Services
13. Injury & Violence
14. Respiratory Diseases

Hospital Implementation Strategy

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

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

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Total Service Area, grouped by health topic.

Reading the Summary Tables

Note that blank table cells in the tables that follow signify that data are not available or are not reliable for that area and/or for that indicator.

- In the following tables, Total Service Area results are shown in the larger, gray column.
- The columns to the left of the Total Service Area column provide comparisons among the four counties, identifying differences for each as "better than" (☀), "worse than" (☁), or "similar to" (⛅) the combined opposing counties.
- The columns to the right of the Total Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Total Service Area compares favorably (☀), unfavorably (☁), or comparably (⛅) to these external data.

SOCIAL DETERMINANTS	DISPARITY AMONG COUNTIES: Daniels County	Phillips County	Roosevelt County	Valley County	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS: vs. MT	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	0.0	0.0	0.0	0.0	0.0	0.3	3.9	
Population in Poverty (Percent)	12.2	7.0	31.6	12.3	19.9	12.4	12.5	8.0
Children in Poverty (Percent)	22.7	4.8	36.5	16.3	25.7	14.7	16.7	8.0
No High School Diploma (Age 25+, Percent)	3.8	6.8	6.8	6.7	6.6	5.5	10.9	
Unemployment Rate (Age 16+, Percent)	2.1	3.0	3.0	2.1	2.6	2.7	4.0	
Housing Exceeds 30% of Income (Percent)	24.0	16.1	17.9	19.3	18.5	27.4	30.5	25.5

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

better | similar | worse

OVERALL HEALTH	DISPARITY AMONG COUNTIES: Daniels County	Phillips County	Roosevelt County	Valley County	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS: vs. MT	vs. US	vs. HP2030
"Fair/Poor" Overall Health (Percent)	18.1	17.7	28.4	18.0	22.5	16.8	17.9	

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

better | similar | worse

ACCESS TO HEALTH CARE	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Uninsured (Adults 18-64, Percent)	13.5	12.8	16.3	15.4	15.1	11.8	11.2	7.6
Uninsured (Children 0-18, Percent)	9.3	5.7	8.8	8.6	8.3	6.9	5.1	7.6
Routine Checkup in Past Year (Percent)	74.1	73.7	70.7	74.0	72.5	72.1	76.1	
Primary Care Doctors per 100,000			111.2	132.0	90.7	117.0	116.3	

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

better | similar | worse

CANCER	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Cancer Deaths per 100,000	262.3	255.2	180.1	225.6	212.6	196.1	182.7	
Cancer Incidence per 100,000	311.0	494.3	476.6	491.6	468.5	457.0	442.3	
Female Breast Cancer Incidence per 100,000		104.2	111.0	142.8	121.3	134.2	127.0	
Prostate Cancer Incidence per 100,000		165.1	106.9	159.2	139.9	131.2	110.5	

CANCER (continued)	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Colorectal Cancer Incidence per 100,000		78.0	84.8	47.5	66.2	36.3	36.5	
Lung Cancer Incidence per 100,000			53.3	52.6	52.9	47.5	54.0	
Breast Cancer Screening in Past 2 Years (Women 50-74, Percent)	72.9	71.0	66.7	69.7	68.8	74.8	76.5	80.5
Cervical Cancer Screening in Past 3 Years (Women 21-65, Percent)	81.4	80.2	77.6	80.3	79.1	81.9	82.8	84.3
Colorectal Cancer Screening (Age 45-75, Percent)	64.6	66.3	54.1	62.8	59.7	63.8	66.3	74.4

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

better similar worse

DIABETES	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Diabetes Prevalence (Percent)	10.4	10.1	12.7	10.4	11.3	8.8	10.0	

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

better similar worse

DISABLING CONDITIONS	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Disability Prevalence (Percent)	20.3	15.6	13.8	16.3	15.3	14.1	12.9	

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

better similar worse

HEART DISEASE & STROKE	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Heart Disease Deaths per 100,000	166.9	176.7	163.5	284.6	203.4	129.9	112.5	
Stroke Deaths per 100,000		54.0	53.3	43.0	50.0	39.1	47.7	
High Blood Pressure Prevalence (Percent)	37.4	36.9	35.3	34.9	35.6	30.4	32.7	42.6
High Blood Cholesterol Prevalence (Percent)	34.8	35.0	29.6	34.4	32.4	30.8	35.5	

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

better similar worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Low Birthweight (Percent of Births)		6.0	9.0	5.7	7.8	7.6	8.3	
Teen Births per 1,000 Females 15-19		26.5	62.1	21.2	45.0	16.7	16.6	

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

better similar worse

INJURY & VIOLENCE	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000		78.5	132.3	123.5	119.6	67.3	60.2	
Motor Vehicle Crash Deaths per 100,000			36.8	40.3	38.2	18.3	12.5	
Violent Crimes per 100,000	484.8	464.4	1314.8	408.3	834.6	393.7	416.0	

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

better similar worse

MENTAL HEALTH	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Suicide Deaths per 100,000			33.1		33.1	28.2	14.5	
Mental Health Providers per 100,000	60.2	71.1	194.6	105.6	136.1	372.9	312.5	

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

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Fast Food Restaurants per 100,000			55.6	79.2	49.5	71.8	80.0	
Population With Low Food Access (Percent)	26.8	36.1	26.1	41.9	32.8	22.3	22.2	
No Leisure-Time Physical Activity (Percent)	16.5	20.5	23.9	21.9	22.0	17.4	19.5	21.8
Obese (Percent)	22.8	30.0	37.4	33.1	33.5	28.2	30.1	36.0

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

better similar worse

ORAL HEALTH	DISPARITY AMONG COUNTIES: Daniels County	Phillips County	Roosevelt County	Valley County	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS: vs. MT	vs. US	vs. HP2030
Dental Visit in Past Year (Percent)	62.8	62.2	46.6	63.4	55.7	63.2	63.9	45.0
Dentists per 100,000	180.6	0.0	64.9	26.4	49.5	69.4	66.5	

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

better similar worse

RESPIRATORY DISEASE	DISPARITY AMONG COUNTIES: Daniels County	Phillips County	Roosevelt County	Valley County	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS: vs. MT	vs. US	vs. HP2030
Lung Disease Deaths per 100,000	119.2	122.7	42.3	51.0	63.9	60.8	46.0	
Asthma Prevalence (Percent)	10.7	11.2	14.4	11.0	12.5	11.1	9.9	
COPD Prevalence (Percent)	8.4	7.9	10.0	8.1	8.9	7.0	6.8	

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

better similar worse

SEXUAL HEALTH	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Chlamydia Incidence per 100,000	61.4	117.9	1466.1	306.1	768.2	364.2	495.0	
Gonorrhea Incidence per 100,000	0.0	143.1	942.6	26.5	384.1	116.8	194.4	

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

better similar worse

SUBSTANCE USE	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Excessive Drinking (Percent)	20.0	20.0	21.1	20.5	20.6	24.4	18.1	
Drug Overdose Deaths per 100,000			29.4		29.4	15.4	26.9	

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

better similar worse

TOBACCO USE	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Daniels County	Phillips County	Roosevelt County	Valley County		vs. MT	vs. US	vs. HP2030
Cigarette Smoking (Percent)	15.1	15.5	28.1	14.6	20.8	15.4	12.9	6.1

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

better similar worse

COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

Total Population
(Estimated Population, 2018-2022)

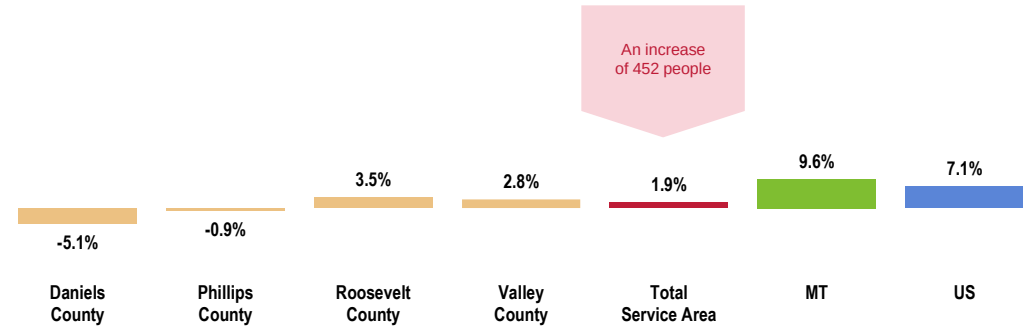
	TOTAL POPULATION	TOTAL LAND AREA (SQUARE MILES)	POPULATION DENSITY (PER SQUARE MILE)
Daniels County	1,535	1,426.27	1
Phillips County	4,233	5,140.42	1
Roosevelt County	10,799	2,354.60	5
Valley County	7,552	4,926.12	2
Total Service Area	24,119	13,847.41	2
Montana	1,091,840	145,550.17	8
United States	331,097,593	3,533,269.34	94

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

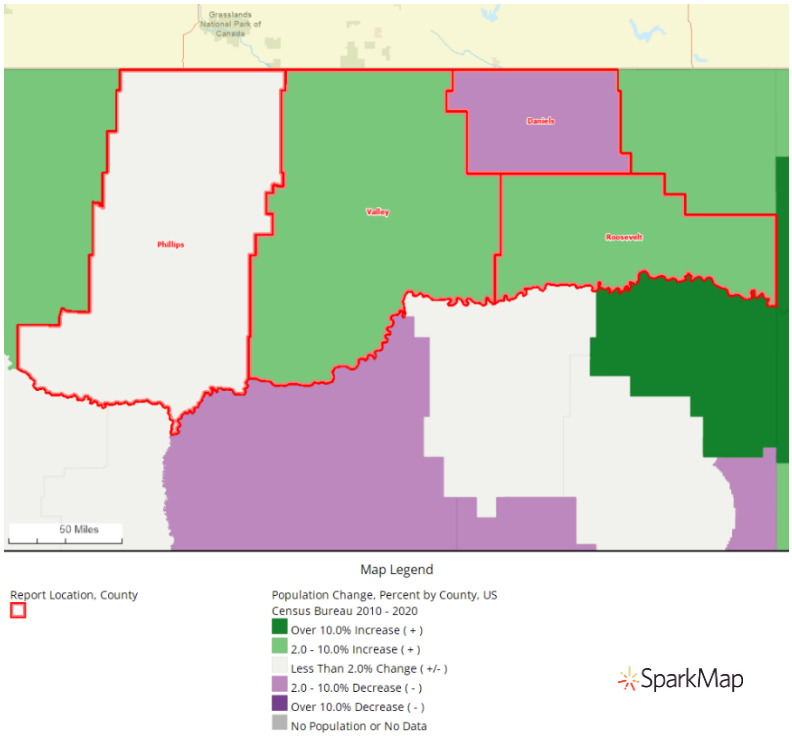
Population Change

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

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

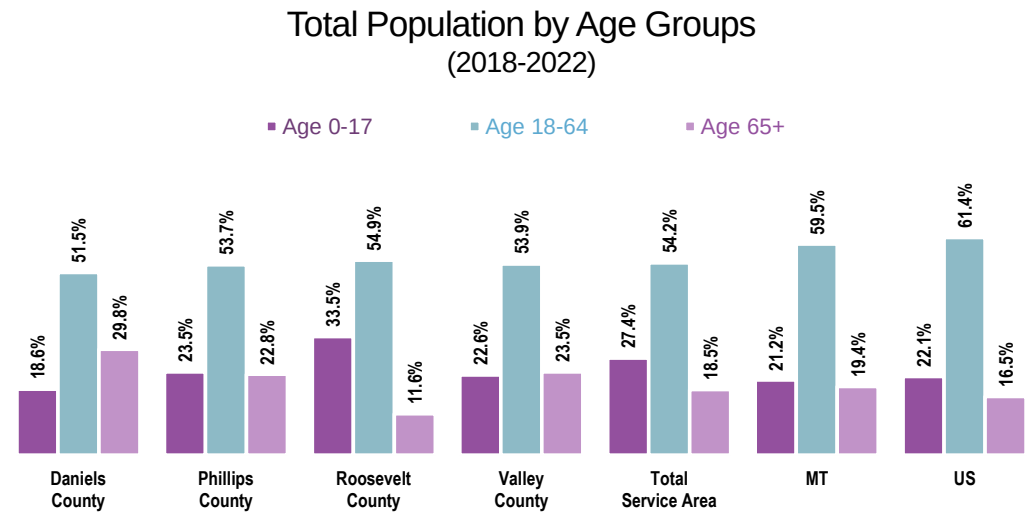


Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).



Age

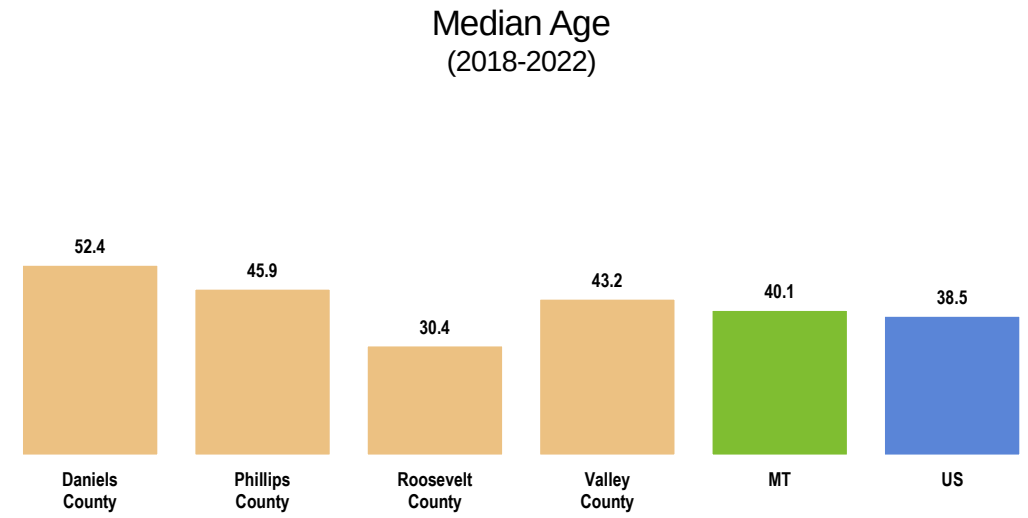
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.



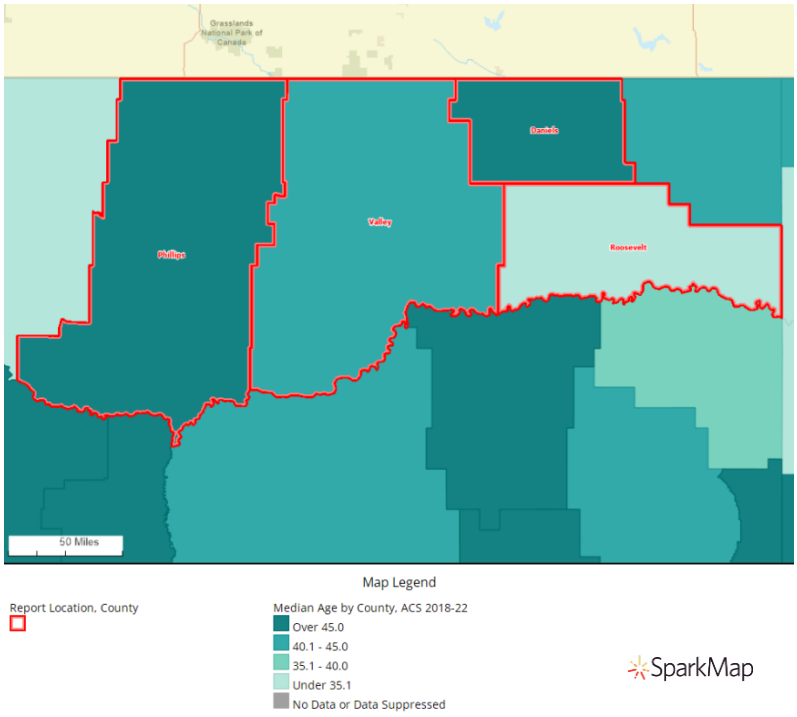
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Median Age

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

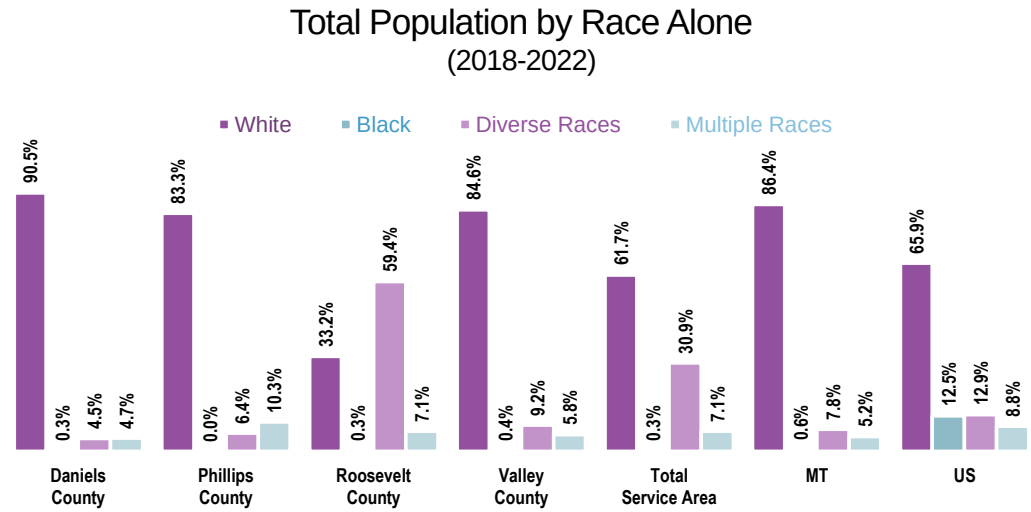


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).



