# 2021 COMMUNITY HEALTH NEEDS ASSESSMENT

## Flathead County, Montana

Sponsored by
Flathead City-County Health Department
Greater Valley Health Center
Logan Health Medical Center (dba Kalispell Regional Medical Center)
Logan Health – Whitefish (dba North Valley Hospital)

© October 2021
2021-0691-02

# TABLE OF CONTENTS




# INTRODUCTION

# PROJECT OVERVIEW

## Project Goals

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2018, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Flathead County, Montana. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

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

This assessment was conducted on behalf of the sponsors by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

## Methodology

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

### PRC Community Health Survey

#### Survey Instrument

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

## Community Defined for This Assessment

The study area for the survey effort is defined as Flathead County, Montana. This community definition, the shared service area of the sponsoring organizations, is illustrated in the following map.

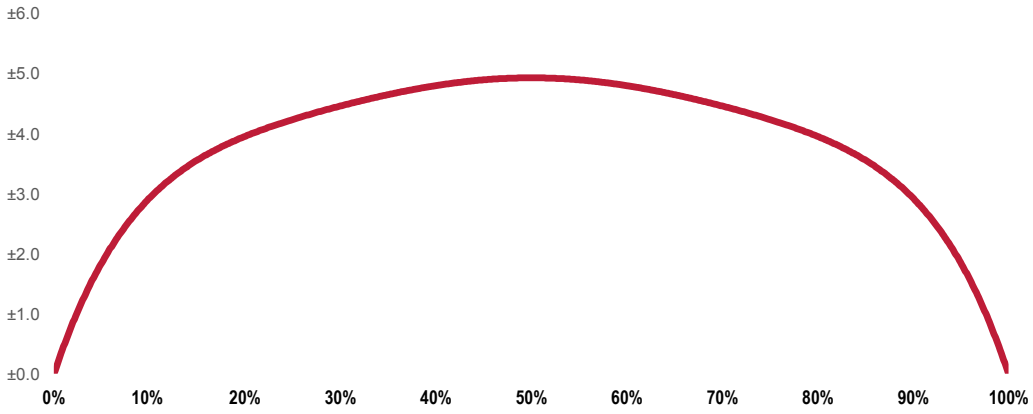

## Sample Approach & Design

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

The sample design used for this effort consisted of a random sample of 400 individuals age 18 and older in Flathead County. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 400 respondents is ±3.1% at the 95 percent confidence level.

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




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

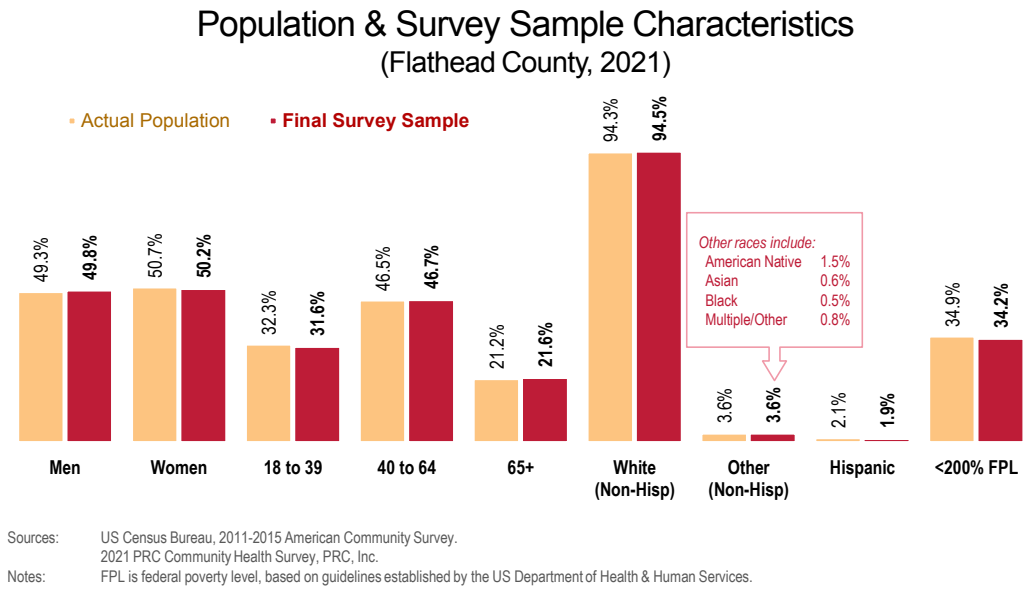
Examples: If 10% of the sample of 400 respondents answered a certain question with a "yes," it can be asserted that between 7.1% and 12.9% (10% 2.9%) of the total population would offer this response.

If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 45.1% and 54.9% (50% 4.9%) of the total population would respond "yes" if asked this question.

### Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual’s responses is maintained, one respondent’s responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

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




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

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

### INCOME & RACE/ETHNICITY

**INCOME ►** Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2020 guidelines place the poverty threshold for a family of four at $26,200 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

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

## Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by the study sponsors; 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, 18 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:

| ONLINE KEY INFORMANT SURVEY PARTICIPATION | |
|---|---|
| KEY INFORMANT TYPE | NUMBER PARTICIPATING |
| Public Health Representatives | 5 |
| Other Health Providers | 3 |
| Social Services Providers | 9 |
| Other Community Leaders | 1 |

Final participation included representatives of the organizations outlined below.

- Columbia Falls School District
- Community Action Partnership
- Evergreen School District
- Flathead City-County Health Department
- Greater Valley Health Center
- Flathead County Agency on Aging
- Flathead Youth Homes
- Logan Health Medical Center (dba Kalispell Regional Medical Center)
- Montana Public Health Institute
- Salvation Army Kalispell
- Sparrow's Nest of NW Montana
- Summit Independent Living Center
- The Abbie Shelter
- United Way

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

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

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

## Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery

- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

## Benchmark Data

### Trending

A similar survey was administered in Flathead County in 2018 by PRC on behalf of the sponsors. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

### Montana Risk Factor Data

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

### Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

### Healthy People 2030

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

Healthy People 2030's overarching goals are to:

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

- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

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

## Determining Significance

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

## Information Gaps

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

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

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

## Public Comment

The sponsoring hospitals made the prior Community Health Needs Assessment (CHNA) report publicly available through their websites; through that mechanism, the hospitals requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, the hospitals 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. Logan Health Medical Center (dba Kalispell Regional Medical Center) and Logan Health – Whitefish (dba North Valley Hospital) will continue to use their websites as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

# IRS FORM 990, SCHEDULE H COMPLIANCE

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

| IRS FORM 990, SCHEDULE H (2019) | See Report Page |
|---|---|
| Part V Section B Line 3a<br>A definition of the community served by the hospital facility | 6 |
| Part V Section B Line 3b<br>Demographics of the community | 30 |
| Part V Section B Line 3c<br>Existing health care facilities and resources within the community that are available to respond to the health needs of the community | 156 |
| Part V Section B Line 3d<br>How data was obtained | 6 |
| Part V Section B Line 3e<br>The significant health needs of the community | 14 |
| Part V Section B Line 3f<br>Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | Addressed Throughout |
| Part V Section B Line 3g<br>The process for identifying and prioritizing community health needs and services to meet the community health needs | 15 |
| Part V Section B Line 3h<br>The process for consulting with persons representing the community's interests | 9 |
| Part V Section B Line 3i<br>The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | 159 |

# SUMMARY OF FINDINGS

## Significant Health Needs of the Community

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

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

| AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT | |
|---|---|
| ACCESS TO HEALTH CARE SERVICES | ▪ Barriers to Access<br>– Appointment Availability<br>– Finding a Physician<br>▪ Difficulty Accessing Children's Health Care<br>▪ Routine Medical Care (Adults)<br>▪ Eye Exams<br>▪ Ratings of Local Health Care |
| CANCER | ▪ Leading Cause of Death<br>▪ Cancer Incidence<br>– Prostate Cancer<br>– Lung Cancer<br>▪ Female Breast Cancer Screening [Age 50-74] |
| HEART DISEASE & STROKE | ▪ Leading Cause of Death |
| INFANT HEALTH & FAMILY PLANNING | ▪ Infant Deaths |
| INJURY & VIOLENCE | ▪ Falls<br>– Fall-Related Deaths [Age 65+]<br>– Prevalence of Falls [Age 45+]<br>▪ Firearm-Related Deaths<br>▪ Violent Crime Experience |
| MENTAL HEALTH | ▪ Suicide Deaths<br>▪ Key Informants: Mental health ranked as a top concern. |
| NUTRITION, PHYSICAL ACTIVITY & WEIGHT | ▪ Overweight [Adults]<br>▪ Meeting Physical Activity Guidelines<br>▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern. |

*—continued on the following page—*

| AREAS OF OPPORTUNITY (continued) | |
|---|---|
| ORAL HEALTH | ▪ Regular Dental Care [Adults] |
| POTENTIALLY DISABLING CONDITIONS | ▪ High-Impact Chronic Pain<br>▪ Alzheimer's Disease Deaths |
| RESPIRATORY DISEASE | ▪ Lung Disease Deaths<br>▪ Asthma Prevalence [Adults]<br>▪ Flu Vaccination [Age 65+] |
| SUBSTANCE ABUSE | ▪ Personally Impacted by Substance Abuse (Self or Other's)<br>▪ Key Informants: Substance abuse 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 community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

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

1. Mental Health
2. Substance Abuse
3. Nutrition, Physical Activity, & Weight
4. Heart Disease & Stroke
5. Injury & Violence
6. Cancer
7. Potentially Disabling Conditions
8. Oral Health
9. Access to Healthcare
10. Infant Health & Family Planning
11. Respiratory Diseases

## Hospital Implementation Strategy

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

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

# Summary Tables:
# Comparisons With Benchmark Data

## Reading the Summary Tables

- In the following tables, Flathead County results are shown in the larger, gray column.
- The columns to the right of the Flathead County column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether Flathead County compares favorably (), unfavorably (), or comparably () to these external data.