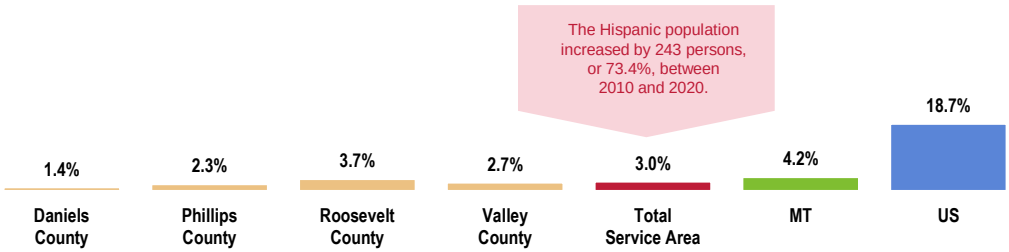
Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. “Race Alone” reflects those who identify with a single race category — people who identify their origin as Hispanic, Latino, or Spanish may be of any race.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Hispanic Population
(2018-2022)



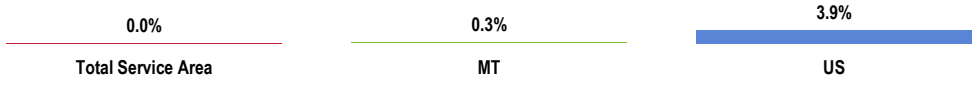
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Linguistic Isolation

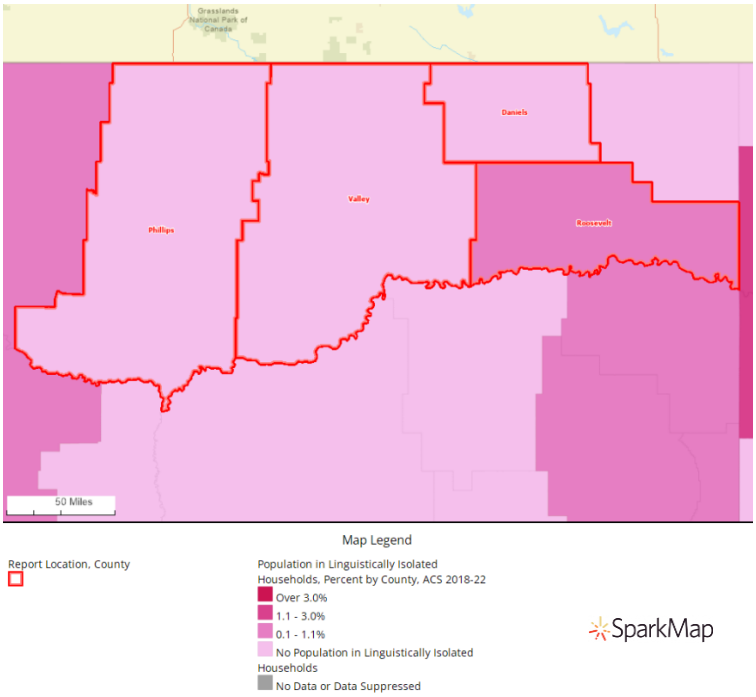
This indicator reports the percentage of the population age 5 years and older who live in a home in which: 1) no person age 14 years or older speaks only English; or 2) no person age 14 years or older speaks a non-English language but also speaks English "very well."

Linguistically Isolated Population
(2018-2022)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 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."


Grasslands National Park of Canada
Daniels
Valley
Phillips
Roosevelt
50 Miles
Map Legend
Report Location, County
Population in Linguistically Isolated Households, Percent by County, ACS 2018-22
Over 3.0%
1.1 - 3.0%
0.1 - 1.1%
No Population in Linguistically Isolated Households
No Data or Data Suppressed
SparkMap

SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

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

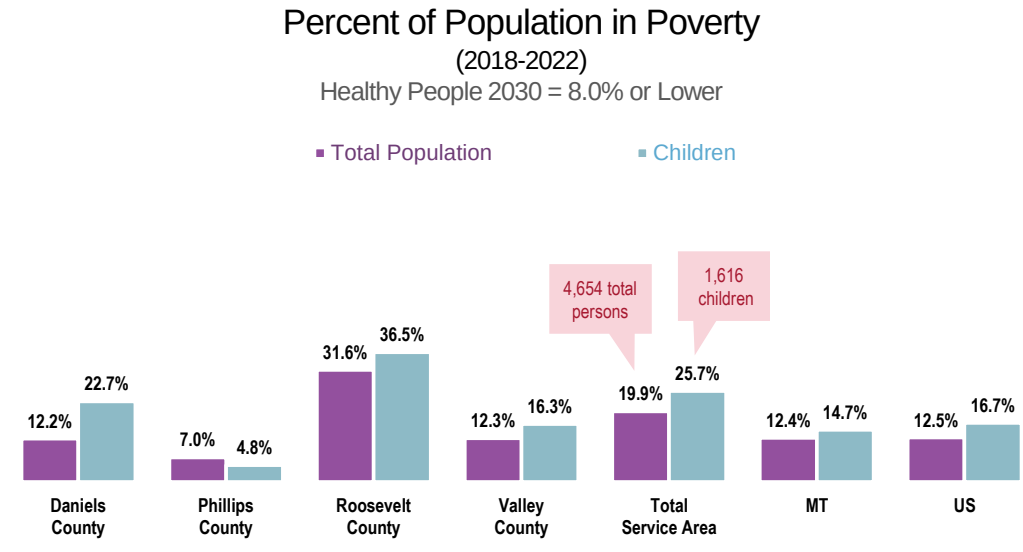
SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy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

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

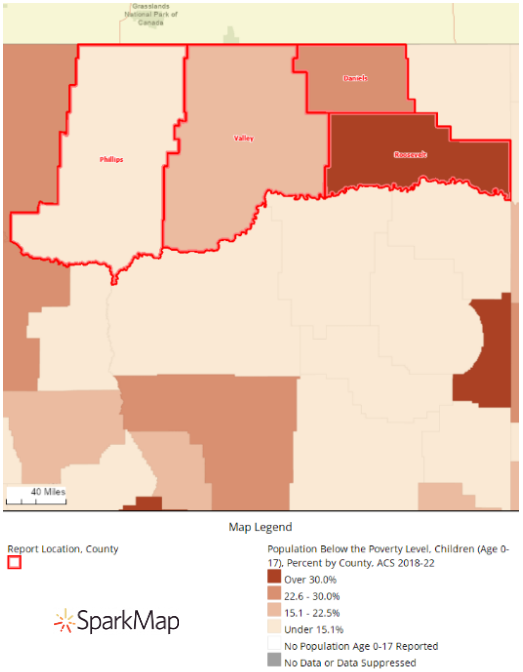
– Healthy People 2030 (https://health.gov/healthypeople)

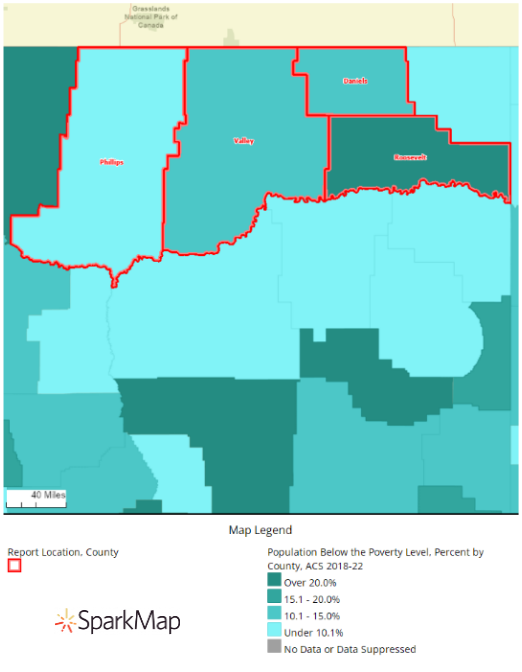
Poverty

Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to accessing health services, healthy food, and other necessities that contribute to health status. The following chart and maps outline the proportion of our population below the federal poverty threshold, as well as the percentage of children in the Total Service Area living in poverty, in comparison to state and national proportions.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

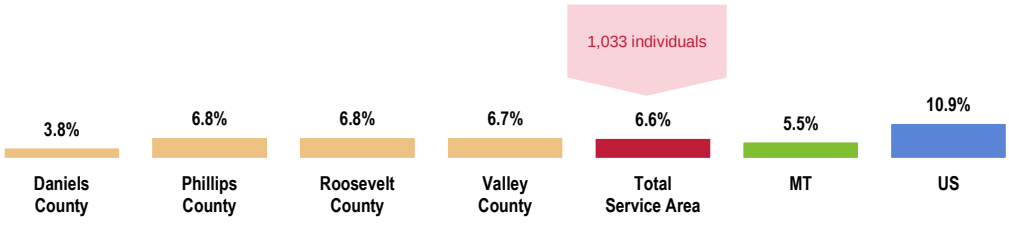




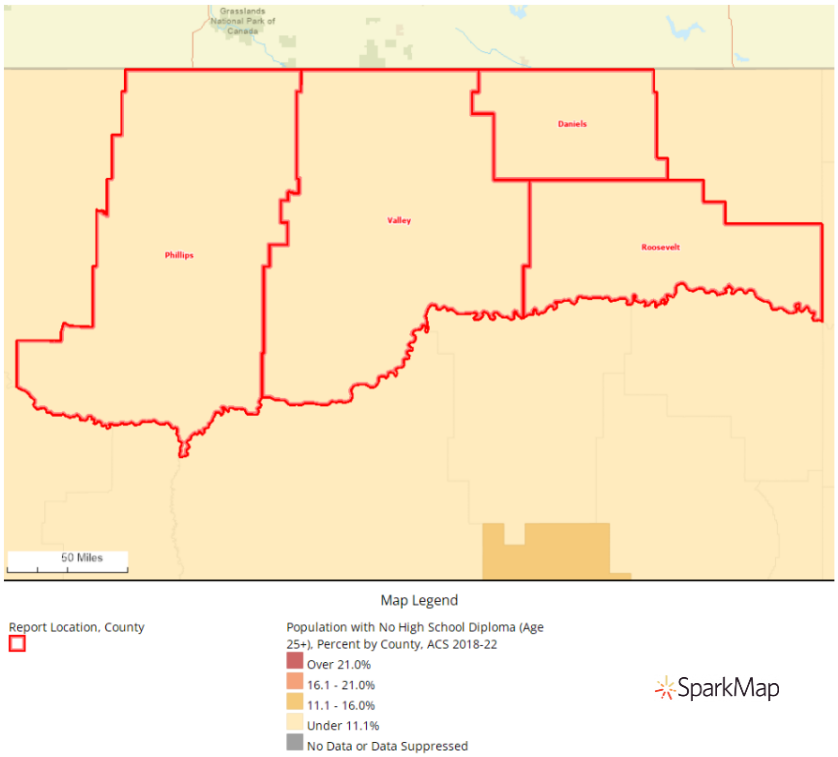
Education

Education levels are reflected in the proportion of our population age 25 and older without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes.

Population With No High School Diploma
(Adults Age 25 and Older, 2018-2022)



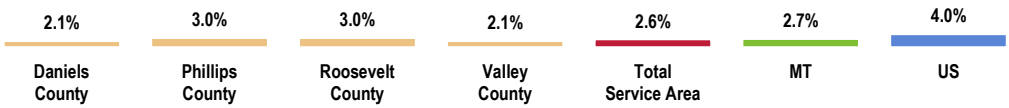
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).



Employment

Changes in unemployment rates in the Total Service Area over the past several years are outlined in the following chart. This indicator is relevant because unemployment creates financial instability and barriers to accessing insurance coverage, health services, healthy food, and other necessities that contribute to health status.

Unemployment Rate
(November 2024)



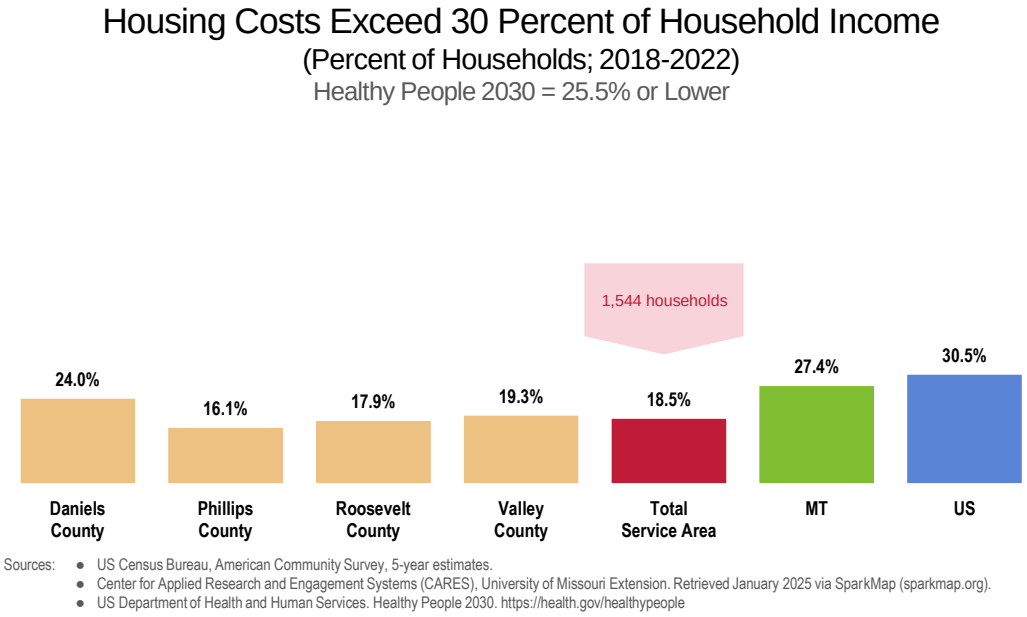
Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Housing Burden

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

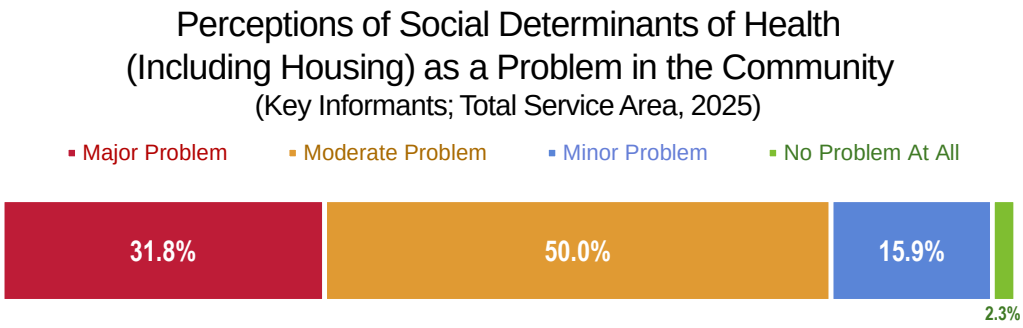
The following chart shows the housing burden in the Total Service Area. This serves as a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.



Sources:
- US Census Bureau, American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Social Determinants of Health

Key informants' ratings of the severity of *Social Determinants of Health (especially Housing)* as a concern in the Total Service Area are outlined below.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Income/Poverty

> I believe that the cost of living in this area is not conducive to the average income and that many people who need assistance (SNAP, WIC etc.) “make too much to qualify.” – Other Health Provider
>
> Low-income and poverty: limited financial resources often mean residents cannot afford basic necessities like healthy food, housing, or healthcare. Unstable employment: irregular or low-paying jobs lead to financial stress, affecting both physical and mental health. Low health literacy: limited access to quality education reduces knowledge about preventive care, nutrition, and health management. Lack of providers: shortages of doctors, specialists, and mental health professionals create barriers to care. Cost barriers: even with Medicaid, out-of-pocket expenses can deter people from seeking care. Limited transportation: lack of reliable public transit prevents access to jobs, healthcare, and grocery stores with fresh, healthy food. Social isolation: limited community engagement and support networks lead to higher rates of mental health issues. – Community Leader
>
> Many people under the poverty level. When people get extra money they spend it on drugs, while their kids go hungry, or have no clothes or shoes. Very few people live a middle-class life. Plus, the education system is lacking, there is a lack of housing, which also means a lack of medical providers, we can afford the provider but there is nowhere for them to live. – Other Health Provider
>
> Priority is given to housing and property costs, median income not conducive to self-pay or adequate coverage insurance plan costs, rural environment promotes traditional attitudes toward tobacco and alcohol over use. – Social Services Provider

Housing

> Housing, food, water, utilities, internet service, communication devices, feeling emotionally/physically/sexually safe within the home environment and community are just the basics that aren't being met. Add a “lack mindset,” a heap of shame, racial discrimination, various forms of entitlement, and hundreds of cognitive distortions and emotional blackmail fueling negative mental health, and we've got ourselves a mess. A “pick yourselves up by the bootstraps” mentality is not serving us or our communities. Free psychoeducation and opportunities to learn positive ways to connect with others needs to be the next step on top of meeting basic needs. Our child protective services appear underfunded and stretched thin. Teacher education should be expanded to include all the credentials of “regular” + SPED + school psychologist training. Not every problem in school is related to ADHD; there's sometimes a lot of trauma going on at home and out at recess (in terms of social rejection). – Other Health Provider
>
> There is an extreme lack of available housing in our area. There appears to be a lot of poverty in our area. I believe those who suffer from mental health of substance use issues are discriminated against and judged. I think if individuals do not have health insurance, they do not follow through with health issues. Health insurance, health costs, medication costs are all very high priced. – Social Services Provider

Rural Community

> Idolization and geographical location – Other Health Provider
>
> Rural location – Physician

Children are not Learning Self-Accountability

> Self-accountability: It is a learned behavior that we are not teaching our children. Children lack the problem-solving and accountability skills they need to be successful in all areas. I think the base of a lot of our problems begin at home. We are very much off balance as a society...parents work too much, costs are ridiculous, the way food or really anything is made is terrible. Poor diet, stress, health, people don't know how to feel anymore or deal with their feelings anymore...who has time? People turn more to things that make them feel good: food, drugs, alcohol, money etc... Just my opinion, and I am guilty of it too. – Community Leader

Transportation

> People express issues with transportation. They have difficulties getting to our organization for healthcare and cannot get home from the ED after hours. They also at times have issues with heat and running water or a place to live. There are not any resources to fill these needs. – Other Health Provider

Vulnerable Populations

> Lack of better opportunities for Native American people. Racism still exists, affecting everyone’s health. – Other Health Provider

HEALTH STATUS

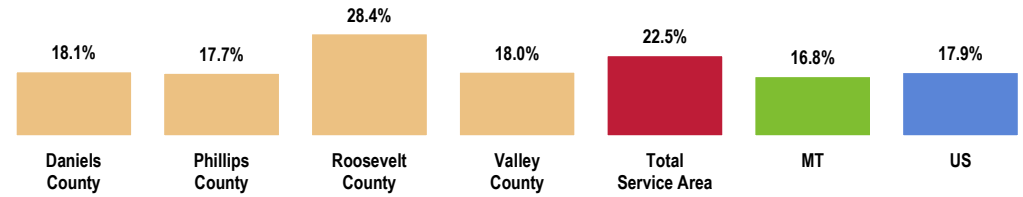
OVERALL HEALTH STATUS

The following indicator provides a relevant measure of overall health status in the Total Service Area, noting the prevalence of residents' "fair" or "poor" health evaluations. While this measure is self-reported and a subjective evaluation, it is an indicator which has proven to be highly predictive of health needs.