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

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

| SOCIAL DETERMINANTS | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| Linguistically Isolated Population (Percent) | 0.1 | 0.3 | 4.4 | | |
| Population in Poverty (Percent) | 11.7 | 13.7 | 14.1 | 8.0 | |
| Children in Poverty (Percent) | 15.7 | 16.4 | 19.5 | 8.0 | |
| No High School Diploma (Age 25+, Percent) | 6.1 | 6.8 | 12.3 | | |
| % Unable to Pay Cash for a $400 Emergency Expense | 6.4 | | 24.6 | | |
| % Worry/Stress Over Rent/Mortgage in Past Year | 15.3 | | 32.2 | | 21.9 |
| % Unhealthy/Unsafe Housing Conditions | 5.7 | | 12.2 | | |
| % Food Insecure | 9.6 | | 34.1 | | 16.6 |
| | | better | similar | worse | |

| OVERALL HEALTH | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| % "Fair/Poor" Overall Health | 12.6 | 15.2 | 12.6 | | 17.7 |
| | | better | similar | worse | |

| ACCESS TO HEALTH CARE | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| % [Age 18-64] Lack Health Insurance | 5.1 | 12.3 | 8.7 | 7.9 | 10.2 |
| % Difficulty Accessing Health Care in Past Year (Composite) | 36.8 | | 35.0 | | 40.2 |
| % Cost Prevented Physician Visit in Past Year | 7.8 | 10.3 | 12.9 | | 19.1 |

| ACCESS TO HEALTH CARE (continued) | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| % Cost Prevented Getting Prescription in Past Year | 8.7 | | 12.8 | | 12.0 |
| % Difficulty Getting Appointment in Past Year | 21.6 | | 14.5 | | 12.0 |
| % Inconvenient Hrs Prevented Dr Visit in Past Year | 11.4 | | 12.5 | | 13.5 |
| % Difficulty Finding Physician in Past Year | 12.1 | | 9.4 | | 7.2 |
| % Transportation Hindered Dr Visit in Past Year | 4.9 | | 8.9 | | 5.2 |
| % Language/Culture Prevented Care in Past Year | 0.0 | | 2.8 | | 0.0 |
| % Skipped Prescription Doses to Save Costs | 6.8 | | 12.7 | | 12.7 |
| % Difficulty Getting Child's Health Care in Past Year | 9.9 | | 8.0 | | 1.6 |
| Primary Care Doctors per 100,000 | 89.9 | 80.0 | 76.6 | | |
| % Have a Specific Source of Ongoing Care | 83.8 | | 74.2 | 84.0 | 81.6 |
| % Have Had Routine Checkup in Past Year | 59.5 | 72.8 | 70.5 | | 64.7 |
| % Child Has Had Checkup in Past Year | 81.0 | | 77.4 | | 79.5 |
| % Two or More ER Visits in Past Year | 3.7 | | 10.1 | | 9.5 |
| % Eye Exam in Past 2 Years | 46.5 | | 61.0 | 61.1 | 54.6 |
| % Rate Local Health Care "Fair/Poor" | 12.5 | | 8.0 | | 12.8 |
| | | better | similar | worse | |

| CANCER | Flathead County | FLATHEAD CO. vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2030 | TREND |
| Cancer (Age-Adjusted Death Rate) | **134.6** | 144.7 | 149.3 | 122.7 | 156.1 |
| Lung Cancer (Age-Adjusted Death Rate) | **27.7** | 30.4 | 34.9 | 25.1 | |
| Prostate Cancer (Age-Adjusted Death Rate) | **17.8** | 22.0 | 18.6 | 16.9 | |
| Female Breast Cancer (Age-Adjusted Death Rate) | **15.7** | 18.3 | 19.7 | 15.3 | |
| Colorectal Cancer (Age-Adjusted Death Rate) | **9.6** | 12.5 | 13.4 | 8.9 | |
| Cancer Incidence Rate (All Sites) | **522.5** | 459.7 | 448.7 | | |
| Female Breast Cancer Incidence Rate | **138.1** | 128.5 | 125.9 | | |
| Prostate Cancer Incidence Rate | **147.9** | 118.4 | 104.5 | | |
| Lung Cancer Incidence Rate | **64.1** | 53.7 | 58.3 | | |
| Colorectal Cancer Incidence Rate | **39.6** | 38.3 | 38.4 | | |
| % Cancer | **10.0** | 14.2 | 10.0 | | |
| % [Women 50-74] Mammogram in Past 2 Years | **64.7** | 74.1 | 76.1 | 77.1 | 70.9 |
| % [Women 21-65] Cervical Cancer Screening | **72.4** | 77.0 | 73.8 | 84.3 | 73.1 |
| % [Age 50-75] Colorectal Cancer Screening | **77.0** | 64.7 | 77.4 | 74.4 | 71.5 |
| | | better | similar | worse | |

| DIABETES | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| Diabetes (Age-Adjusted Death Rate) | 11.5 | 20.2 | 21.5 | | 15.6 |
| % Diabetes/High Blood Sugar | 8.7 | 7.6 | 13.8 | | 10.9 |
| % Borderline/Pre-Diabetes | 8.6 | | 9.7 | | 9.4 |
| % [Non-Diabetics] Blood Sugar Tested in Past 3 Years | 43.7 | | 43.3 | | 48.6 |
| | | better | similar | worse | |

| HEART DISEASE & STROKE | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| Diseases of the Heart (Age-Adjusted Death Rate) | 152.5 | 158.4 | 163.4 | 127.4 | 151.6 |
| % Heart Disease (Heart Attack, Angina, Coronary Disease) | 5.0 | 6.7 | 6.1 | | 5.4 |
| Stroke (Age-Adjusted Death Rate) | 30.1 | 31.5 | 37.2 | 33.4 | 40.5 |
| % Stroke | 3.7 | 3.1 | 4.3 | | 3.7 |
| % Told Have High Blood Pressure | 32.8 | | 36.9 | 27.7 | 32.0 |
| % Told Have High Cholesterol | 31.0 | | 32.7 | | 27.9 |
| % 1+ Cardiovascular Risk Factor | 82.4 | | 84.6 | | 83.9 |
| | | better | similar | worse | |

| INFANT HEALTH & FAMILY PLANNING | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| Low Birthweight Births (Percent) | 6.0 | 7.3 | 8.2 | | 6.3 |
| Infant Death Rate | 4.7 | 4.8 | 5.6 | 5.0 | 3.7 |
| Births to Adolescents Age 15 to 19 (Rate per 1,000) | 23.9 | 24.6 | 22.7 | 31.4 | |
| | | better | similar | worse | |

| INJURY & VIOLENCE | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| Unintentional Injury (Age-Adjusted Death Rate) | 46.6 | 52.2 | 48.9 | 43.2 | 48.5 |
| Motor Vehicle Crashes (Age-Adjusted Death Rate) | 13.0 | 16.0 | 11.3 | 10.1 | |
| [65+] Falls (Age-Adjusted Death Rate) | 91.1 | 87.1 | 65.1 | 63.4 | |
| % [Age 45+] Fell in the Past Year | 37.0 | | 27.5 | | |
| Firearm-Related Deaths (Age-Adjusted Death Rate) | 17.7 | 19.6 | 11.9 | 10.7 | |
| Homicide (Age-Adjusted Death Rate) | 2.9 | 3.5 | 5.6 | 5.5 | |
| Violent Crime Rate | 300.7 | 393.7 | 416.0 | | |
| % Victim of Violent Crime in Past 5 Years | 4.1 | | 6.2 | | 1.1 |
| % Victim of Intimate Partner Violence | 17.2 | | 13.7 | | 13.9 |
| | | better | similar | worse | |

| KIDNEY DISEASE | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| Kidney Disease (Age-Adjusted Death Rate) | 12.7 | 9.7 | 12.9 | | 9.9 |
| % Kidney Disease | 0.9 | 2.4 | 5.0 | | 3.0 |
| | | better | similar | worse | |

| MENTAL HEALTH | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| % "Fair/Poor" Mental Health | 15.8 | | 13.4 | | 14.0 |
| % Diagnosed Depression | 25.0 | 24.1 | 20.6 | | 24.8 |
| % Symptoms of Chronic Depression (2+ Years) | 29.6 | | 30.3 | | 31.3 |
| % Typical Day Is "Extremely/Very" Stressful | 14.0 | | 16.1 | | 13.4 |
| Suicide (Age-Adjusted Death Rate) | 23.8 | 26.7 | 14.0 | 12.8 | 18.5 |
| Mental Health Providers per 100,000 | 65.9 | 34.0 | 42.6 | | |
| % Taking Rx/Receiving Mental Health Trtmt | 16.4 | | 16.8 | | 20.2 |
| % Unable to Get Mental Health Svcs in Past Yr | 4.7 | | 7.8 | | 5.0 |
| | | better | similar | worse | |