The CDC's Behavioral Risk Factor Survey, from which these data are derived, asked respondents:

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

Adults With "Fair" or "Poor" Overall Health
(2022)



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

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

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

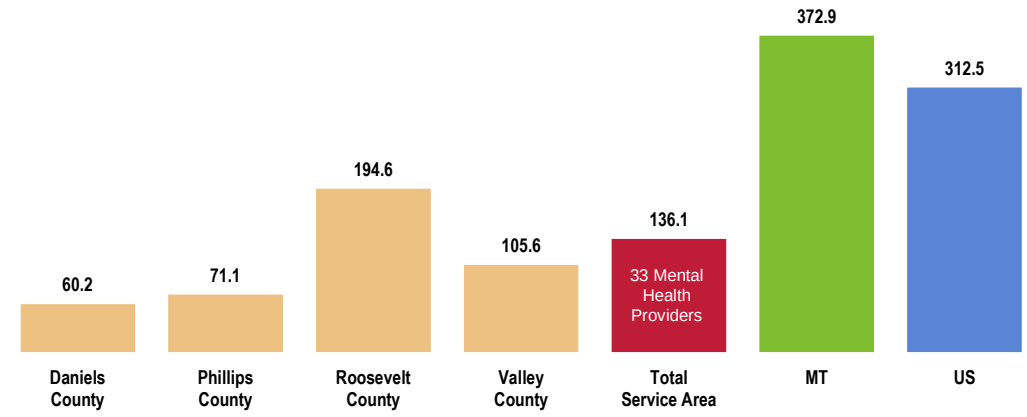
– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Providers

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care.

Note that this indicator only reflects providers practicing in the Total Service Area and residents in the Total Service Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

The data below show the number of mental health care providers in the Total Service Area relative to the Total Service Area population size (per 100,000 residents). This is compared to the rates found statewide and nationally.

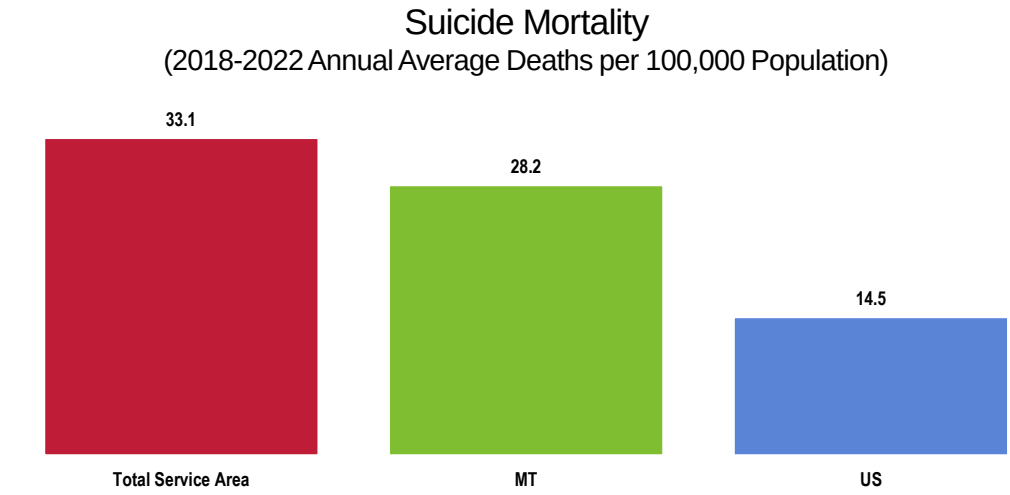


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Suicide

The following reports the rate of death in the Total Service Area due to intentional self-harm (suicide) in comparison to statewide and national rates. This measure is relevant as an indicator of poor mental health.

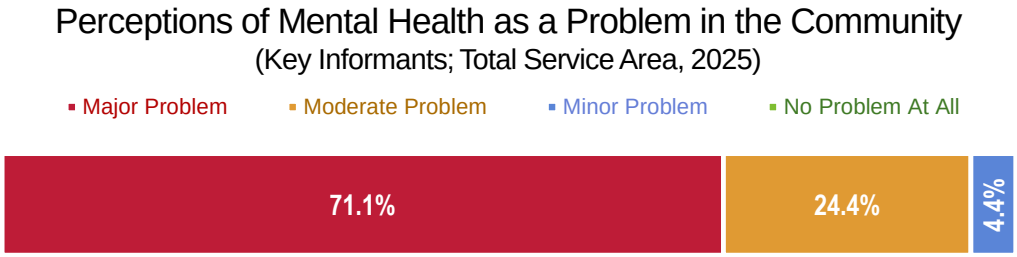


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

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

Key Informant Input: Mental Health

Key informants' ratings of the severity of *Mental Health* as a concern in the Total Service Area are outlined below.



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Lack of Providers

> Lack of providers, lack of inpatient services. – Community Leader
>
> Lack of in person providers, lack of psychiatric medication services, lack of transportation issues for those who have to travel out of town to seek services from providers. Still struggle with stigma for seeking services for mental health issues. – Social Services Provider

> The lack of mental health providers, combined with the stigma of mental health, makes the people who actually receive local care the sickest, so if you are depressed you don't receive proper care. You pretty much have to be suicidal to do anything. If you are a minor and you are suicidal you get, put in jail for your safety, but it also goes on your record. Why would a child ask for help when they will get incarcerated, so they grow up as adults and never ask for help. – Other Health Provider
>
> No providers for referrals. Cannot discharge more minor patients for community follow up as there aren't resources to set them up with. Length of time to get a referral or evaluation on an outpatient. Medication monitoring programs to ensure people are taking their medications. Medication teaching. Support programs. – Other Health Provider
>
> Lack of counselors and psychiatrists. – Community Leader
>
> Lack of mental health providers. No psychiatrist. Difficulty with transfers to psychiatric hospitals. – Physician
>
> The 2 biggest challenges to mental health care and Valley County are lack of providers and the stigma associated with mental health care. Patient's do not access mental health until their entire need. Unfortunately, there are very few resources available, and those resources are overwhelmed. – Other Health Provider
>
> Lack of resources, to include trained professionals, medications, housing, places to go out of the weather, and financial support. – Community Leader
>
> The biggest challenges include lack of providers, lack of crisis intervention treatment, stigma of seeking treatment, lack of providers specialized in mental health medication management, lack of referral sources, and lack of knowledge of services. – Community Leader

Access to Care/Services

> The biggest issues I see is that we don't have a lot of outlets for people to go. In the last year we have had our hospital hire someone that is now available. – Community Leader
>
> Access to providers, limited or nonexistent insurance coverage, transportation for some remote residents. – Community Leader
>
> Finding appropriate mental health care. – Other Health Provider
>
> The lack of mental health services is a major concern, especially for adolescents. The fact that the nearest inpatient treatment facility for mental health is nearly 400 miles away is another major concern and roadblock when it comes to individuals who need a higher level of care. – Community Leader
>
> Access to support. – Community Leader
>
> Access to care and help with nutrition that might help mental health conditions. – Community Leader
>
> Access to health care professionals. Transferring patients to a higher level of care. Lack of transportation and beds for these patients. – Other Health Provider

Denial/Stigma

> There is a stigma in our community around mental health. I believe people feel judged if they struggle mentally. People are told just to get over it. We also don't have enough professionals to help people with mental health issues if they all came forward. I wish people felt that could get help and it's okay not to be okay. – Community Leader
>
> Not feeling comfortable enough to ask for help. When they do get the courage, not knowing who to speak to, or where to go. – Social Services Provider

Isolation/Loneliness

> Depression and substance abuse. These are major issues here due to the isolation that comes with our geographic location. I also feel that there is still a large stigma around mental health issues and being seen as weak or attention seeking. – Other Health Provider
>
> Social isolation, weather, limited access, stigma. – Other Health Provider

Affordable Care/Services

> There seems to be a wide gap between those who can afford mental health services and those who cannot. The Medicaid program that was working so well to facilitate this hit a wall and a lot of people who were remaining stable and productive with some extra help lost their support services. Also, housing costs are so high and seem to still be rising. There is not enough low-income housing, or even clean, good quality rentals in the area. Few jobs can make basic financial ends meet. The biggest offenders adding to the problem seem to be alcohol, tobacco, and cannabis -- short-term “fixers” that don't lead people to long-term positive results. Lack of transportation to and from mental health services contributes as well. For every mental health provider, there ought to be at least one case manager, but not many places can seem to afford them or offer a livable wage to do their sometimes questionably dangerous work. There's a huge “fall between the cracks” regarding disruptive behavior. – Other Health Provider

Suicide

> Suicide awareness, education and prevention efforts on a community scale. High rate of attempts and completed suicide in this region. – Other Health Provider

Awareness/Education

> Mental health issue awareness. Understanding that it is a huge concern in Northeast Montana. Access to mental health resources, such as therapists, psychiatrist, etc. – Community Leader

Disease Management

> The willingness to be diagnosed and/or treated. Treatment options are very limited here and throughout the state. Follow-up opportunities. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

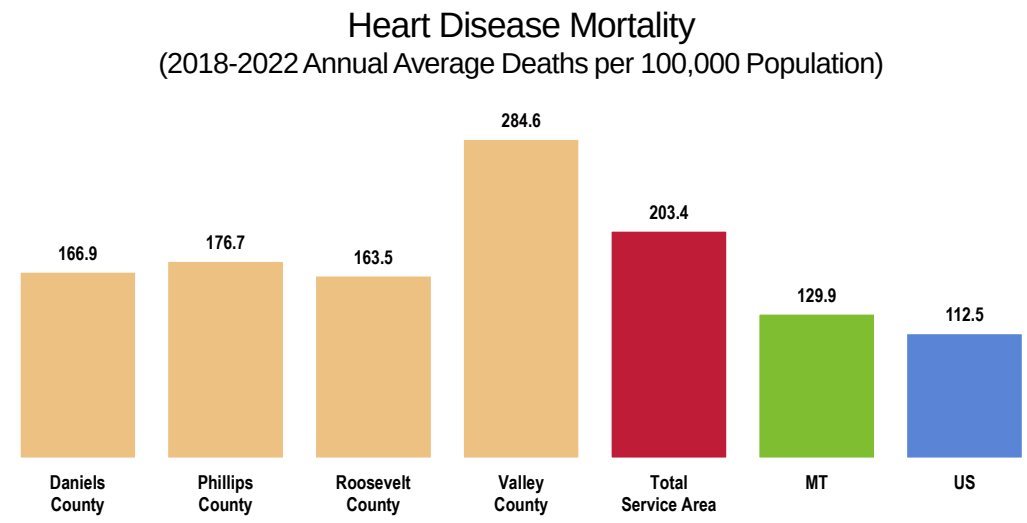
Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

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)

Heart Disease Deaths

Heart disease is a leading cause of death in the Total Service Area and throughout the United States. The chart that follows illustrates how our mortality rate compares to rates in Montana and the US.

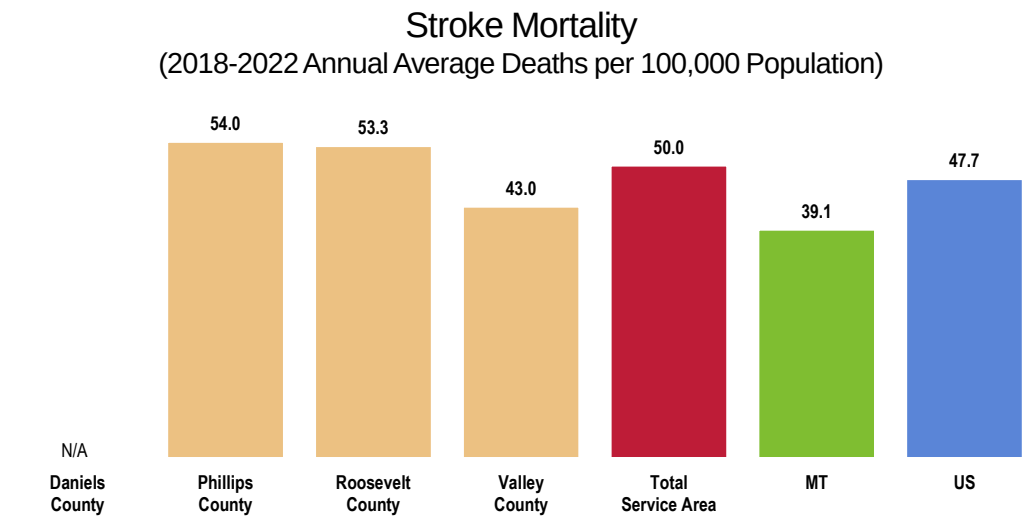


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

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

Stroke Deaths

Stroke, a leading cause of death in the Total Service Area and throughout the nation, shares many of the same risk factors as heart disease. Outlined in the following chart is a comparison of stroke mortality locally, statewide, and nationally.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

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

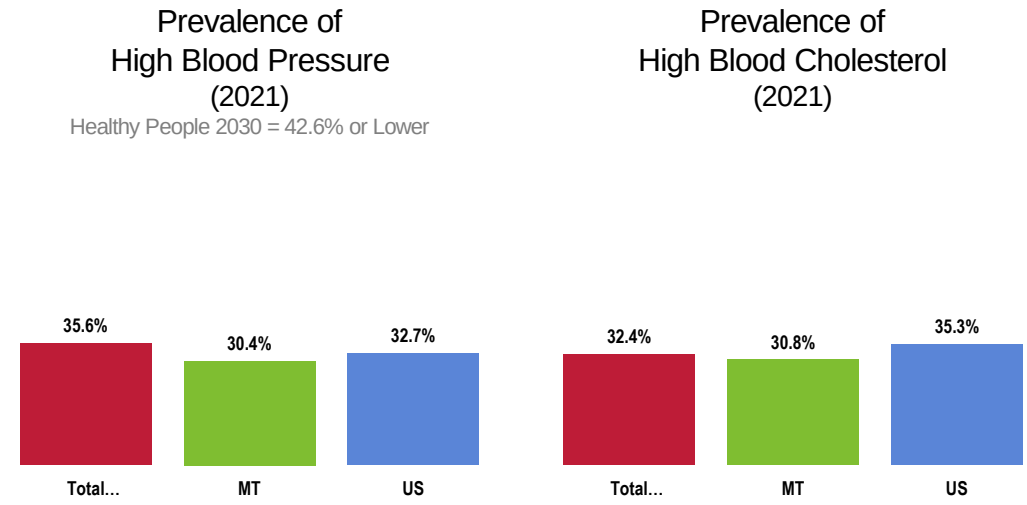
Blood Pressure & Cholesterol

The following chart illustrates the percentages of Total Service Area adults who have been told that they have high blood pressure or high cholesterol, known risk factors for cardiovascular disease.

The CDC's Behavioral Risk Factor Survey asked:

"Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?"

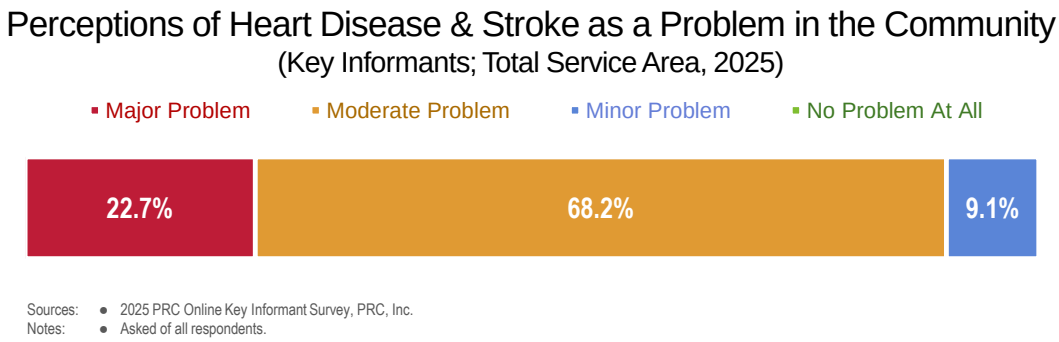
"Have you ever been told by a doctor, nurse, or other health professional that your cholesterol is high?"



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Heart Disease & Stroke

Outlined below are key informants' levels of concern for *Heart Disease & Stroke* as an issue in the Total Service Area.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Access to Care/Services

> Rural communities have the same struggles. The vast and sparsely populated region around Glasgow creates logistical challenges for residents needing regular follow-ups, screenings, or treatment. Weather conditions and long travel distances can further complicate access to timely care, especially for those with mobility or financial constraints. In our rural community, access to healthcare is a persistent challenge due to the limited availability of resources and services. – Other Health Provider
>
> Our rural community has difficulty accessing health care because of geographical issues and lack of insurance, which often causes delays in treatment of diseases. Our health behaviors tend to not be as healthy as those in more urban communities. – Other Health Provider
>
> Due to the only hospitals in the area being Critical Access Hospitals, the likelihood of surviving a heart attack or stroke very small. If you make it to the ER, you will have to wait at least an hour for a life flight to come from Billings. They get you ready and fly back to Billings, all in all about 3 hours later is when you will receive high level care for heart attack or stroke. We all know time=brain with stroke, and not all of the Critical Access Hospitals have a CT scanner, so you will be transported by ambulance 25 miles away to receive a CT if you are having a stroke. Not to mention there are a lack of EMTs meaning one or two ambulances in each community. If there are two people in need of help at the same time, turnaround time can be hours. – Other Health Provider
>
> We have many people that we fly out with heart issues. Not as much for stroke. I think this goes back to groceries that are expensive, so people eat not as healthy. Hobbies like going to the bars. – Community Leader

Incidence/Prevalence

> Heart disease is the most common medical problem, which would lead to stroke, and the community is a moderate risk with the elderly population, which is affected by these issues. – Other Health Provider
>
> It is the leading cause of death throughout the country, but is more prevalent in rural populations, especially with a high proportion of Native Americans. Our remoteness makes access to definitive interventional procedures to be delayed or not possible with some weather events. While smoking has declined, tobacco abuse disorder remains still prevalent in the region. – Community Leader
>
> High or average incidence of these conditions in our community, although maybe not higher than national averages. May be related to stress and consumption of processed foods and excessive added sugar. – Community Leader

CANCER

ABOUT CANCER

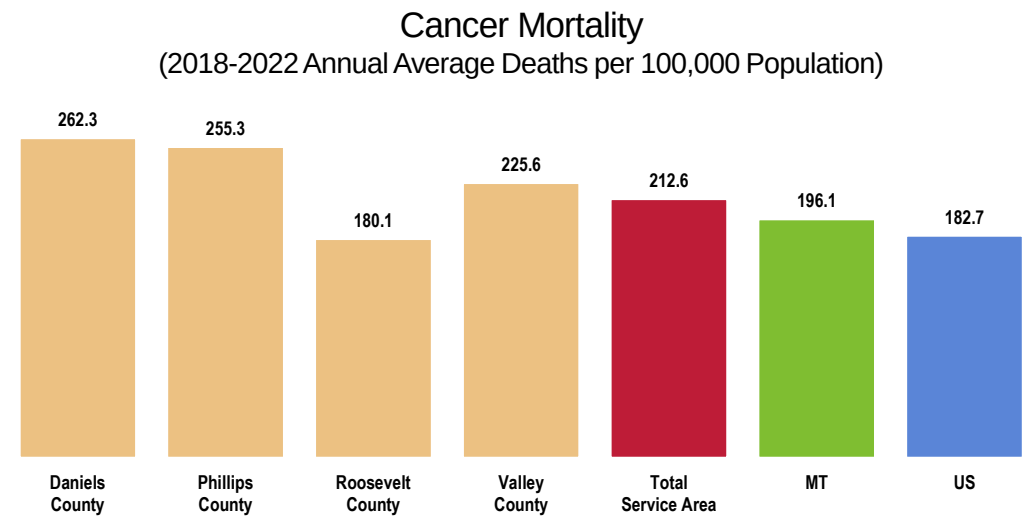
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are 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)

Cancer Deaths

Cancer is a leading cause of death in the Total Service Area and throughout the United States. Cancer mortality rates are outlined below.



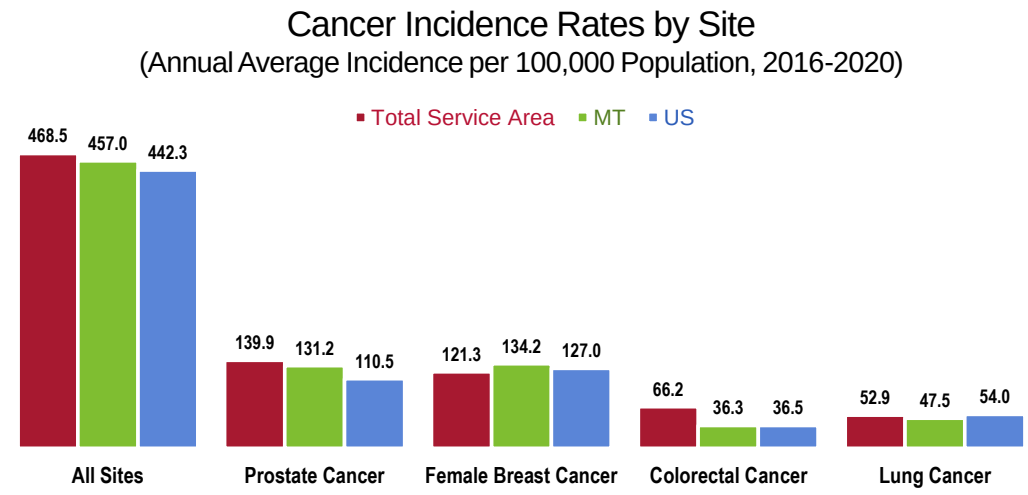
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

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

Cancer Incidence

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

It is important to identify leading cancers by site in order to better address them through targeted intervention. The following chart illustrates the Total Service Area incidence rates for leading cancer sites.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

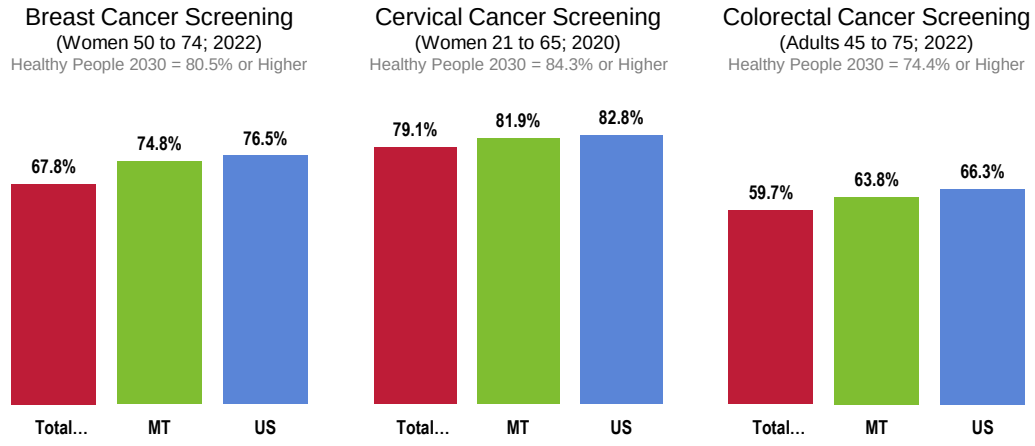
COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

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

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

The following outlines the percentages of residents receiving these age-appropriate cancer screenings. These are important preventive behaviors for early detection and treatment of health problems. Low screening levels can highlight a lack of access to preventive care, a lack of health knowledge, or other barriers.

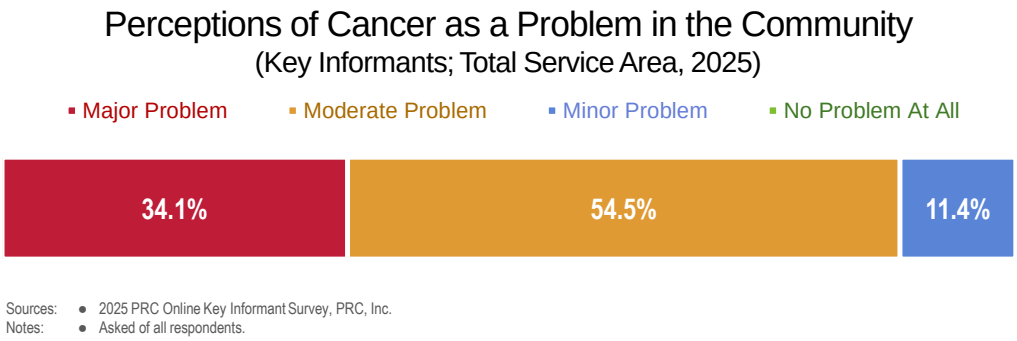


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the age group specified. Breast cancer screenings are mammograms among females age 50-74 in the past 2 years. Cervical cancer screenings are Pap smears among women 21-65 in the past 3 years. Colorectal cancer screenings include the percentage of population age 45-75 years who report having had 1) a fecal occult blood test (FOBT) within the past year, 2) a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or 3) a colonoscopy within the past 10 years.

Key Informant Input: Cancer

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



Top Concerns

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

Incidence/Prevalence

> So many people diagnosed with this. I'm not sure the exact statistics, but for being a rural smaller area, it seems like it is very prevalent. – Community Leader
>
> I believe that the abundance of Cancer within our community outweighs the options that we have for treatment available here in Glasgow. Thus, it puts more burden on people to have to travel to seek proper treatment, therefore losing out on money/income in having to do so. – Other Health Provider
>
> Health and wellness seem to be declining in some areas while cancer seems to be on the rise. – Other Health Provider
>
> There seems to be high rates of cancer in the area, although maybe not different from the nation at large. Could be related to agricultural chemicals and/or unhealthy ultra-processed foods. – Community Leader
>
> I feel that Valley County and Northeast Montana seem to have an unusually high rate of pancreatic cancer and multiple myeloma. All other forms of cancer seem to be closer to baseline rates. I would be curious to see the rates of these two diseases. – Other Health Provider
>
> Too common. – Community Leader
>
> We seem to have a very high amount of cancer patients. – Community Leader

Access to Care/Services

> Limited access to specialized care, geographical location, limited preventative care and screening programs. Environmental factors. – Other Health Provider
>
> Many people travel back and forth from our county to receive treatments in Billings and other areas. Cancer continues to grow, even though we are an aging population, I feel we are seeing it in younger generations more...maybe we are effective on pro-active screenings? – Community Leader
>
> There are a high proportion of people in this area with cancers, and access to appropriate treatment is basically non-existent. There is one location that I know of that does provide some IV chemotherapy infusions, but if radiation or specialty cancer treatment is necessary people must travel many hours away, if not to a different state to larger medical centers. – Other Health Provider
>
> Major diagnosis and treatment are 300 miles from local. – Community Leader
>
> Cost. – Community Leader

Aging Population

> We have an older than usual population, incidence is high and our access to oncology is very limited. – Community Leader

Prevention/Screenings

> The population generally does not consider preventive or early maintenance. They wait until it is already a problem. – Social Services 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.

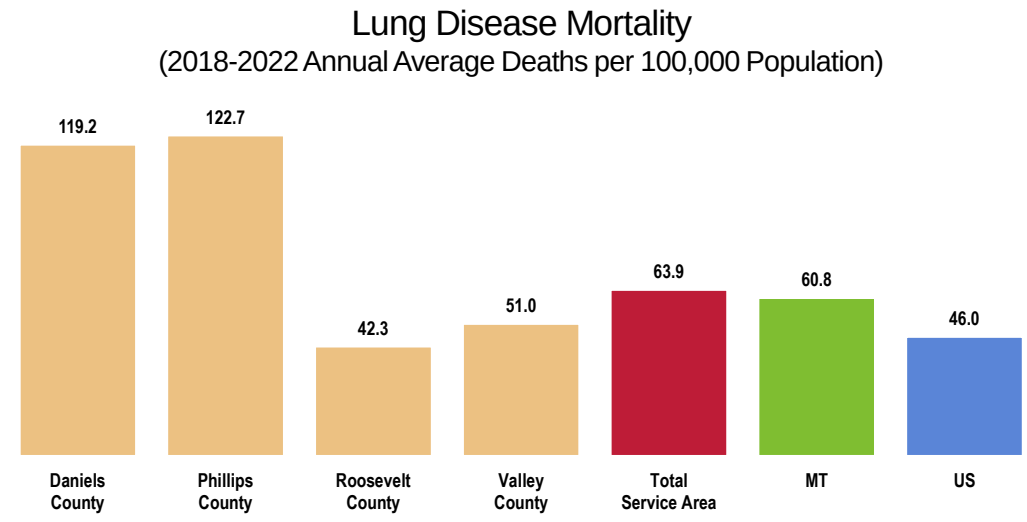
– Healthy People 2030 (https://health.gov/healthypeople)

Note that this section also includes data relative to COVID-19 (coronavirus disease).

Lung Disease Deaths

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

The mortality rate for lung disease in the Total Service Area is summarized below, in comparison with Montana and national rates.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

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

Asthma Prevalence

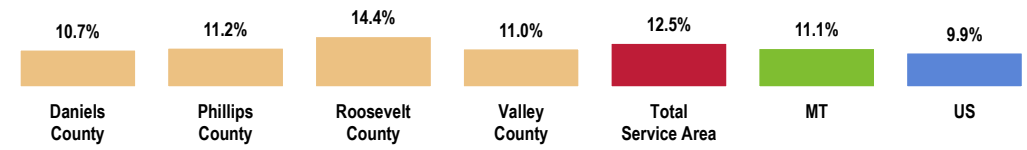
The following chart shows the prevalence of asthma among Total Service Area adults.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

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

"Do you still have asthma?"

Prevalence includes those responding "yes" to both.



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

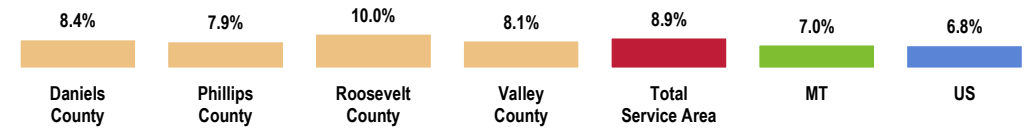
Notes:
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

COPD Prevalence

The following chart shows the prevalence of chronic obstructive pulmonary disease (COPD) among Total Service Area adults.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had COPD (chronic obstructive pulmonary disease), emphysema, or chronic bronchitis?"

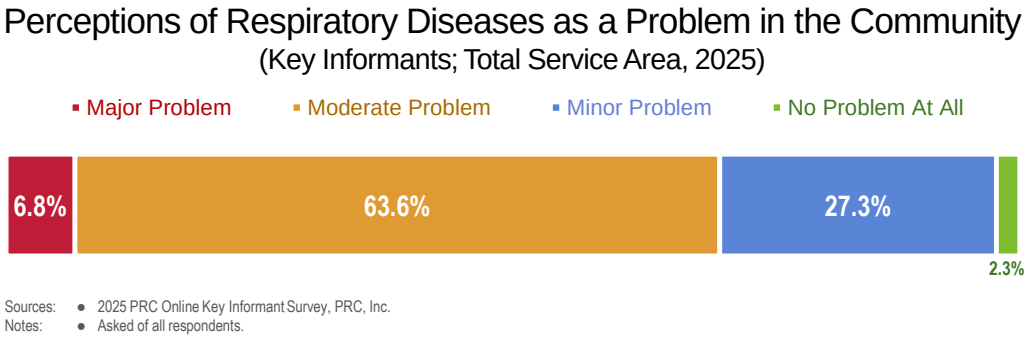


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- Includes those who have ever been diagnosed with chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis.

Key Informant Input: Respiratory Disease

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



Top Concerns

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

Access to Care/Services

> Lack of proper care if people are extremely sick. Each Critical Access Hospital only has one or two respirators and if you get put on one, you are flown out, leaving you with one less ventilator during that transport. – Other Health Provider

Aging Population

> We continue to see an evolution of COPD and her aging population. Unfortunately, these folks are widely susceptible to respiratory diseases such as COVID-19, influenza and RSV. Given her harsh winters this forces people indoors and tight quarters causing widespread viral contamination – Other Health Provider

Lack of Specialists

> We do not have a pulmonologist or pulmonology rehab center here in Glasgow. – 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.

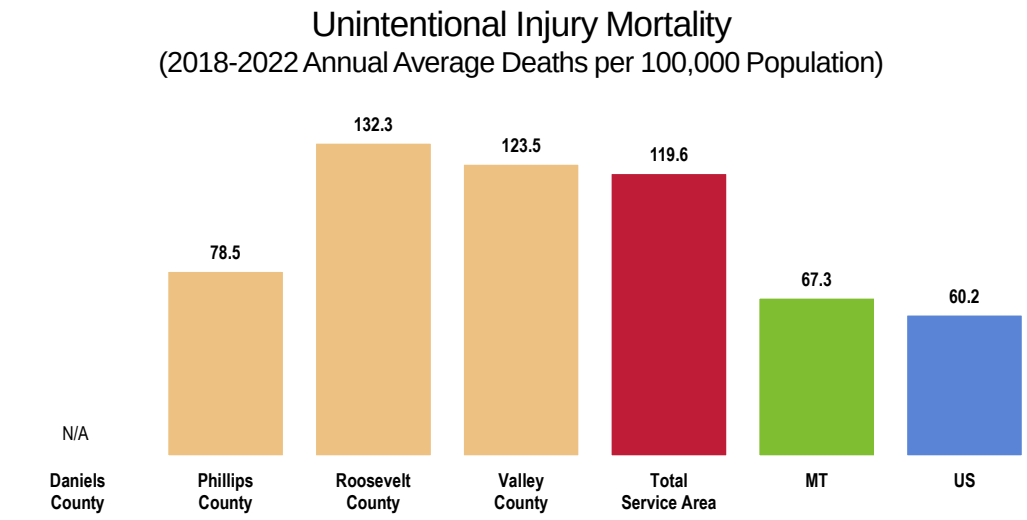
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

Unintentional Injury

Unintentional Injury Deaths

Unintentional injury is a leading cause of death. The chart that follows illustrates unintentional injury death rates for the Total Service Area, Montana, and the US.

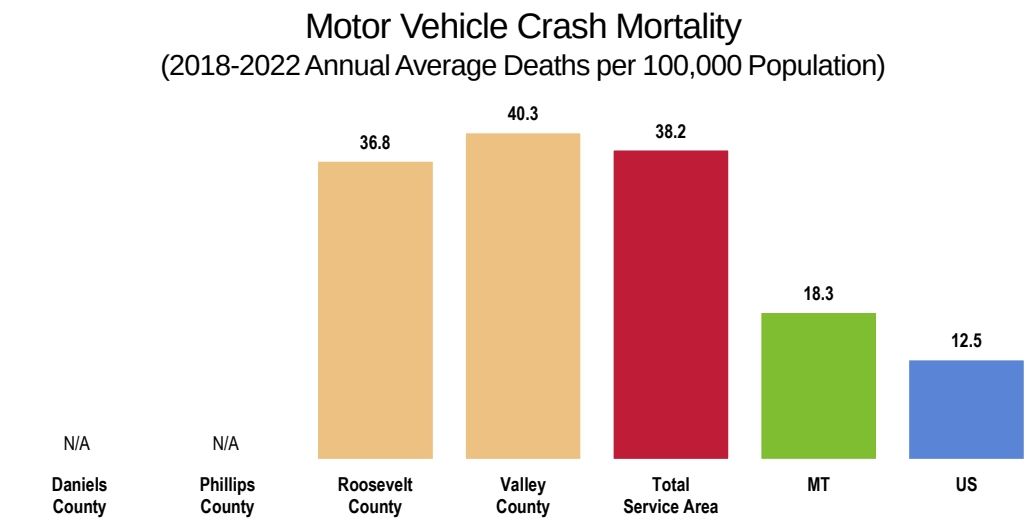


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

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

Motor Vehicle Crash Deaths

Motor vehicle crash deaths are preventable and are a cause of premature death. Mortality rates for motor vehicle crash deaths are outlined below.