| NUTRITION, PHYSICAL ACTIVITY & WEIGHT | Flathead County | FLATHEAD CO. vs. BENCHMARKS | | | |
|---|---|---|---|---|---|
| | | vs. MT | vs. US | vs. HP2030 | TREND |
| Population With Low Food Access (Percent) | **15.3** | 24.3 | 22.4 | | |
| % "Very/Somewhat" Difficult to Buy Fresh Produce | **11.7** | | 21.1 | | 20.3 |
| % 5+ Servings of Fruits/Vegetables per Day | **37.4** | | 32.7 | | 36.1 |
| % No Leisure-Time Physical Activity | **19.3** | 19.7 | 31.3 | 21.2 | 19.5 |
| % Meeting Physical Activity Guidelines | **20.9** | 28.3 | 21.4 | 28.4 | 23.2 |
| % Child [Age 2-17] Physically Active 1+ Hours per Day | **67.0** | | 33.0 | | 71.9 |
| Recreation/Fitness Facilities per 100,000 | **15.4** | 17.4 | 11.8 | | |
| % Healthy Weight (BMI 18.5-24.9) | **29.1** | | 34.5 | | 30.8 |
| % Overweight (BMI 25+) | **68.8** | 64.7 | 61.0 | | 68.1 |
| % Obese (BMI 30+) | **29.8** | 28.3 | 31.3 | 36.0 | 28.8 |
| % Children [Age 5-17] Healthy Weight | **70.8** | | 47.6 | | 61.7 |
| % Children [Age 5-17] Overweight (85th Percentile) | **26.1** | | 32.3 | | 22.8 |
| % Children [Age 5-17] Obese (95th Percentile) | **16.8** | | 16.0 | 15.5 | 9.4 |
| | | better | similar | worse | |

| ORAL HEALTH | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| % Have Dental Insurance | 67.5 | | 68.7 | 59.8 | 55.3 |
| % [Age 18+] Dental Visit in Past Year | 57.5 | 66.4 | 62.0 | 45.0 | 65.0 |
| % Child [Age 2-17] Dental Visit in Past Year | 91.7 | | 72.1 | 45.0 | 83.4 |
| | | better | similar | worse | |

| POTENTIALLY DISABLING CONDITIONS | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| % 3+ Chronic Conditions | 30.7 | | 32.5 | | 39.5 |
| % Activity Limitations | 24.6 | | 24.0 | | 28.8 |
| % With High-Impact Chronic Pain | 23.0 | | 14.1 | 7.0 | |
| Alzheimer's Disease (Age-Adjusted Death Rate) | 18.7 | 21.7 | 30.4 | | 13.5 |
| % Caregiver to a Friend/Family Member | 26.8 | | 22.6 | | 22.7 |
| | | better | similar | worse | |

| RESPIRATORY DISEASE | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| CLRD (Age-Adjusted Death Rate) | 52.7 | 50.4 | 39.6 | | 48.7 |
| Pneumonia/Influenza (Age-Adjusted Death Rate) | 15.2 | 11.5 | 13.8 | | 14.6 |
| % [Age 65+] Flu Vaccine in Past Year | 63.0 | 60.2 | 71.0 | | 77.0 |

| RESPIRATORY DISEASE (continued) | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| % [Adult] Asthma | 10.0 | 10.0 | 12.9 | | 5.0 |
| % [Child 0-17] Asthma | 4.1 | | 7.8 | | 1.9 |
| % COPD (Lung Disease) | 6.0 | 6.8 | 6.4 | | 4.5 |
| | | better | similar | worse | |

| SEXUAL HEALTH | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| HIV Prevalence Rate | 47.7 | 71.8 | 372.8 | | |
| Chlamydia Incidence Rate | 329.0 | 468.1 | 539.9 | | |
| Gonorrhea Incidence Rate | 51.0 | 112.4 | 179.1 | | |
| | | better | similar | worse | |

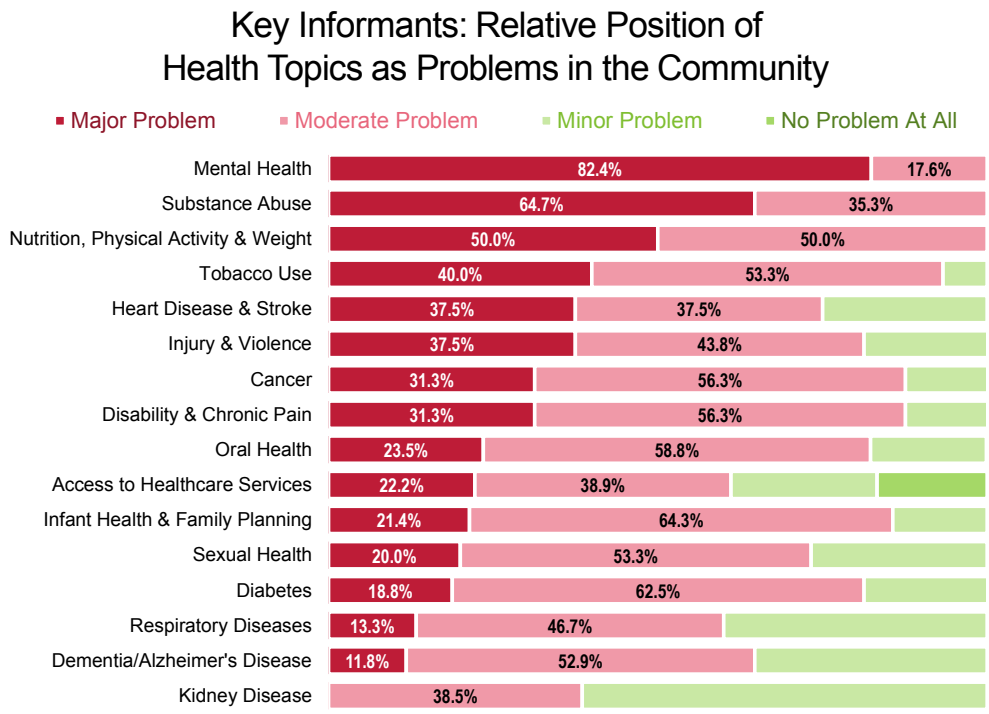
| SUBSTANCE ABUSE | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| Cirrhosis/Liver Disease (Age-Adjusted Death Rate) | 11.1 | 14.3 | 11.1 | 10.9 | 10.3 |
| % Excessive Drinker | 24.9 | 22.7 | 27.2 | | 23.6 |
| % Drinking & Driving in Past Month | 1.8 | | | | 4.5 |
| Unintentional Drug-Related Deaths (Age-Adjusted Death Rate) | 10.9 | 9.8 | 18.8 | | 11.3 |
| % Illicit Drug Use in Past Month | 3.9 | | 2.0 | 12.0 | 4.0 |

| SUBSTANCE ABUSE (continued) | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| % Used a Prescription Opioid in Past Year | 14.6 | | 12.9 | | |
| % Ever Sought Help for Alcohol or Drug Problem | 6.4 | | 5.4 | | 4.6 |
| % Personally Impacted by Substance Abuse | 45.3 | | 35.8 | | 45.7 |
| | | better | similar | worse | |

| TOBACCO USE | Flathead County | FLATHEAD CO. vs. BENCHMARKS vs. MT | vs. US | vs. HP2030 | TREND |
|---|---|---|---|---|---|
| % Current Smoker | 12.3 | 16.6 | 17.4 | 5.0 | 16.3 |
| % Someone Smokes at Home | 10.0 | | 14.6 | | 7.0 |
| % [Household With Children] Someone Smokes in the Home | 8.5 | | 17.4 | | 3.9 |
| % Currently Use Vaping Products | 2.6 | | 8.9 | | 4.6 |
| | | better | similar | worse | |

# Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 16 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



# COMMUNITY DESCRIPTION

# POPULATION CHARACTERISTICS

## Total Population

**Flathead County, the focus of this Community Health Needs Assessment, encompasses**

Total Population
(Estimated Population, 2014-2018)

| | TOTAL POPULATION | TOTAL LAND AREA (square miles) | POPULATION DENSITY (per square mile) |
|---|---|---|---|
| Flathead County | 98,082 | 5,087.16 | 19.28 |
| Montana | 1,041,732 | 145,546.98 | 7.16 |
| United States | 322,903,030 | 3,532,068.58 | 91.42 |