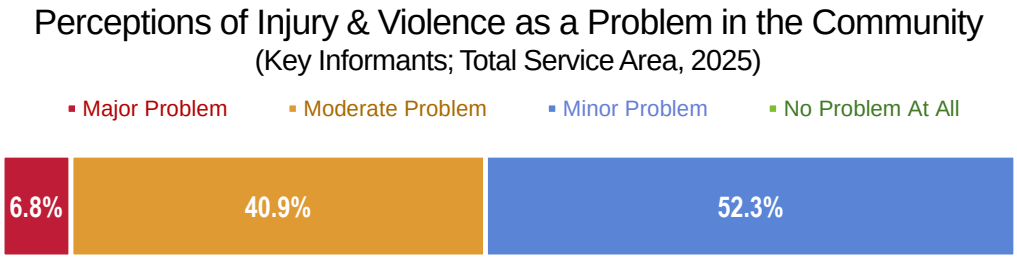


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

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

Key Informant Input: Injury & Violence

Key informants' perceptions of *Injury &* Violence in our community:



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Vulnerable Populations

> The large population of homeless people on the Reservation, combined with a high usage of illegal drugs, are a recipe for disaster. The local law enforcement is often too scared to even do anything to the criminals and if they do bring them into the jail, the courts don't charge them with anything. So, they are right back out without consequences. – Other Health Provider

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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

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

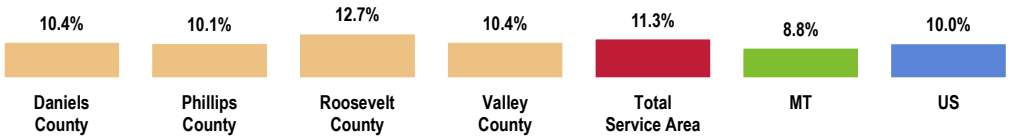
Prevalence of Diabetes

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

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

Diabetes is a prevalent and long-lasting (chronic) health condition with a number of adverse health effects, and it may indicate an unhealthy lifestyle. The prevalence of diabetes among Total Service Area adults age 20 and older is outlined below, compared to state and national prevalence levels.

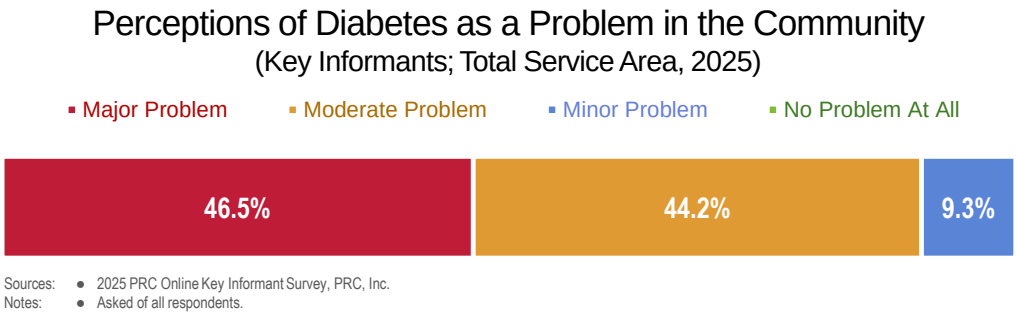
Prevalence of Diabetes
(Adults Age 20 and Older; 2021)



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Key Informant Input: Diabetes

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



Top Concerns

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

Awareness/Education

> Education, knowledge about the disease process and how it affects everything else in your body and health, compliance, it is hard to be disciplined with the diet, foot care, medications, access to insulin, very insurance-dependent. – Community Leader
>
> I think that there is a lack of education and general desire to take health seriously in our area. I also know that COST plays a huge part in individuals not treating their Diabetes. Also, due to our location, we have an abundance of bars and access to alcohol, which only contributes to the complications with Diabetes. – Other Health Provider
>
> Knowledge of, and access to, an appropriate whole-foods diet. – Community Leader
>
> Access to education and support with medication management. Services to help monitor insulin dosing and drawing up insulin at home. – Other Health Provider

Access to Affordable Healthy Food

> Cost of healthy foods, cost of medications, challenge to include physical activity within a harsh environment. – Other Health Provider
>
> Affordable healthy food choices. – Other Health Provider
>
> Access to affordable healthy food. – Physician
>
> Groceries can be hard to get and are expensive. Long winters where people can't get out and exercise. we have a facility that you can work out in, but it's expensive. – Community Leader

Access to Medications/Supplies

> Access to medications that are effective, limitation due to cost, limitation to diabetic counseling with a dietitian. – Other Health Provider
>
> Availability to get pump supplies and testing supplies. – Community Leader

Access to Care/Services

> 1) Limited access to healthcare providers. Specialized care, such as endocrinologists or diabetes educators, is often unavailable locally. Patients may need to travel long distances for consultations, which can delay care or reduce the frequency of follow-ups needed to manage the disease effectively. 2) Scarcity of diabetes education and resources. Access to diabetes education programs, nutritional counseling, and support groups may be limited. Without these resources, patients may lack the necessary knowledge to manage their condition properly, including diet, exercise, and medication adherence. 3) Challenges in medication and supply availability. Pharmacies in rural areas may have limited stock of diabetes medications, testing supplies, and devices like insulin pumps or continuous glucose monitors. This can make it difficult for patients to maintain consistent management of their condition. 4) Transportation barriers, traveling to appointments, picking up medications. – Other Health Provider

Disease Management

> I feel that there is adequate education and health care services available, however I believe there is resistance in our population to put forth the effort to not only access healthcare but maintain a plan of care laid out by their providers. This will require an evolution in community wide mindset. While I do see positive change in activity, I also see negative change in the use of alcohol, tobacco, marijuana and other substances of abuse. – Other Health Provider

Lack of Providers

> No provider who specializes in type 1 monitoring, so the patient needs to travel to a larger facility. Not much awareness about type 1, plenty about type 2 and the general public not being made aware of the difference. – Social Services Provider

Vulnerable Population

> The highest percentage of the population with diabetes are Native Americans who face many challenges and barriers to quality diets, education and care. Access to endocrinologists is problematic for our entire population. – Community Leader

Co-Occurrences

> Type two secondary to obesity. Lack of access to specialists, lack of adequate walking or exercise facilities, food expense, lack of healthy dining options. – Community Leader

DISABLING CONDITIONS

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)

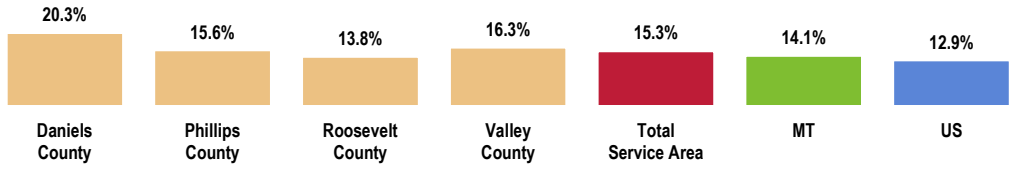
Disability

The following represents the percentage of the total civilian, non-institutionalized population in the Total Service Area with a disability. This indicator is relevant because disabled individuals may comprise a vulnerable population that requires targeted services and outreach.

Disability data come from the US Census Bureau's American Community Survey (ACS), Survey of Income and Program Participation (SIPP), and Current Population Survey (CPS). All three surveys ask about six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent-living difficulty.

Respondents who report any one of the six disability types are considered to have a disability.

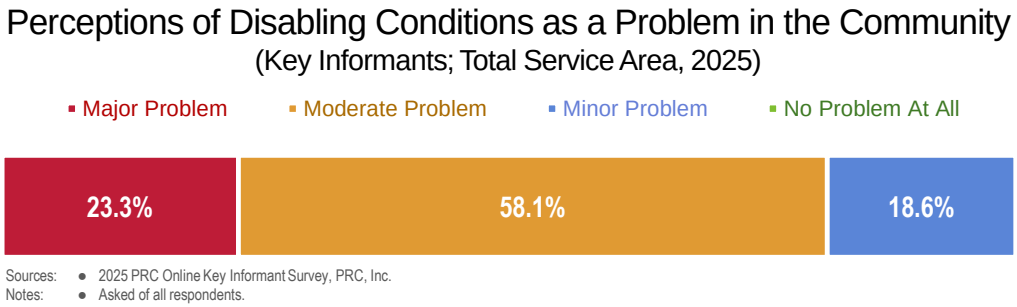
Population With Any Disability
(Among Civilian Non-Institutionalized Residents; 2018-2022)



Sources:
- US Census Bureau, American Community Survey.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Key Informant Input: Disabling Conditions

Key informants' perceptions of *Disabling Conditions* are outlined below.



Top Concerns

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

Access to Care/Services

> Limited access to healthcare providers, education, transportation barriers. – Other Health Provider
>
> Very limited access to home care and limited nursing home beds and necessary staff creates a family burden. – Community Leader

Aging Population

> For an older than normal state, we have an even older population with many listed conditions and very few community-based services. – Community Leader
>
> We have an elderly population that experiences many of these conditions. – Community Leader

Isolation/Loneliness

> 1) Isolation social disconnection: Disabling conditions often make it harder for individuals to participate in social activities, leading to feelings of loneliness and isolation. Transportation barriers: limited mobility or lack of accessible transport options may prevent individuals from leaving their homes. 2) Limited facilities for low-income residents. Healthcare access: affordable healthcare options, especially for those managing chronic conditions or requiring assistive devices, may be insufficient. Affordable housing: accessible and disability-friendly housing is often expensive or unavailable for low-income individuals. 3) Few activities, lack of programming: many communities lack inclusive activities designed for individuals with disabilities or chronic conditions, contributing to reduced mental and physical stimulation. Community awareness: a lack of understanding about the importance of inclusive activities may result in a lack of funding or development of such programs. – Community Leader

Vulnerable Population

> Due to the community being partially a Native American Reservation which has a higher incidence of health conditions that leave people disabled, not only are the numbers higher, but the access to appropriate care and assistive devices is limited. People have to wait for grants from the Tribe, and others to get wheelchair ramps installed, if disability with limitations is a factor, and this can take months. There is a very limited number of nursing home/SNF services in the area, probably under 50 beds, including dementia care. Chronic pain services do not exist, family medicine providers bare this burden along with the emergency rooms, and substance use disorder is prevalent. There are no special services for loss of vision, regular optometry is not available either. There are a few resources for hearing, but mainly testing, not hearing aids. – Other Health Provider

Co-Occurrences

> Mental health and cognitive deficit are a major part of this as well as accident- or stroke-related conditions. Because of where we live and the need to transport patients to high levels of care for certain emergencies, time is not on our side. Lack of respite care (workers and funding), no home care through insurance available, mental and cognitive deficit resources are lacking. – Community Leader

Chronic Pain

> Chronic pain, large number of population that have legitimate chronic pain from industry, military and agricultural injuries, are widely the reason for alcohol and substance abuse. If there were more pain-focused clinics that provided holistic recovery over pharmaceutical treatments, it would lessen the rate of addictions and suicide. – Social Services Provider

Lack of Providers

> There are not enough specialists available to residents in the polled counties to keep up with the patient load. – Other Health Provider

BIRTHS

BIRTH OUTCOMES & RISKS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

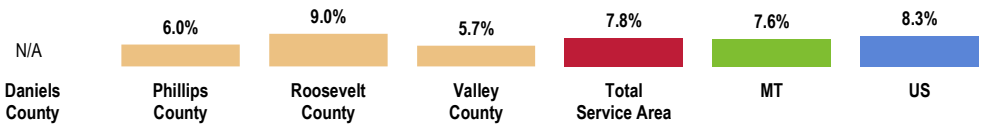
– Healthy People 2030 (https://health.gov/healthypeople)

Low-Weight Births

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

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. The following chart illustrates the percent of total births that are low birth weight.

Low-Weight Births
(Percent of Live Births, 2016-2022)



Sources: ● University of Wisconsin Population Health Institute, County Health Rankings.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g).

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.

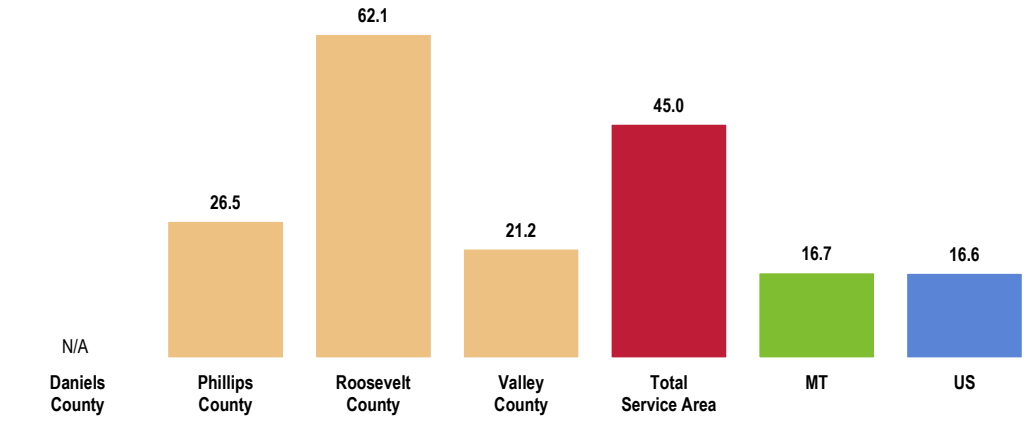
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

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

Births to Adolescent Mothers

Here, teen births include births to women ages 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

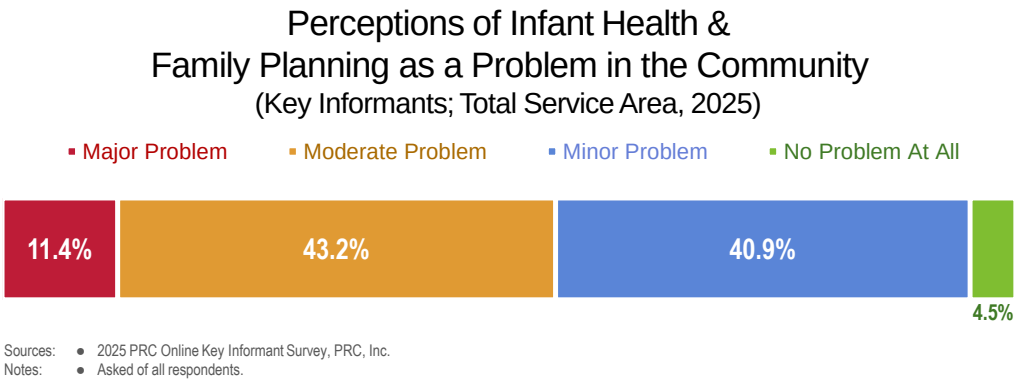
The following chart outlines the teen birth rate in the Total Service Area, compared to rates statewide and nationally. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Key Informant Input: Infant Health & Family Planning

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



Top Concerns

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

Access to Care/Services

> In our rural community, access to healthcare is a persistent challenge due to the limited availability of resources and services. – Other Health Provider
>
> There are no family planning services, and the pregnancy rate is staggering, for unplanned pregnancies, especially for young girls. The closest thing to infant health is WIC. Most people do not receive proper prenatal care, and some are drug addicted. – Other Health Provider

Lack of Lactation Support/Board Certified Consultants

> Lack of lactation support. Lack of certified lactation consultants. Lack of breastfeeding support and education. – Physician

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

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

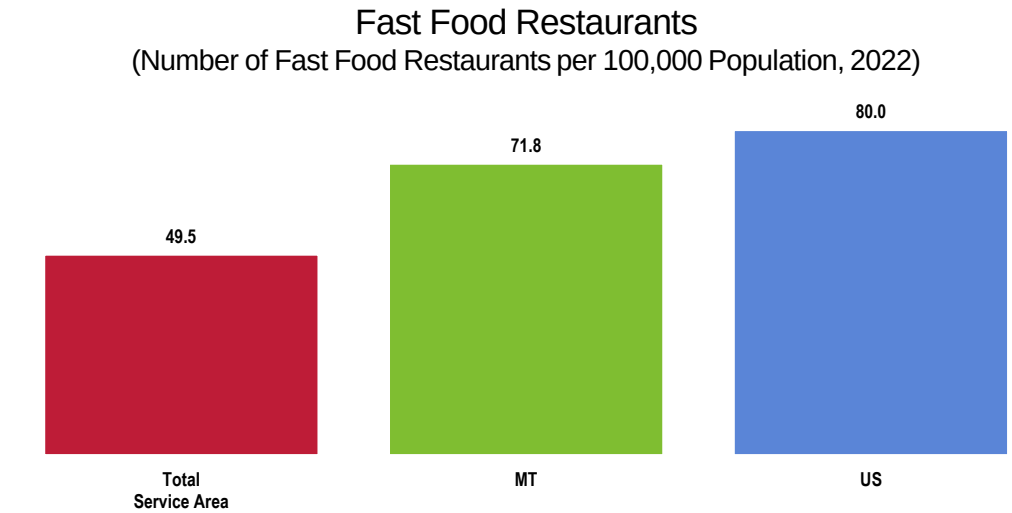
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

Food Environment: Fast Food

Here, fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating.

The following shows the number of fast food restaurants in the Total Service Area, expressed as a rate per 100,000 residents. This indicator provides a measure of healthy food access and environmental influences on dietary behavior.



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

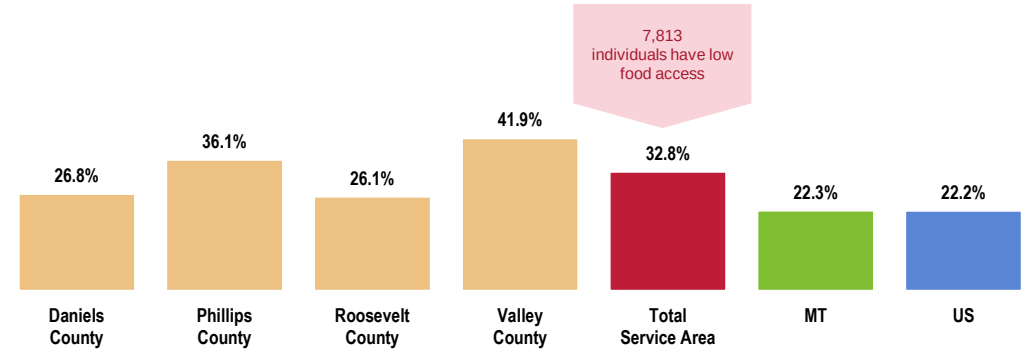
Low Food Access

Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store (or 10 miles in rural areas).