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

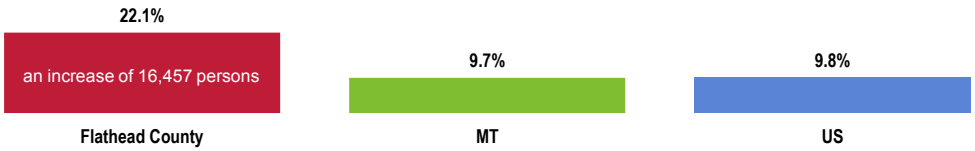
### Population Change 2000-2010

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

**Between the 2000 and 2010 US Censuses, the population of Flathead County increased by 16,457 persons, or 22.1%.**

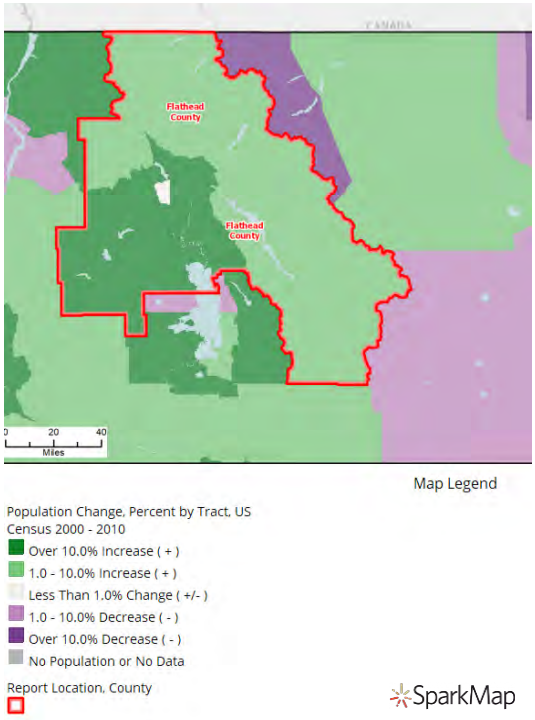
BENCHMARK ► This is greater than state and national increases.

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




Sources: US Census Bureau Decennial Census (2000-2010).
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
Notes: A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

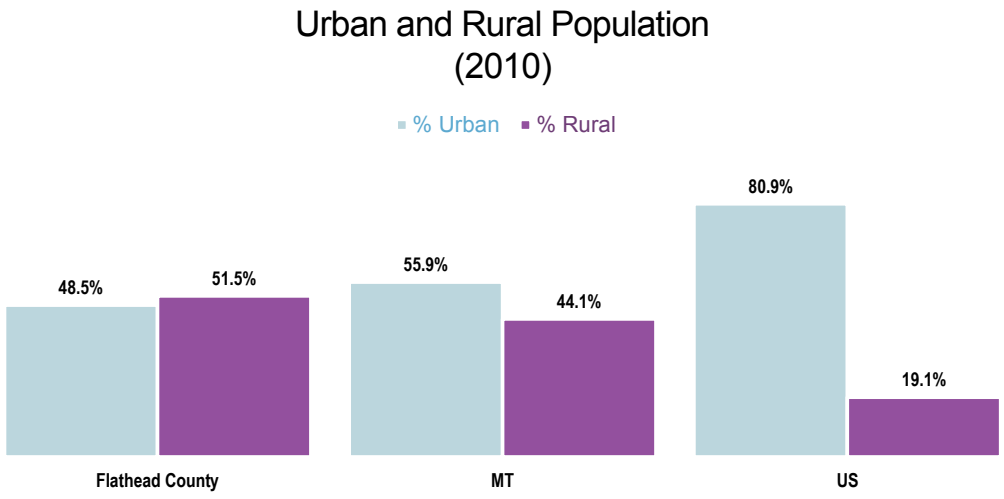
This map shows the areas of greatest increase or decrease in population between 2000 and 2010.



# Urban/Rural Population

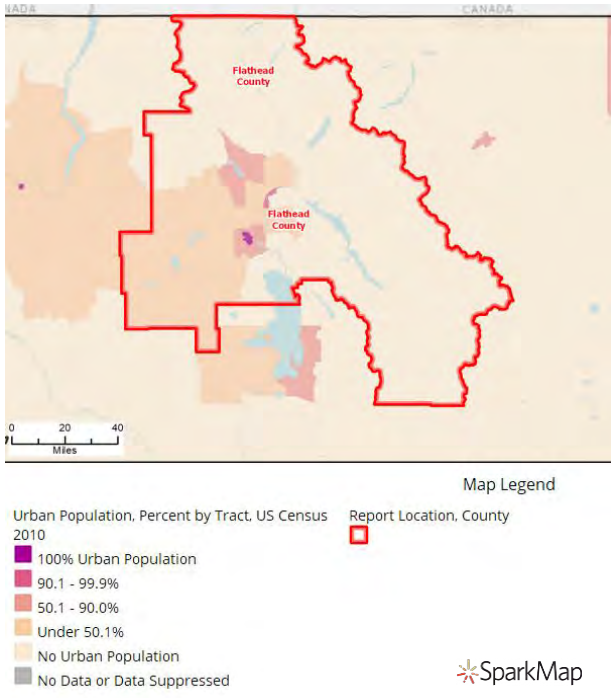
Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

**Flathead County is essentially equally urban and rural, with 51.5% of the population living in**




Sources: US Census Bureau Decennial Census.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

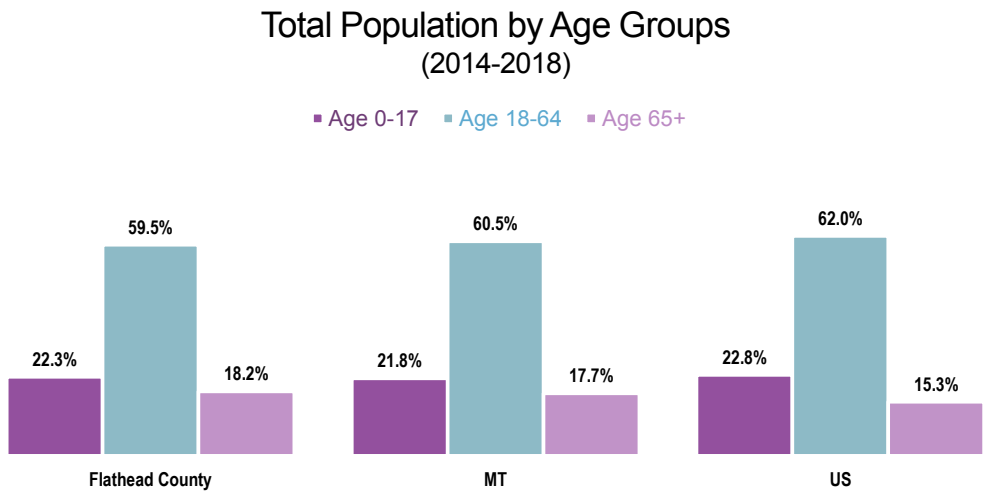
Notes: This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not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



# Age

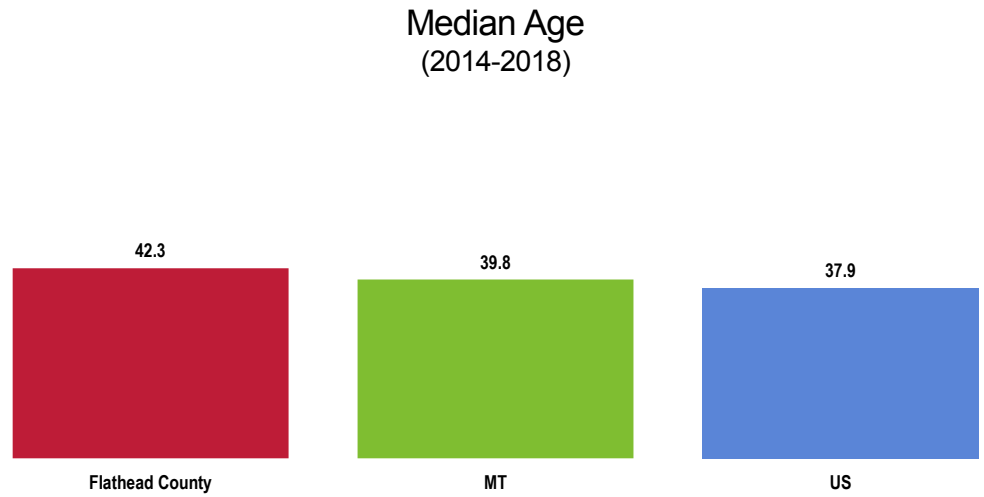
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

**In Flathead County, 22.3% of the population are children age 0-17; another 59.5% are age 18 to**



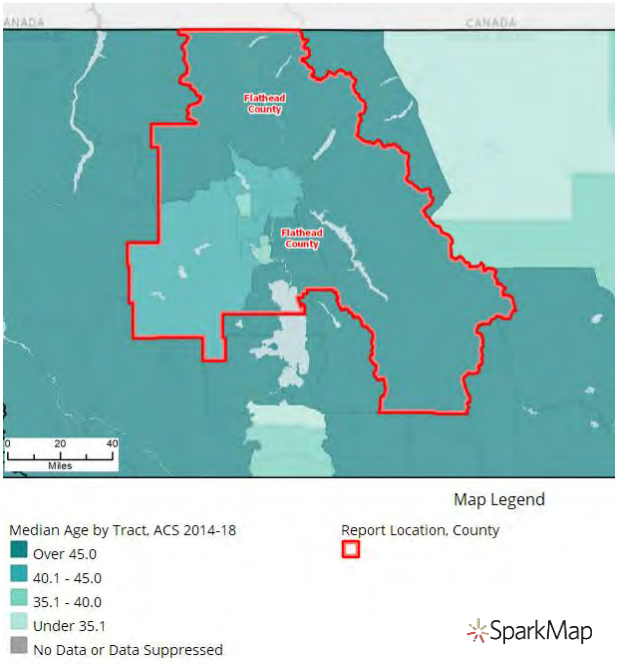

Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

## Median Age




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

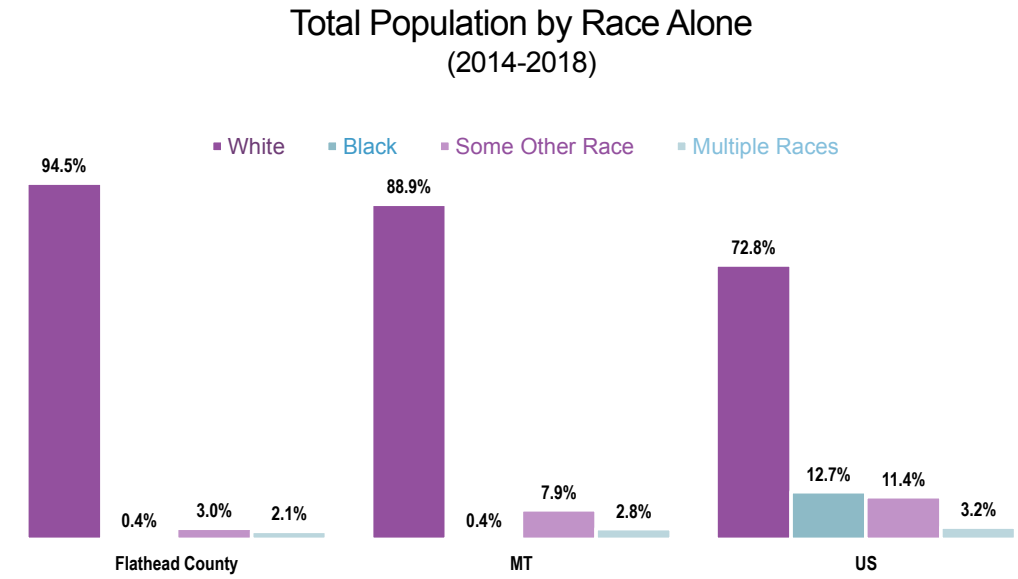
The following map provides an illustration of the median age in Flathead County.



# Race & Ethnicity

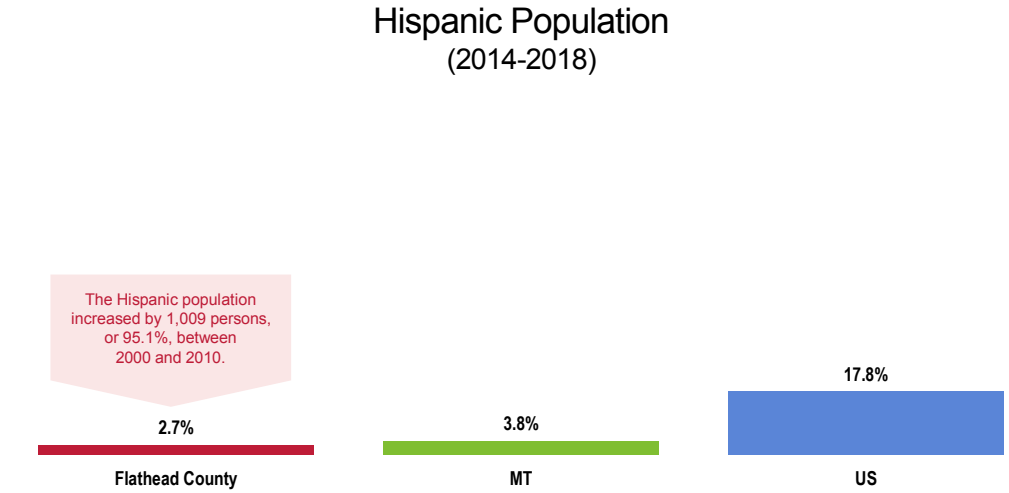
## Race

**In looking at race independent of ethnicity (Hispanic or Latino origin), 94.5% of residents of Flathead County are White and 0.4% are Black.**




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

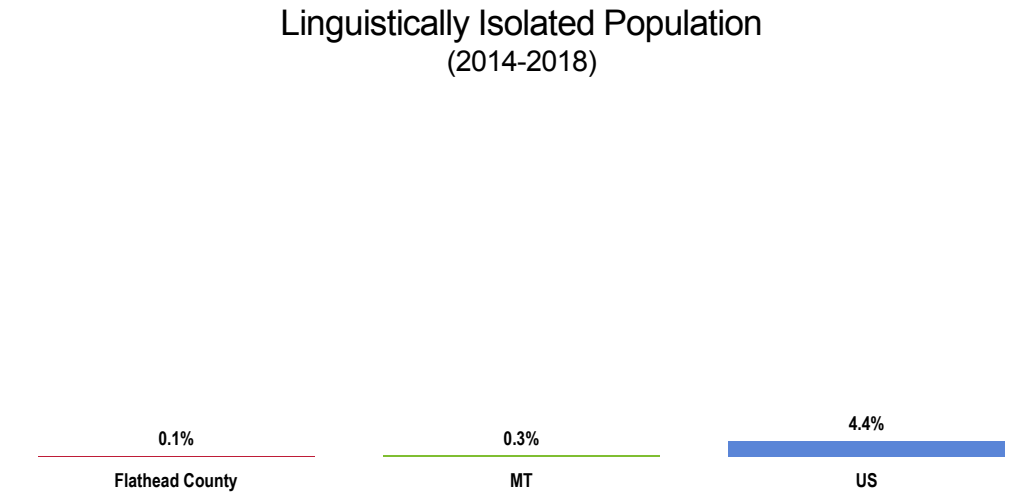
## Ethnicity




Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
Notes: Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

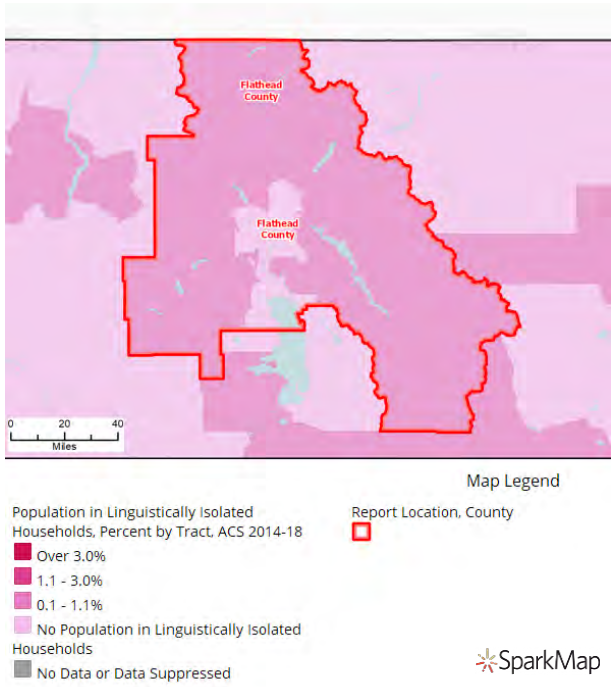
# Linguistic Isolation

**Almost none (0.1%) of the Flathead County population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English**




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

Note the following map illustrating linguistic isolation throughout Flathead County.



# SOCIAL DETERMINANTS OF HEALTH

## ABOUT SOCIAL DETERMINANTS OF HEALTH

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

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

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

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

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

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

## Poverty

**The latest census estimate shows 11.7% of Flathead County total population living below the federal poverty level.**

BENCHMARK ► More favorable than state and national percentages but fails to satisfy the HP2030 target of 8.0% or lower.

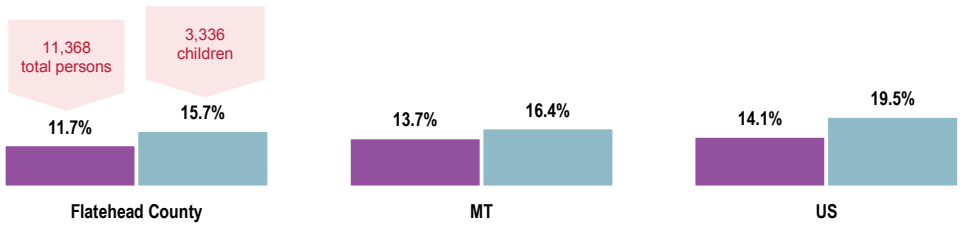
**Among just children (age 0 to 17), this percentage in Flathead County is 15.7% (representing an estimated 3,336 children).**

BENCHMARK ► More favorable than the national percentage but fails to satisfy the HP2030 target of 8.0% or lower.