The following chart shows US Department of Agriculture data determining the percentage of Total Service Area residents found to have low food access, meaning that they do not live near a supermarket or large grocery store.

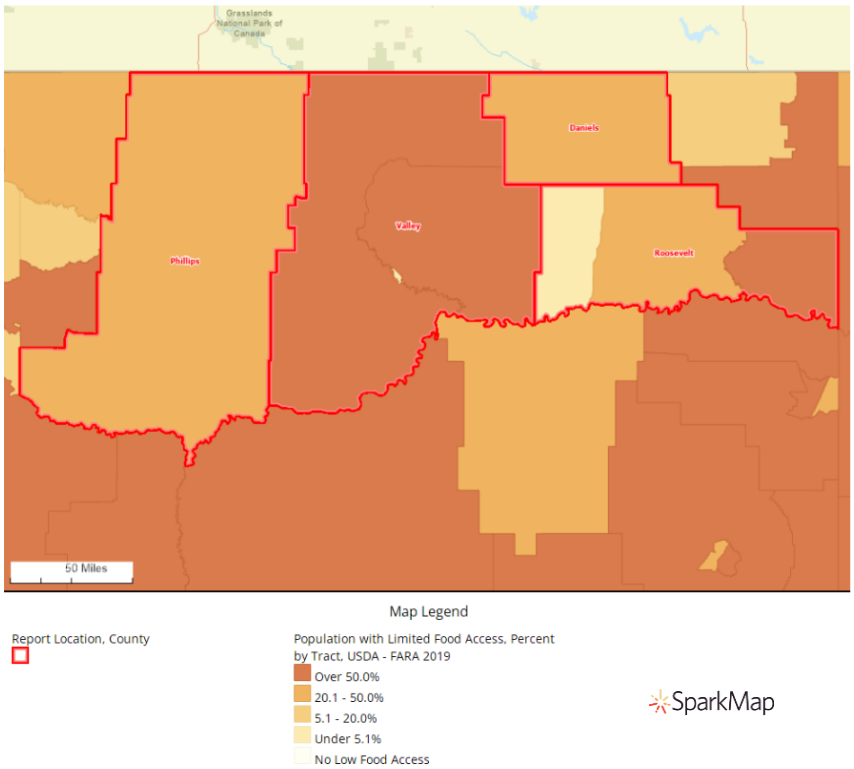
Population With Low Food Access

(Percent of Population Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living far (more than 1 mile in urban areas, more than 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.



PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

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

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

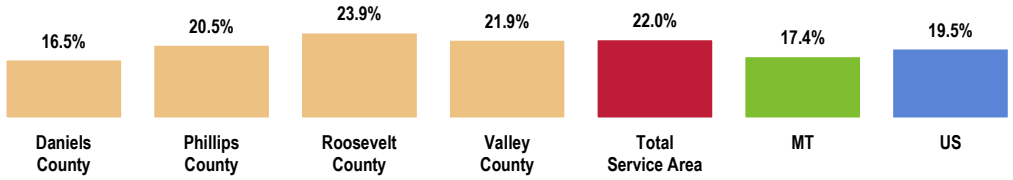
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

Below is the percentage of Total Service Area adults age 20 and older who report no leisure-time physical activity in the past month. This measure is important as an indicator of risk for significant health issues such as obesity or poor cardiovascular health.

No Leisure-Time Physical Activity in the Past Month
(Among Adults Age 20 and Older, 2021)
Healthy People 2030 = 21.8% or Lower



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

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

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

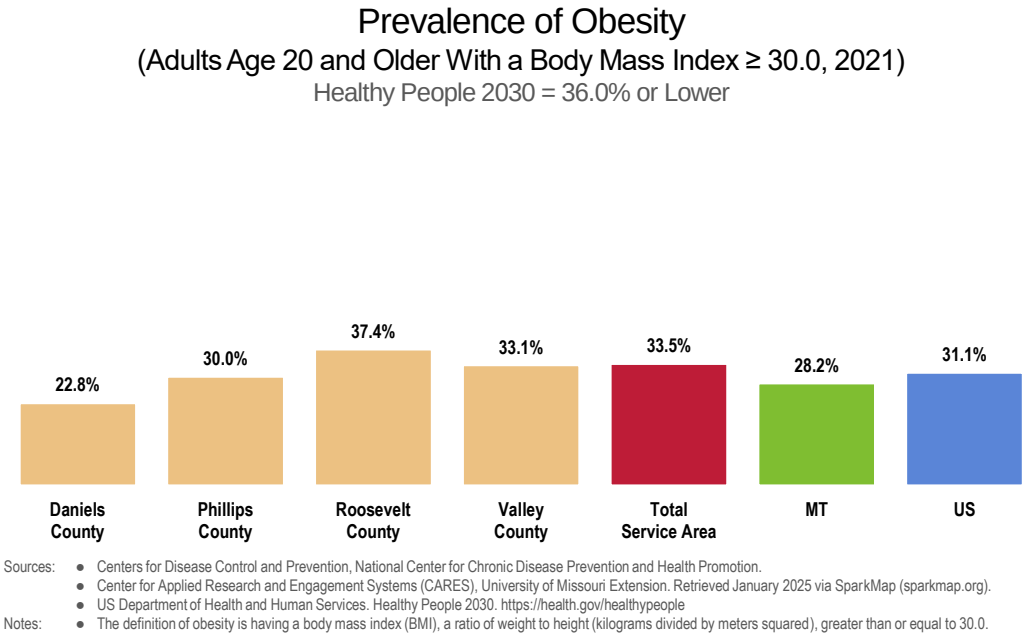
CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Obesity

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

Outlined below is the percentage of Total Service Area adults age 20 and older who are obese, indicating that they might lead an unhealthy lifestyle and be at risk for adverse health issues.

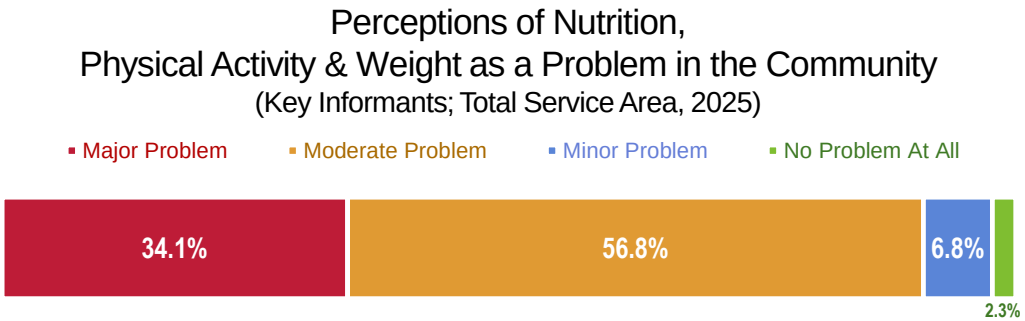


Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Key Informant Input: Nutrition, Physical Activity & Weight

Key informants' ratings of *Nutrition, Physical Activity & Weight* as a community health issue are illustrated below.



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Access to Affordable Healthy Food

> Cost of eating healthy foods, more limited selection of fresh foods. We live in a harsh environment where year-round outside physical activity is challenging. – Other Health Provider
>
> Poor access to healthy food that is affordable. – Physician
>
> High cost of groceries, cold climate. – Other Health Provider
>
> The economy has a lot to do with the nutrition aspect, as groceries and fresh produce are very expensive here. Getting people to access the parks, civic center, etc. The lack of a pool for the last two years. – Social Services Provider

Insufficient Physical Activity

> Lack of activity, poor dietary choices made by patients. – Other Health Provider
>
> Lack of activity and desire to be healthy. – Community Leader
>
> Reduced physical activity: harsh winter conditions limit outdoor activities, making it harder for individuals to stay active. Limited options for families: families with children may struggle to find safe, accessible indoor spaces for physical activity. Healthy food costs: fresh, nutritious food is often more expensive than processed or fast food, making it inaccessible for low-income households. Time constraints: people living in poverty often work long hours or multiple jobs, leaving little time to focus on meal preparation or exercise. Food deserts: some areas lack grocery stores that carry affordable fresh produce, meat, and dairy. Transportation barriers: residents without reliable transportation may struggle to access stores with fresh food options. Reliance on processed foods: limited access to fresh food often leads to higher consumption of processed, high-calorie, low-nutrient foods. Limited skills: people who lack cooking knowledge are more likely to rely on fast food or processed food. – Community Leader

Lifestyle

> I think a lot of the time, nutrition, physical activity, and weight is really determined on lifestyle and how each individual family operates. Families that are not knowledgeable when it comes to these three things may not even know where to start when it comes to eating healthy, working out, and managing weight. I feel like in our area, there is not a whole lot of support such as nutrition coaches, nutritionists, and workout places where people can go to get help without having to spend a ton of money. Sometimes when people are struggling with these three areas, they do not have the money that is needed to address them. – Community Leader
>
> Food desert, lack of quality food, grocery stores, affordable healthy foods, lack of exercise facilities, and lack of medical weight loss options. – Other Health Provider

Income/Poverty

> Limited money, raised in a sedentary lifestyle. – Community Leader

Nutrition

> Overabundance of processed foods and added sugars, lack of whole foods in the diet. – Community Leader

Climate

> Weather, poor infrastructure, expensive groceries, lack of services. – Community Leader

SUBSTANCE USE

ABOUT DRUG & ALCOHOL USE

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

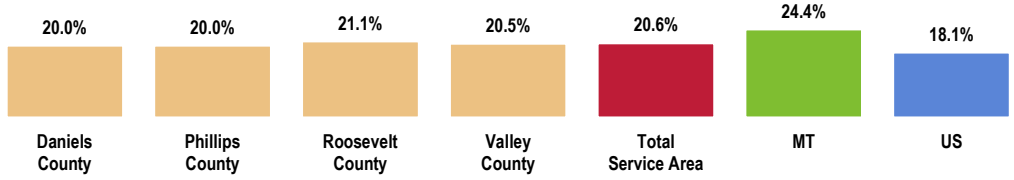
Excessive Alcohol Use

Excessive drinking includes heavy and/or binge drinking:

- HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

The following illustrates the prevalence of excessive drinking in the Total Service Area, as well as statewide and nationally. Excessive drinking is linked to significant health issues, such as cirrhosis, certain cancers, and untreated mental/behavioral health issues.

Engage in Excessive Drinking
(2021)

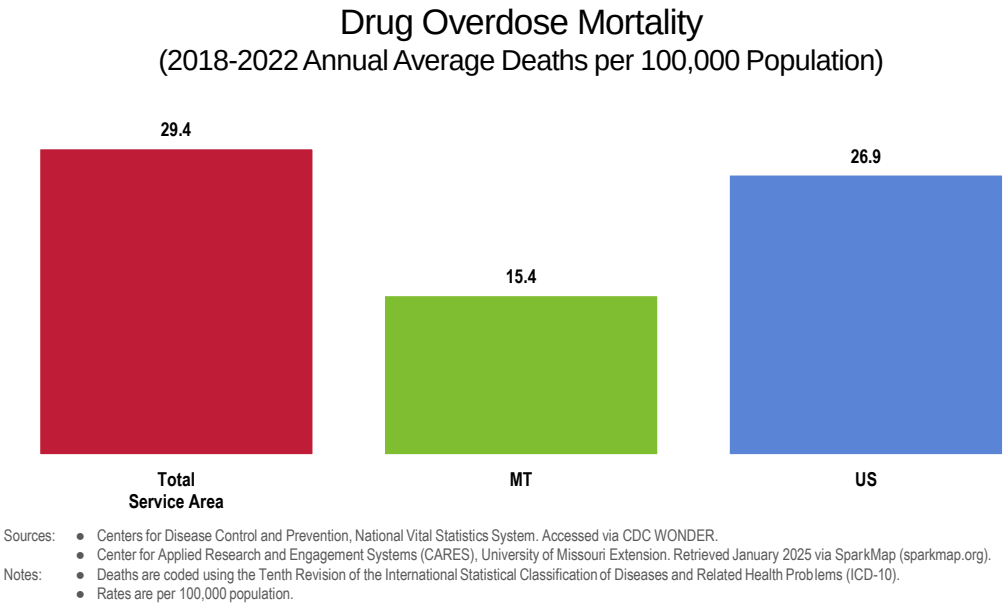


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period.

Drug Overdose Deaths

The chart that follows illustrates death rates attributed to drug overdoses (all substances, excluding alcohol) for the Total Service Area, Montana, and the US.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

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

Key Informant Input: Substance Use

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

Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Access to Care/Services

> There aren't any directly related substance abuse treatment facilities. Substances are readily available for people to obtain but nothing to help them when they are addicted to them. – Community Leader
>
> The lack of a detox center in our hospital. The length of time it takes to get people into treatment. Transportation barriers to get to treatment. Not enough support groups once out of treatment. Not enough community events provided that do not allow alcohol. – Social Services Provider
>
> There is no inpatient treatment nearby. There is an incredible need for this care, and only a few get chosen to get care. It runs in families, so it is extremely difficult for someone to be rehabilitated and come back to that environment and remain sober. – Other Health Provider
>
> Lack of outpatient treatment. – Other Health Provider
>
> Location. – Community Leader
>
> First off, we do not have inpatient treatment for substance abuse in Valley County which is a huge concern. Being in a small town there is still the stigma of seeking help just like with mental health. Alcohol use is such a “normal” thing in these communities that drinking every night (numerous drinks at a time) is not looked at as a problem. The nearest inpatient treatment facility is nearly 300 miles away which makes it less likely for someone to get the help because they would have to leave their community. – Community Leader
>
> There are no programs. – Community Leader
>
> There are no rehab centers here for alcohol abuse. I know we have Ideal Options, but it is my understanding that it does not cover people who are addicted to alcohol, only other substances. – Other Health Provider
>
> We are too rural, and we have no local treatment centers. – Other Health Provider
>
> Inpatient treatment options. Stigma of treatment. Lack of referral options. Lack of co-occurring treatment including medication management. In patient options are hours from community. Lack of medical providers understanding the complexities of addiction and mental health. – Community Leader

Lack of Providers

> There is no specific facility or providers dedicated to this type of treatment. – Other Health Provider
>
> The way the whole process is set up needs attention: Substance abusers usually have mental health issues that contribute to their substance use, yet there is one distinct camp for substance use treatment: Licensed Addiction Counselors. Why can't LCPCs or LCSWs easily get the education needed to add to their scope of service? I don't think LACs need to be mental health counselors, unless something has changed. Mental health issues exist in LAC work. It's expensive to keep going to school. Why doesn't the State offer more reasonable means to get this licensure? – Other Health Provider
>
> Lack of providers, lack of patients accessing this resource when available. Lack of treatment for mental health and other reasons of underlying substance use disorders. – Physician
>
> Lack of providers, no inpatient rehab anywhere close, and many are over capacity in the state. – Community Leader

Denial/Stigma

> People realizing they have an issue, distance to the closest facility, and cost. – Community Leader
>
> The social stigma associated with substance abuse specifically alcohol is widespread. This will require a commitment of the public to work on cessation and I am not sure that they are ready for it. Alcohol for one is widely accepted and used in more social outings. This seems to be a perfect storm for addiction – Other Health Provider

Diagnosis/Treatment

> How do you break the cycle and what about after-care from treatment facilities? – Community Leader
>
> There is no treatment, at least not inpatient; access is lacking. – Other Health Provider

Affordable Care/Services

> Cost. We have made strides in removing the stigma but when potential clients come in for services and find out how costly services are, they opt to forgo seeking further services. No after care residential facility when a person comes out of inpatient treatment. Most come back to the environment that perpetuated their substance abuse. – Social Services Provider

Most Problematic Substances

Note below which substances key informants (who rated this as a “major problem”) identified as causing the most problems in the Total Service Area.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Use as a “Major Problem”)	
ALCOHOL	86.4%
MARIJUANA	9.1%
HEROIN OR OTHER OPIOIDS	4.5%

TOBACCO USE

ABOUT TOBACCO USE

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

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

Cigarette Smoking Prevalence

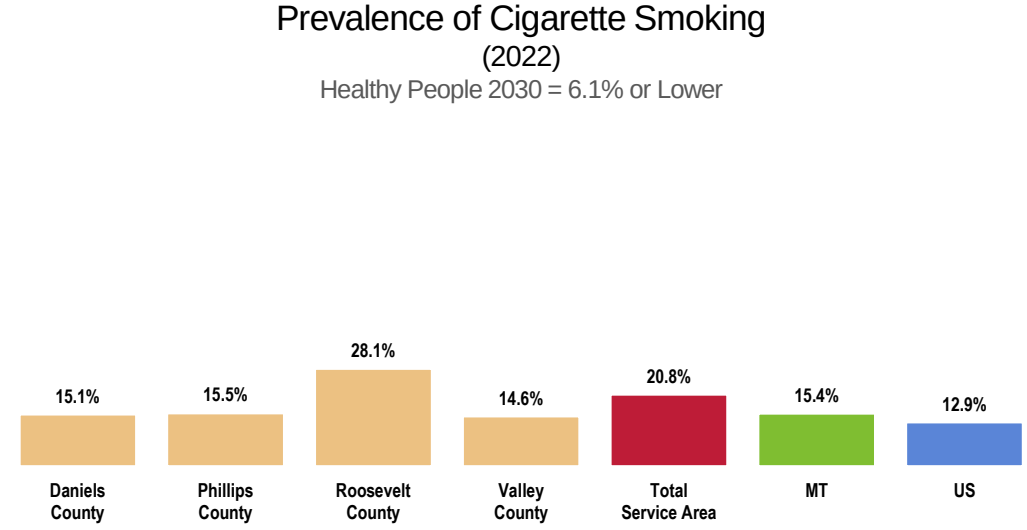
Tobacco use is linked to the two major leading causes of death: cancer and cardiovascular disease. Note below the prevalence of cigarette smoking in our community.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Have you smoked at least 100 cigarettes in your entire life?"

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

Cigarette smoking prevalence includes those who report having smoked at least 100 cigarettes in their lifetime and who currently smoke every day or on some days.