## Population in Poverty

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

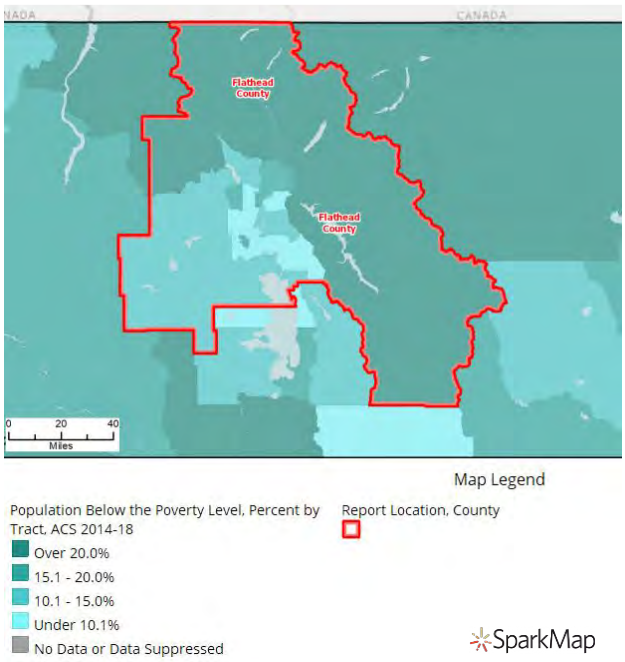
Healthy People 2030 = 8.0% or Lower

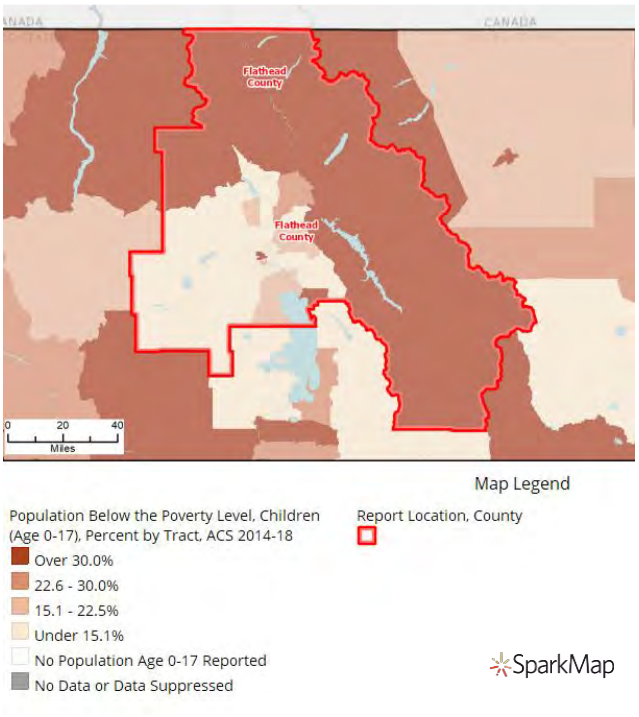



Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

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



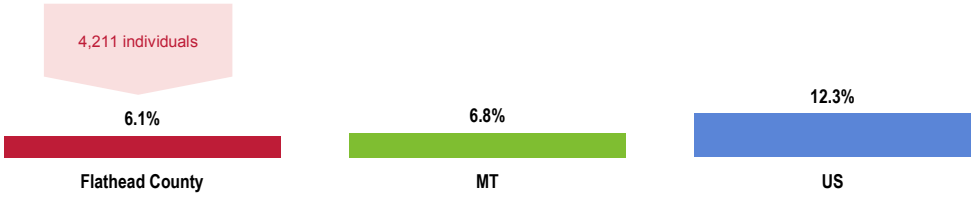



# Education

**Among the Flathead County population age 25 and older, an estimated 6.1% (over 4,200 people) do not have a high school education.**

## Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2014-2018)




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

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

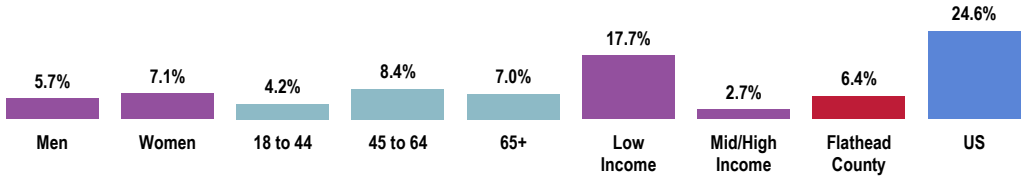
# Financial Resilience

**A total of 6.4% of Flathead County residents would <u>not</u> be able to afford an unexpected $400 expense without going into debt.**

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

BENCHMARK ▶ Well below the national prevalence

## Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Flathead County, 2021)

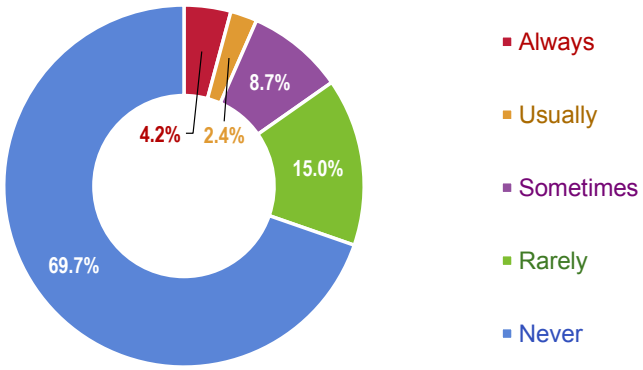



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 63]
Notes: Asked of all respondents.
Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

# Housing

## Housing Insecurity

## Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year
(Flathead County, 2021)



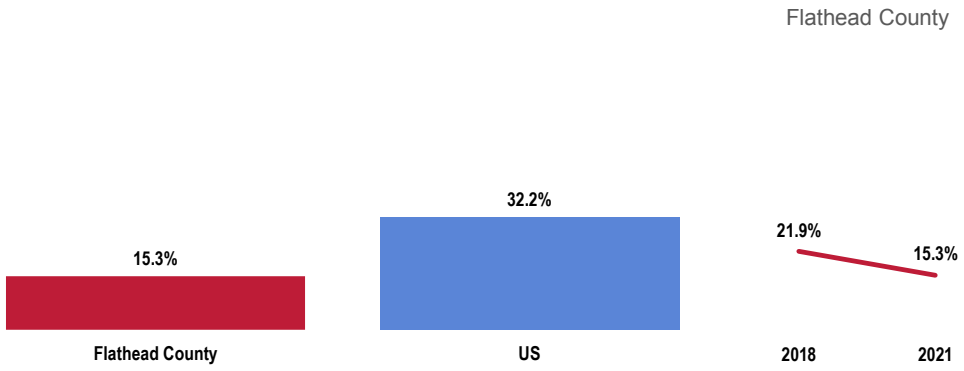

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: Asked of all respondents.

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

**However, a considerable share (15.3%) report that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.**

BENCHMARK ► Less than half the US figure.

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

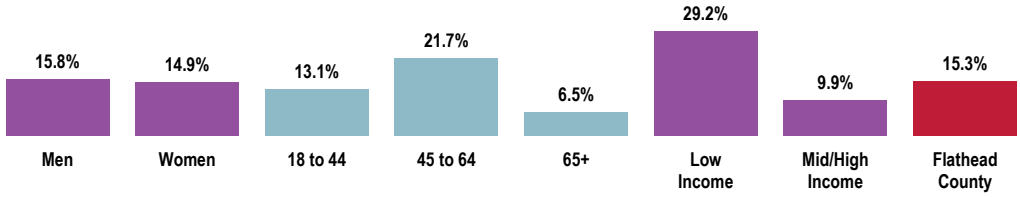



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 66]

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

Here, "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

## "Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year
(Flathead County, 2021)



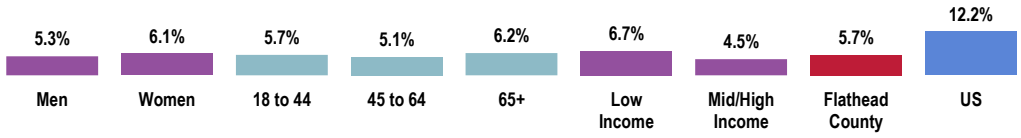

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: Asked of all respondents.

## Unhealthy or Unsafe Housing

**A total of 5.7% of Flathead County residents report living unhealthy or unsafe housing**

Respondents were asked: "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

### Unhealthy or Unsafe Housing Conditions in the Past Year
(Flathead County, 2021)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 65]
Notes: Asked of all respondents.
Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

# Food Access

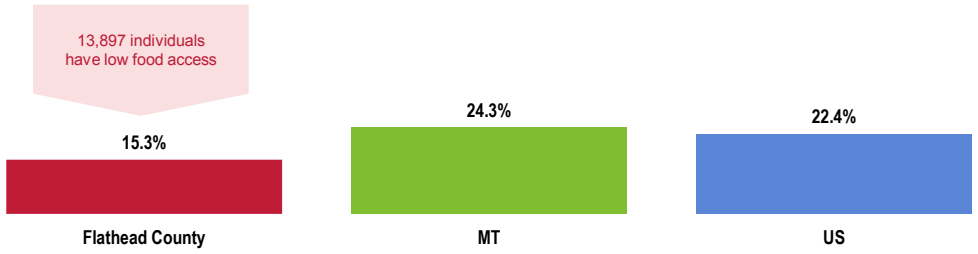
## Low Food Access

**US Department of Agriculture data show that 15.3% of Flathead County population**

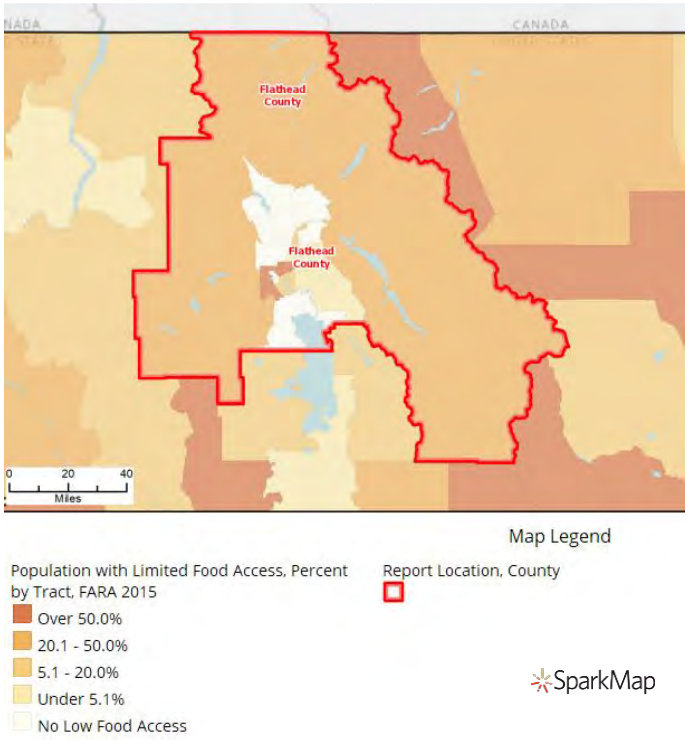
Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

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

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




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




## Food Insecurity

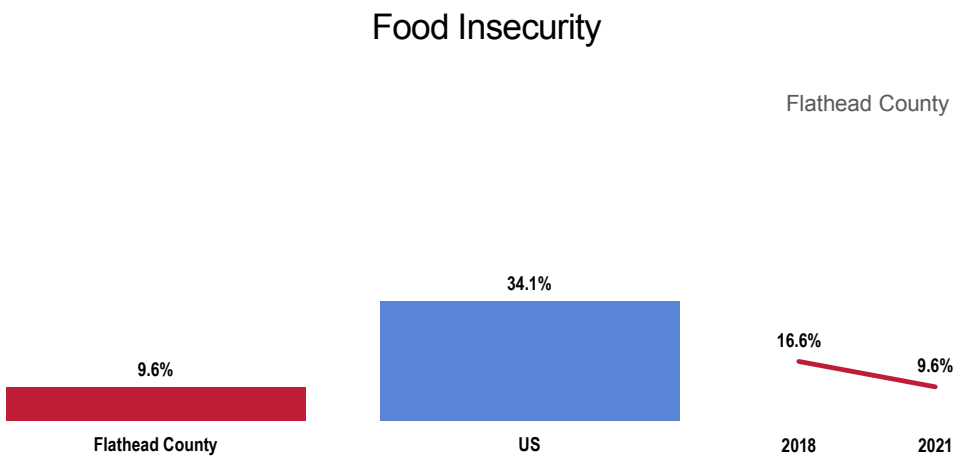
**Overall, 9.6% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.**

BENCHMARK ► More favorable than the national percentage.

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

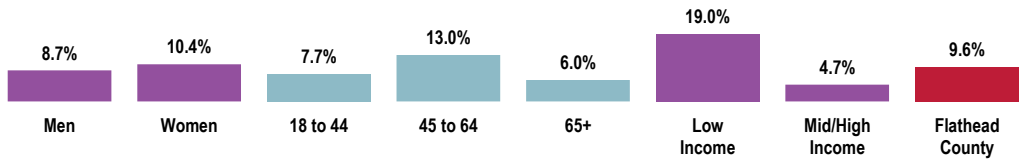
- I worried about whether our food would run out before we got money to buy more.
- The food that we bought just did not last, and we did not have money to get more."

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




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 112]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

## Food Insecurity
(Flathead County, 2021)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 112]
Notes: Asked of all respondents.
Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

# Key Informant Input: Social Determinants

These related comments were reported among key informants taking part in an online survey about community issues:

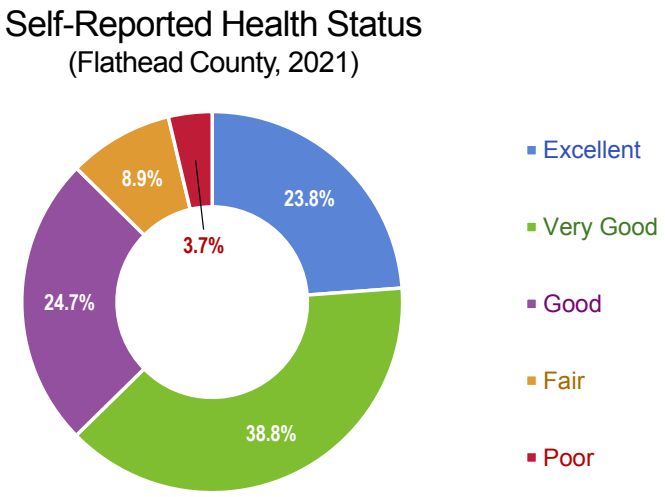
### Housing

> Failure to thrive due to lack of stable housing. – Social Services Provider
>
> Housing as healthcare. There is a lack of affordable housing in the Flathead Valley. This leads to unfavorable health outcomes. – Other Health Provider

# HEALTH STATUS

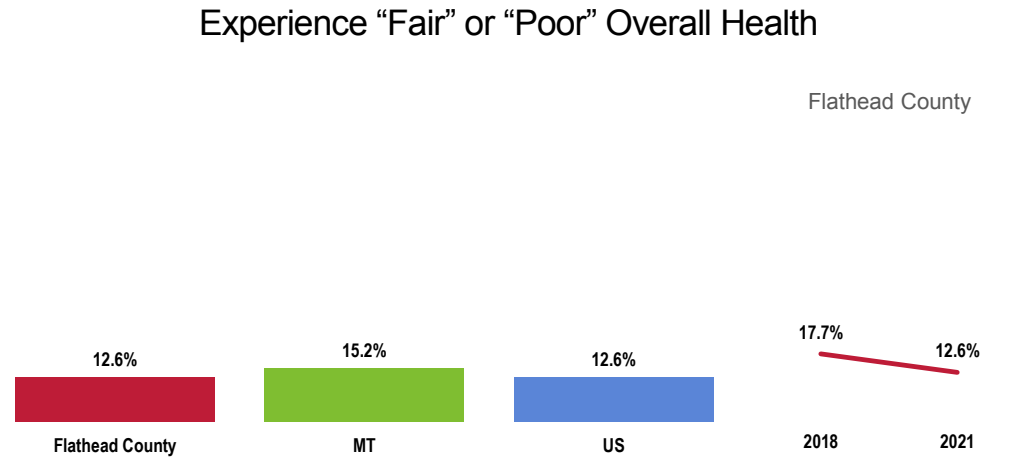
# OVERALL HEALTH STATUS

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



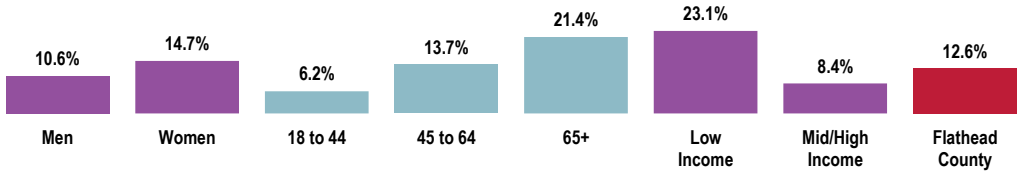

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: Asked of all respondents.

**However, 12.6% of Flathead County adults believe that their overall health is "fair" or "poor."**




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

## Experience “Fair” or “Poor” Overall Health
(Flathead County, 2021)




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

# MENTAL HEALTH

## ABOUT MENTAL HEALTH & MENTAL DISORDERS

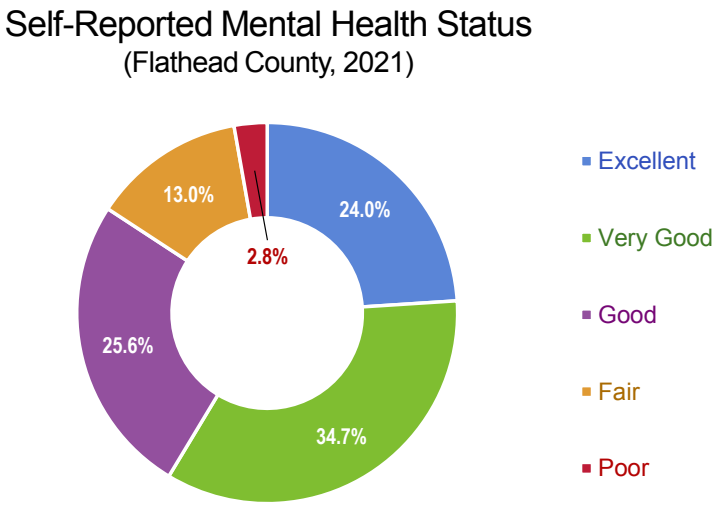
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental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

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

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

## Mental Health Status

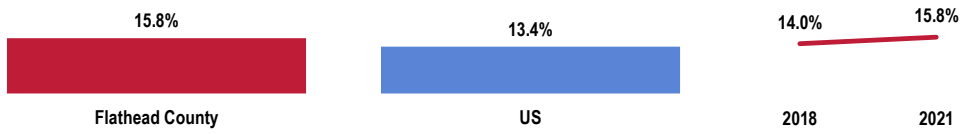
"Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: Excellent, Very Good, Good, Fair, or Poor?"