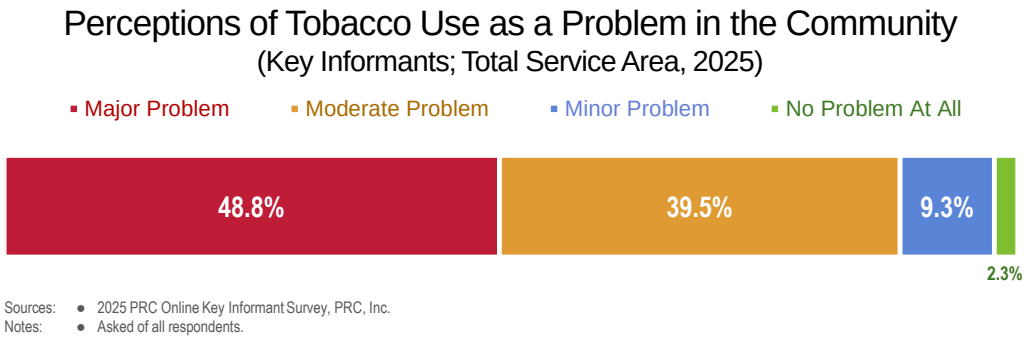


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Includes those who report having smoked at least 100 cigarettes in their lifetime and currently smoke cigarettes every day or on some days.

Key Informant Input: Tobacco Use

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



Top Concerns

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

Incidence/Prevalence

> A lot of people use. – Community Leader
>
> Lots of smoking. Difficult to get support for quitting for mental health and substance abuse programs. – Physician
>
> Lots of smokers, chewers and vapers. – Community Leader
>
> It seems as though everyone smokes, chews or vapes. Our health department works very hard to try and help people. – Community Leader

Socially Acceptable

> Tobacco is readily accepted by the community and easily accessible. Workplaces give people breaks who smoke, which seems like a good reason. It's easier to turn to tobacco when life is hard than look to healthier options. – Community Leader
>
> It is just so accepted. It has helped that people aren't allowed to smoke in establishments, but there still seems to be a lot of people who smoke. The younger population of smokers has increased. – Social Services Provider
>
> Social acceptance, tradition, ease of access for youth. – Social Services Provider

Addiction

> Tobacco was addicting, a known problem, access to obtain is using. – Other Health Provider
>
> It is a huge addiction. I know more men that are friends and family that use it than not. – Community Leader

Impact on Quality of Life

> Tobacco use affects people's physical health and when smoked, everyone in the household within the smoke's reach is negatively affected. It is a crutch used by many to avert anxiety and a 'quick' form of emotional regulation (and modeled for kids). A lot of money is spent on it -- money that could be used to assist elsewhere within the family budget to bolster basic needs. The stigma is not there as it would be if a person were to drink alcohol or overeat, leading to other obvious health issues. Although no one seems to be a "champion coper" at all times, tobacco flies under the stigma radar as it destroys people's health when used in excess. Calling it legal doesn't erase all its grey areas that affect our community's overall health. [Lots of synthetic insecticides (e.g., Imidacloprid) are inspired by, or even structurally related to nicotine. (npic.orst.edu) It might be nice if this was further studied.] Often smoking and drinking alcohol go hand-in-hand: special double whammy. – Other Health Provider

Aging Population

> Valley County in Northeastern Montana is a very old community and unfortunately tobacco use was placed 40 years ago. Some of those traditions, although not healthy, continued to be propagated amongst the generations. – Other Health Provider

E-Cigarettes

> Vaping has become more of the problem I would say when it comes to tobacco use especially with adolescents. It seems to be easily accessed (they are getting it from parents or people of age) and is a lot easier for adolescents to hide (it doesn't smell like cigarette smoke, and some are made to look like school supplies). – Community Leader

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

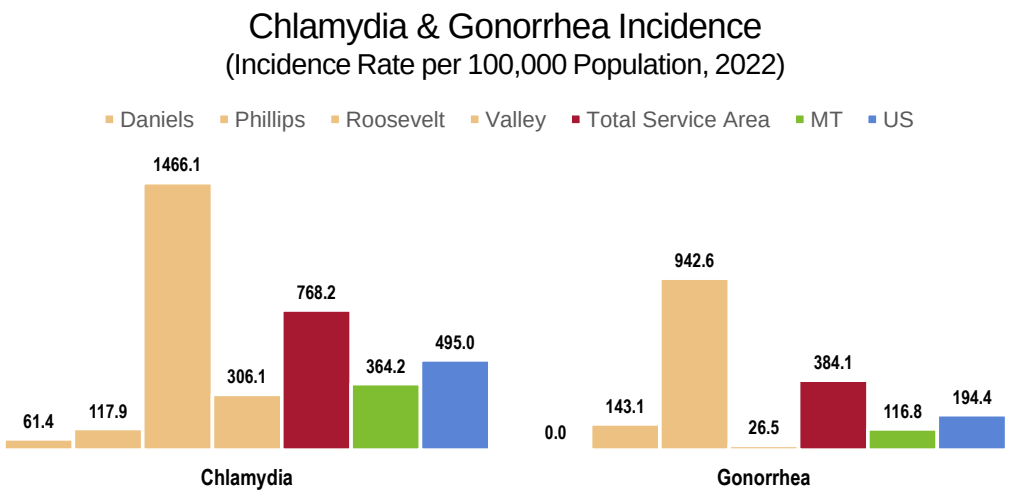
Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the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

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

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

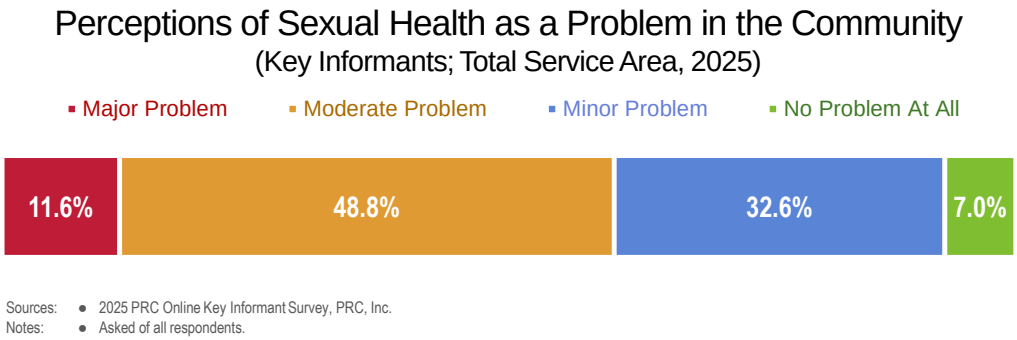
Chlamydia and gonorrhea are reportable health conditions that might indicate unsafe sexual practices in the community. Incidence rates for these sexually transmitted diseases are shown in the following chart.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

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



Top Concerns

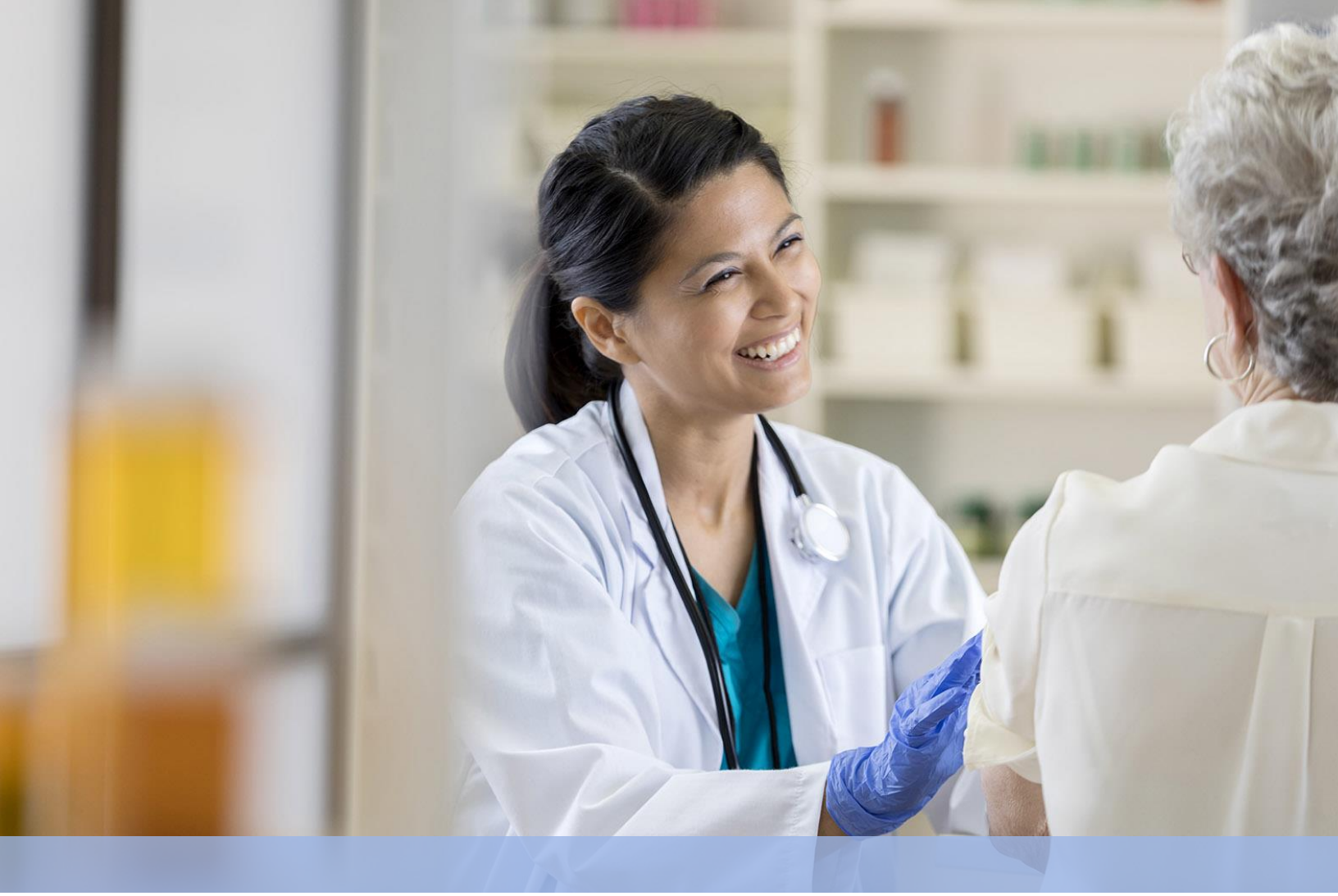
Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> I just feel like people are not very educated when it comes to STDs, HIV, etc. There also is not a whole lot of support for these areas of concern. – Community Leader

Vulnerable Population

> There is the highest rate of syphilis on the Reservation here, people are reported to the health department, so people know who they are. – Other Health Provider



ACCESS TO HEALTH CARE

BARRIERS TO HEALTH CARE ACCESS

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

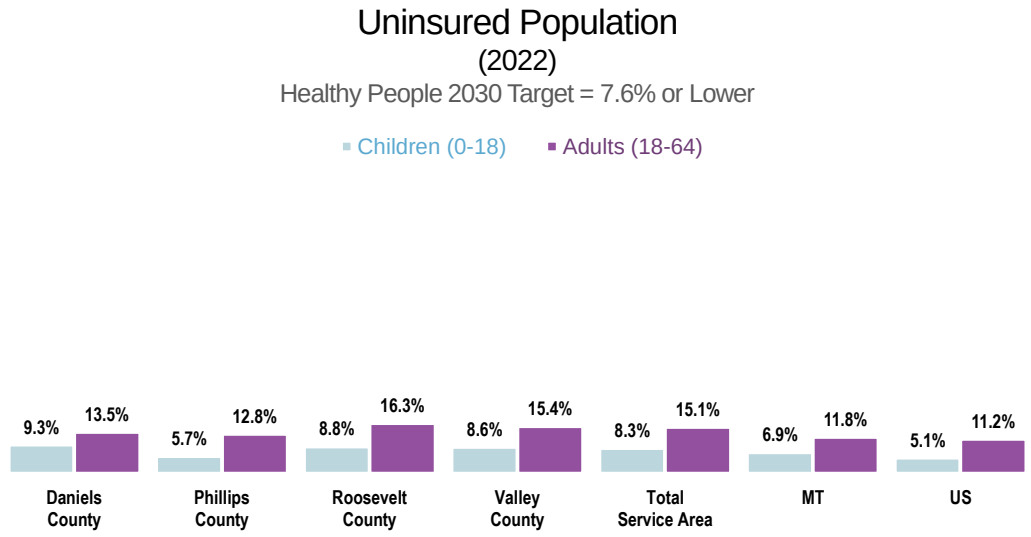
Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

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

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects those younger than 65 (thus excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

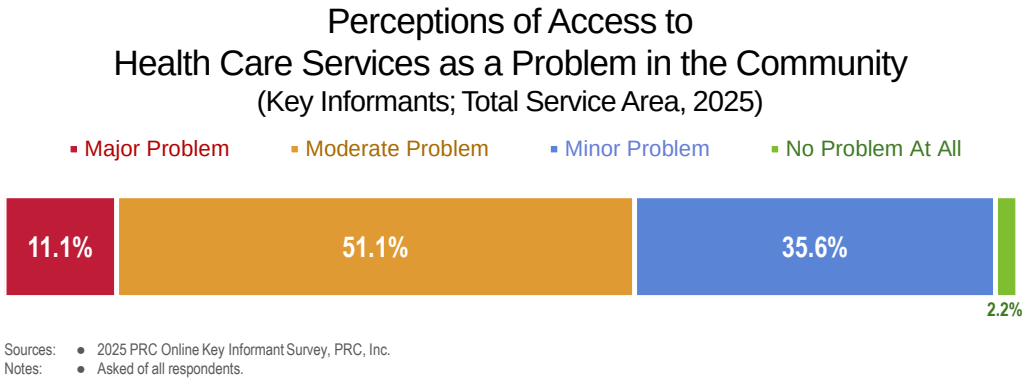
Health insurance coverage is a critical component of health care access and a key driver of health status. The following chart shows the latest figures for the prevalence of uninsured adults (age 18 to 64 years) and of uninsured children (under the age of 19) in the Total Service Area.



Sources:
- US Census Bureau, Small Area Health Insurance Estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Access to Health Care Services

Key informants' ratings of *Access to Health Care Services* as a problem in the Total Service Area is outlined below.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Access to Care/Services

> In our rural community, access to healthcare is a persistent challenge due to the limited availability of resources and services. Unlike urban areas with numerous medical facilities and providers, our region faces significant gaps in general healthcare, making it difficult for residents to receive even routine care in a timely manner. The shortage of healthcare professionals, combined with the long travel distances often required to reach the nearest clinic or hospital, creates barriers that many find difficult to overcome. These challenges are further compounded by the lack of infrastructure and funding, which restricts the ability to expand or improve local healthcare options. – Other Health Provider
>
> Rural location. Lack of travelling specialists to get higher level of care patients need up here, especially those who can travel due to cost, availability of a working vehicle, disability, age, or other reasons. – Physician
>
> Cost, availability, experience is lacking. – Community Leader
>
> Inadequate staffing in many of the smaller hospitals and clinics. Great travel distances for the most rural people. Inadequate transportation, particularly on the Fort Peck Indian reservation. Rate of adult vaccination is way too low, in large part due to rampant disinformation. – 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.

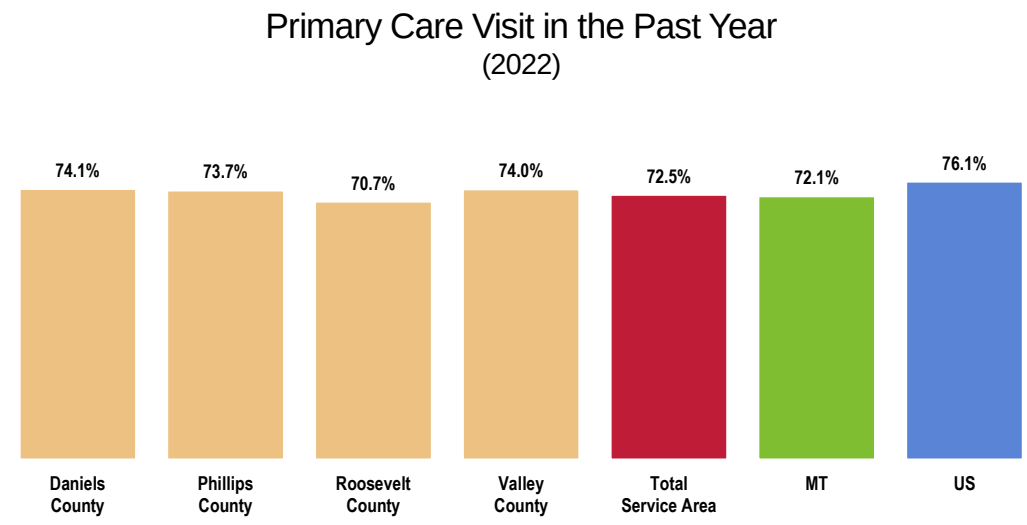
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't 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)

Primary Care Visits

The following chart reports the percentage of Total Service Area adults who visited a doctor for a routine checkup in the past year.



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

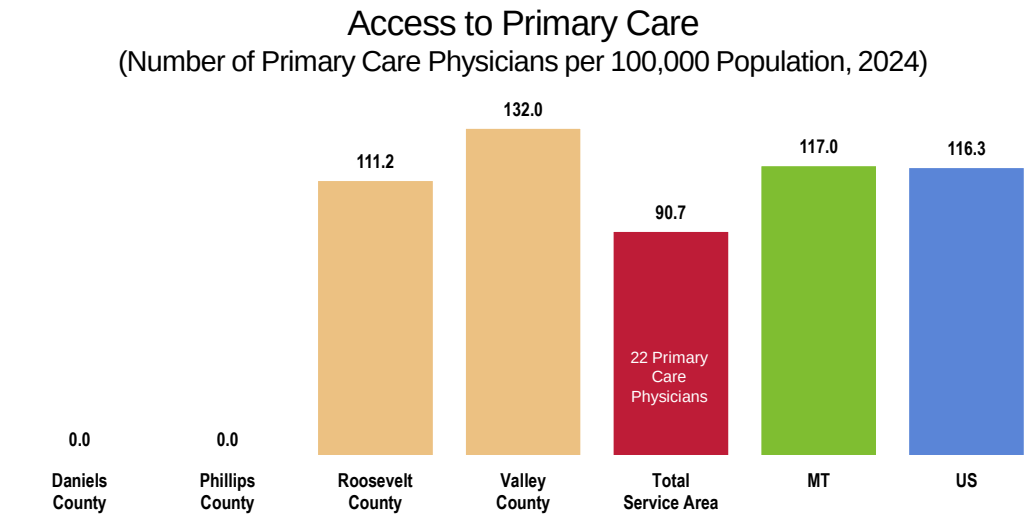
Notes:
- This indicator reports the number and percentage of adults age 18 and older with one or more visits to a doctor for routine checkup within the past one year.

Access to Primary Care

Doctors classified as "primary care physicians" by the AMA include: general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians age 75 and over and physicians practicing subspecialties within the listed specialties are excluded.

Note that this indicator takes into account only primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following indicator outlines the number of primary care physicians per 100,000 population in the Total Service Area. Having adequate primary care practitioners contributes to access to preventive care.



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

ORAL HEALTH

ABOUT ORAL HEALTH

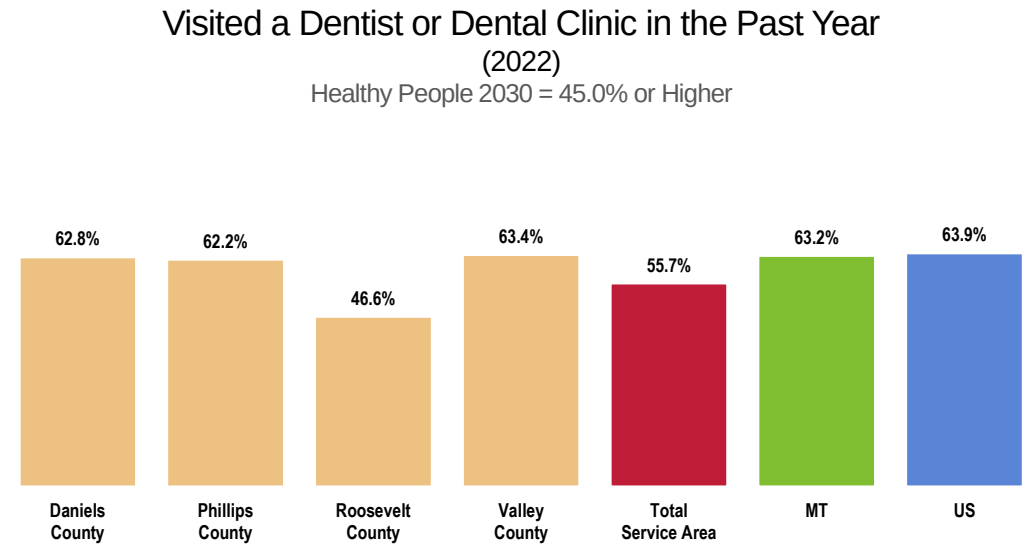
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems 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 Visits

The following chart shows the percentage of Total Service Area adults age 18 and older who have visited a dentist or dental clinic in the past year.

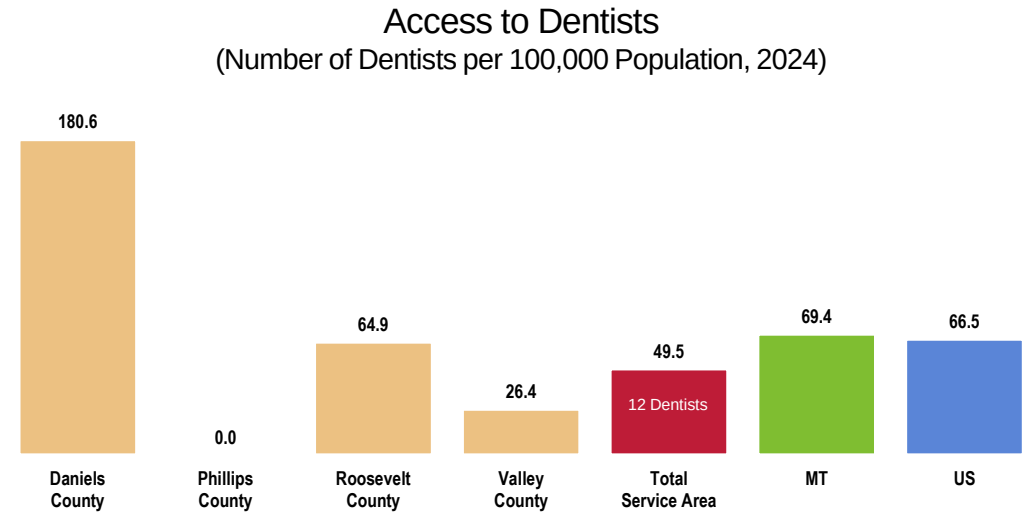


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Access to Dentists

This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD), who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

The following chart outlines the number of dentists for every 100,000 residents in the Total Service Area.

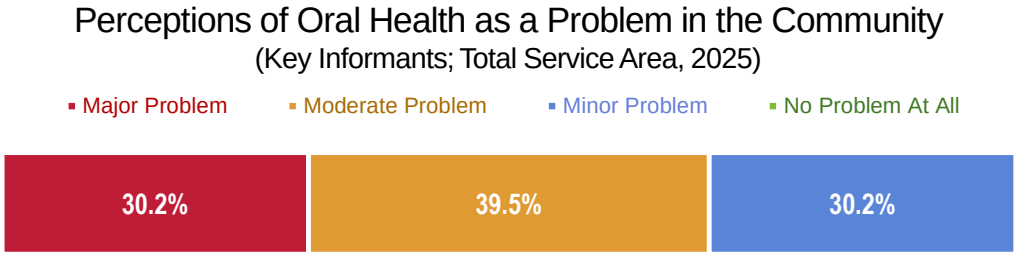


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved January 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the number of dentists per 100,000 population. This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD) — who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

Key Informant Input: Oral Health

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



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Access for Medicaid Patients

> There are no dentists in town that accept Medicaid. This is a huge issue as most children in the area are covered under this insurance. – Other Health Provider

> Limited access: many dentists refuse Medicaid due to low reimbursement rates, leaving low-income individuals without affordable care. Health disparities: those without access to regular dental care often face higher rates of tooth decay, gum disease, and other oral health issues. Emergency room visits: lack of preventive care often leads to dental emergencies, resulting in costly and inefficient ER visits for issues that could have been prevented. Untreated emergencies: dental pain or emergencies often occur outside regular business hours, leaving people to suffer until they can schedule an appointment. ER Overload: people may turn to emergency rooms for dental pain relief, which is often temporary and does not address the root cause. Job constraints: those who work during typical office hours may struggle to find time for dental visits, leading to postponed or skipped care. – Community Leader
>
> Cost of dental care. Do not have local dentists that accept Medicaid. – Other Health Provider
>
> No Medicaid provider for dental care. Limited number of Dental care providers. All dental procedures are way too expensive for the average consumer even if they have Insurance dental plans. Large sector of the population does not have Employer Insurance Plans as they are Farmers, Ranchers and Small business owners. Few Jobs in the area are large enough companies to provide insurance plans. – Social Services Provider

Lack of Providers

> Lack of access to dental care and what is accessible in the area takes very long to get into the appointment. – Other Health Provider
>
> Lack of access to dental providers, as they are booked really far out, and also not enough pediatric dental providers. Very far out scheduling. – Physician
>
> There is a lack of dental care. There are virtually no dentists in the area compared to the need. The area with the most is the Indian Health Service, but there is such a demand that by the time someone gets in their tooth is to the point of pulling, they cannot be repaired. People have even died from sepsis related to teeth abscesses. – Other Health Provider
>
> Limited providers. No provider that takes Medicaid. Cost of services. – Community Leader
>
> Lack of dentists in the area. – Community Leader

Disease Management

> People just don’t take the time or give the attention that is needed. – Community Leader

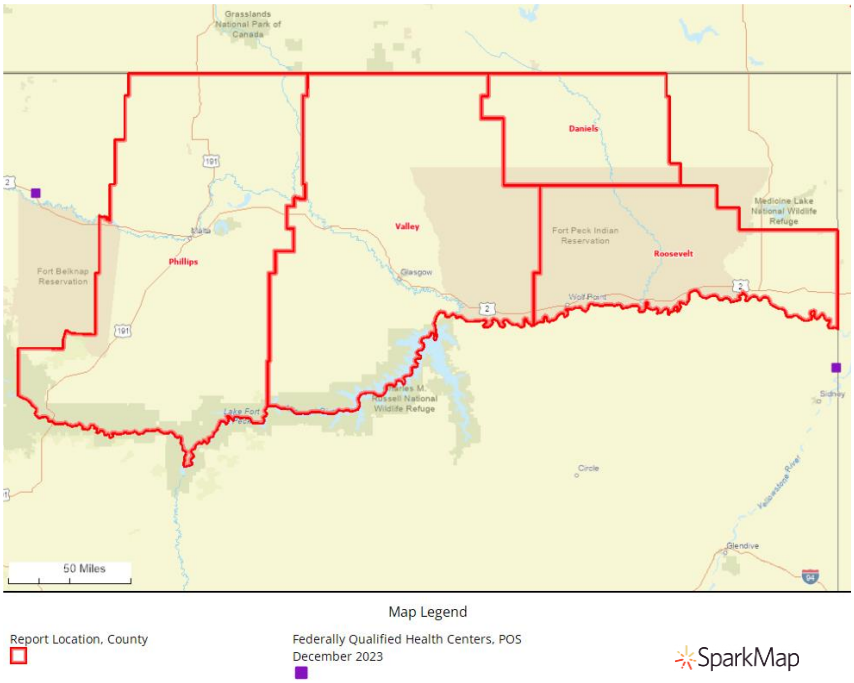
LOCAL RESOURCES

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

FQHCs are community assets that provide health care to vulnerable populations; they receive federal funding to promote access to ambulatory care in areas designated as medically underserved.

The following map details Federally Qualified Health Centers (FQHCs) within the Total Service Area.



Resources Available to Address 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

- Doctors' Offices
- Eastern Montana Community Mental Health Center
- Frances Mahon Deaconess Hospital
- Hi-Line Home Programs
- Sugg Clinic
- Telehealth
- Valley County Health Department
- Valley County VA
- Valley View Nursing Home

Cancer

- Community Integrated Health
- Daniels Memorial Healthcare
- Dentists' Offices
- Diagnostic Testing
- Doctors' Offices
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Health Department
- Medicare Annual Wellness Visits
- Preventative Screenings
- Sugg Clinic
- Trinity Hospital
- Valley County Hope Project
- Veterans Services

Diabetes

- Daniels Memorial Healthcare
- Doctors' Offices
- Food Banks/Pantries
- Fort Peck Diabetic Program
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Grocery Stores
- Health Department
- Indian Health Services
- Library
- Listerud and Riverside Clinics
- Lund Workout Facility
- Parks and Recreation
- Poplar Community Hospital
- School System
- Sugg Clinic
- Trinity Hospital
- Valley County Health Department

Disabling Conditions

- Food Banks/Pantries
- Frances Mahon Deaconess Hospital
- Home Care Services
- North Eastern Montana Mental Health Center
- Northeast Montana Health Services Nursing Home
- Nursing Homes
- Prairie Ridge
- Senior Center
- Senior Citizens
- Sugg Clinic
- Valley County Health Department
- Valley County Transit
- Valley View Nursing Home

Heart Disease & Stroke

- AEDs
- Ambulances
- Chronic Disease Management Education
- Community Integrated Health
- Daniels Memorial Healthcare
- Doctors' Offices
- Frances Mahon Deaconess Hospital
- Health Department
- Telehealth

Infant Health & Family Planning

- Frances Mahon Deaconess Hospital
- Phillips County Health Department
- Phillips County Hospital
- Valley County Health Department

Injury & Violence

- AA/NA
- Eastern Montana Community Mental Health Center
- Frances Mahon Deaconess Hospital

Mental Health

- 988
- Churches
- Daniels Memorial Healthcare
- Doctors' Offices
- Eastern Montana Community Mental Health Center
- Frances Mahon Deaconess Hospital
- Frontier Psychiatry
- Glasgow Clinic
- Glasgow Public Schools
- Health Department
- Hi-Line Home Programs
- Mental Health Center
- North Eastern Montana Mental Health Center
- Phillips County Hospital
- Private Counselors/Therapists
- School System
- Sugg Clinic
- Telehealth
- Valley County CARE Coalition
- Valley County Health Council
- Valley County Health Department
- Valley County Sheriff's Department
- Youth Dynamics

Nutrition, Physical Activity & Weight

- Civic Center
- Food Banks/Pantries
- Frances Mahon Deaconess Hospital
- Grocery Stores
- Gyms/Fitness Centers
- Hi-Line Gymnastics
- Kraze
- Local Activities
- Parks and Recreation
- School System
- Senior Center
- Sugg Clinic
- Thundering Buffalo Health and Wellness Center

Oral Health

- Budde Family Dentistry
- Dentists' Offices
- Doctors' Offices
- Frances Mahon Deaconess Hospital
- Glasgow Pediatrics
- MACT Program
- Reyling Dentist
- Valley County Health Department
- Wilson Dentist

Respiratory Diseases

- Doctors' Offices
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Sugg Clinic
- Tobacco Cessation

Sexual Health

- Frances Mahon Deaconess Hospital
- Valley County Health Department

Social Determinants of Health

- Eastern Montana Community Mental Health Center
- Food Banks/Pantries
- Frances Mahon Deaconess Hospital
- Kiwanis Club
- MACT Program
- Mental Health Center
- North Eastern Montana Mental Health Center
- Northern Heights
- School System
- Valley County Health Department
- Valley County Transit

Substance Use

- AA/NA
- Action for Eastern Montana
- Eastern Montana Community Mental Health Center
- Frances Mahon Deaconess Hospital
- Glasgow Clinic
- Ideal Options
- Pastoral Care
- Sugg Clinic
- Telehealth
- Veterans Services

Tobacco Use

- Daniels Memorial Healthcare
- Doctors' Offices

Eastern Montana Community Mental Health Center

Frances Mahon Deaconess Hospital

Glasgow Clinic

Health Department

Law Prohibiting Smoking Indoors

Online Quit Programs

Quit Lines

School System

Tobacco Cessation

Valley County Health Department

Valley County Juvenile Probation

Veterans Services

APPENDIX

EVALUATION OF PAST ACTIVITIES

Evaluation of Past Activities (2022 – 2024)

1. Infant Health & Family Planning

- **2022**: Remote intern created content for campaigns focusing on post-partum and infant health, mental health & tobacco/substance abuse through social media posts, radio ads, and newspaper articles.
- **2023 & 2024**: A Nurturing Nook was established at the NEMT Fair for mothers to nurse or change their infants.
- **2022 - 2024**: Monthly OB pre-registration advertisements were initiated, and online registration for prenatal classes became available.
- **2024**: Family planning posters from VCHD were displayed in public restrooms across FMDH facilities & throughout Valley County.

2. Sexual Health

- No specific updates were provided in the reviewed reports for this category.

3. Access to Healthcare Services

- **Transportation & Accessibility**:
  - **2022**: Free passes for the Transit Bus were provided for medical care.
  - **2022**: A handicap-accessible van was purchased for Valley View Home.
  - **2024**: Car seat safety checks initiated by a certified technician.
- **New Providers**:
  - **2023:** Dr. Tyson Cochran, MD (Family Medicine)
  - **2023:** Haylee Thompson, FNP (Family Nurse Practitioner)
  - **2024:** Kristina Bengochea, LCPC (Counselor)
  - **2024:** Dr. John Keeley (General Surgeon)
  - **2024:** Mark Hiesterman, DO (General Surgeon)
  - **2024:** Jon MacNaughton, MD (Orthopedic Surgeon)
  - **2024:** Keenan Kuckler, MD (Family Medicine)
- **2024**: Outreach appointments in Malta and Wolf Point for OB/GYN, Ortho, and General Surgery increased throughout the year.
- **2024:** EMS transported 20 patients home after they were discharged who didn't have anyone to pick them up.
- **2024:** EMS helped 20 patients with Referral Management to facilities like Billings Clinic

- **Educational Initiatives**:
    - **2022- 2024**: Monthly first aid, CPR, and AED classes were held.
    - **2023-2024**: Free EMT classes held.
    - **2024**: “Stepping On” and SAIL (Stay Active and Independent Living) classes were launched.
- **2023 - 2024**: Camp Med provided hands-on healthcare career experiences for middle and high school students.

4. Mental Health

- **Valley CARE Coalition Activities**:
    - **2022-2024**: Hosted community awareness events, including the Mental Health Walk and Slash the Stigma Ice Hockey Tournament.
    - **2023**: Sponsored the Hands of Hope mural project.
    - **2023**: Distributed mental health resources at the NE MT Fair.
- **Trainings & Resources**:
    - **2022-2024**: QPR (Question, Persuade, Refer) and Mental Health First Aid training were provided.
    - **2022-2023**: 988 crisis hotline billboards were installed.
    - **2024**: Posters with crisis hotline sticky notes placed in public restrooms throughout Valley County.
- **Youth Engagement**:
    - **2023**: Activities like rock painting and door decorating contests encouraged mental health awareness.

5. Tobacco Use/Substance Abuse

- **Campaigns**:
    - **2022-2023**: Awareness campaigns on vaping and substance abuse through social media, radio ads, and Courier articles.
- **Community Trainings**:
    - **2024**: Free NARCAN training sessions were offered.
    - **2022**: Substance abuse awareness articles and ads were published.

6. Physical Activity, Weight & Nutrition

- **Blood Pressure Clinics**:
    - **2022-2024**: Offered six times a month in locations like Fort Peck, St. Marie, Reynolds Market (in Glasgow), and Glasgow & Nashua senior centers.
- **Educational Initiatives**:
    - **2023-2024**: Sponsored healthy menu tips in the Glasgow Courier.
    - **2023**: Supported updating the physical activity guide for Glasgow.
    - **2024**: Donated for new hockey nets at the Valley Event Center.
- **Community Engagement**:
    - **2023**: Organized health and wellness fairs, including flu shot clinics and informational booths.
    - **2024**: Planned a community garden project with the help of Prairie Ridge Village. They will now take it over spring 2025.
    - **2024**: EMS taught an EMT Course to high school students during their 0 period each morning