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

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

Flathead County




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

# Depression

### Diagnosed Depression

## Have Been Diagnosed With a Depressive Disorder

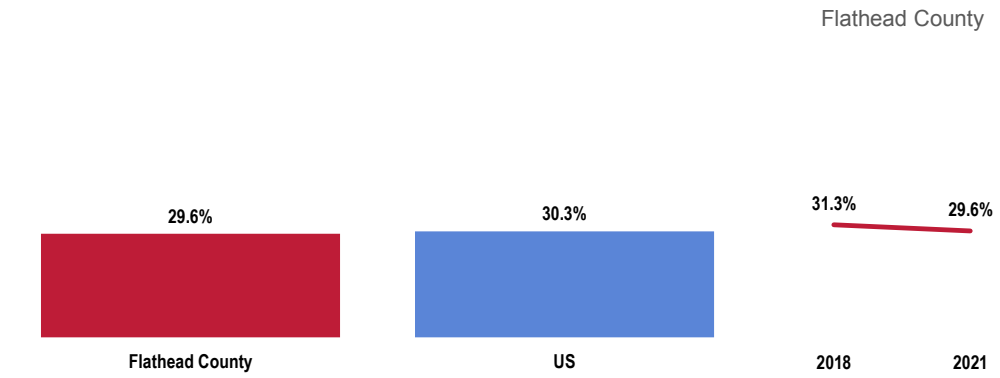
Flathead County


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 93]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Depressive disorders include depression, major depression, dysthymia, or minor depression.

## Symptoms of Chronic Depression

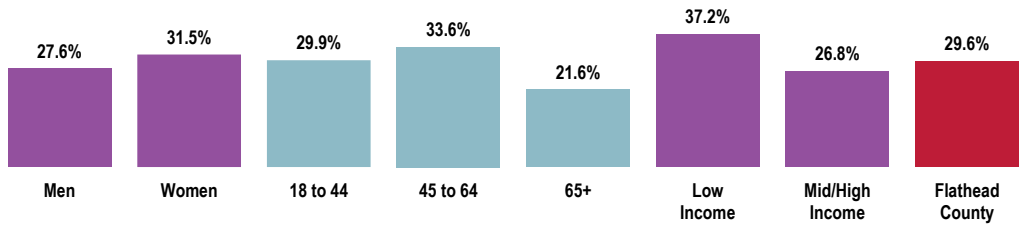
**A total of 29.6% of Flathead County adults have had two or more years in their lives when they**

### Have Experienced Symptoms of Chronic Depression



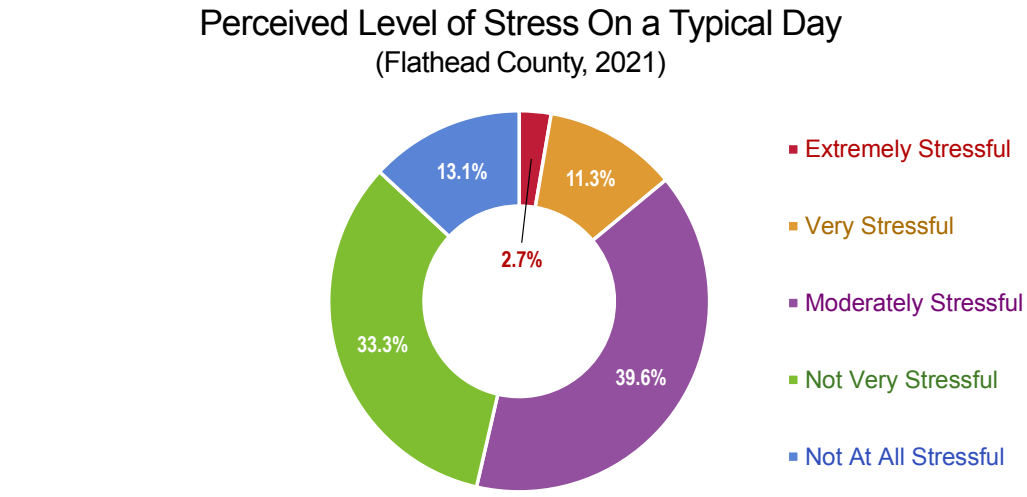

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 91]
2020 PRC National Health Survey, PRC, Inc.

### Have Experienced Symptoms of Chronic Depression
(Flathead County, 2021)



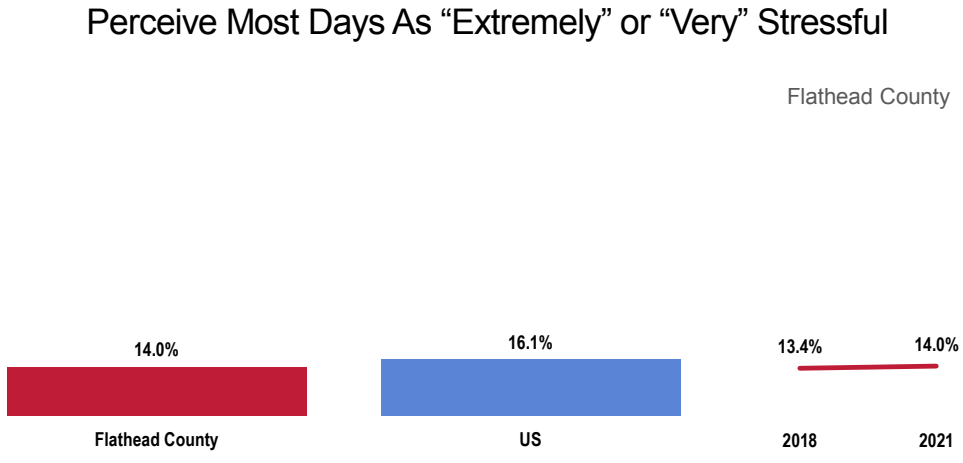

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 91]
Notes: Asked of all respondents.
Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

# Stress



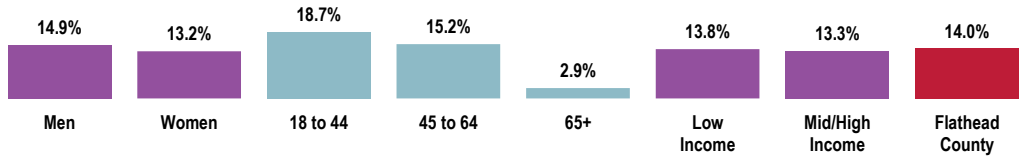

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: Asked of all respondents.

**In contrast, 14.0% of Flathead County adults feel that most days for them are "very" or "extremely" stressful.**




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

## Perceive Most Days as “Extremely” or “Very” Stressful
(Flathead County, 2021)



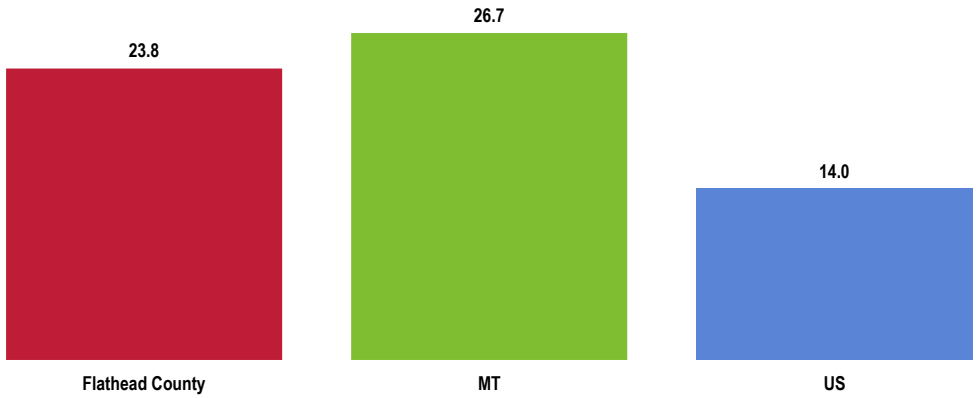

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: Asked of all respondents.

# Suicide

**In Flathead County, there were 23.8 suicides per 100,000 population (2017-2019 annual average age-adjusted rate).**

BENCHMARK ► Higher than the national rate. Fails to satisfy the HP2030 target of 12.8 or lower.

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

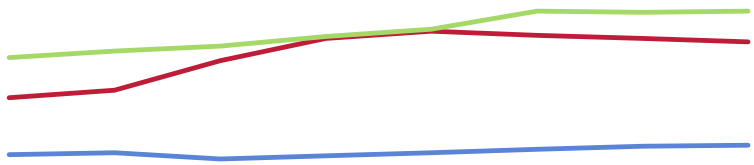



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

## Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 18.5 | 19.2 | 22.0 | 24.1 | 24.8 | 24.4 | 24.1 | 23.8 |
| MT | 22.3 | 22.9 | 23.4 | 24.3 | 25.0 | 26.7 | 26.6 | 26.7 |
| US | 13.1 | 13.3 | 12.7 | 13.0 | 13.3 | 13.6 | 13.9 | 14.0 |

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

# Mental Health Treatment

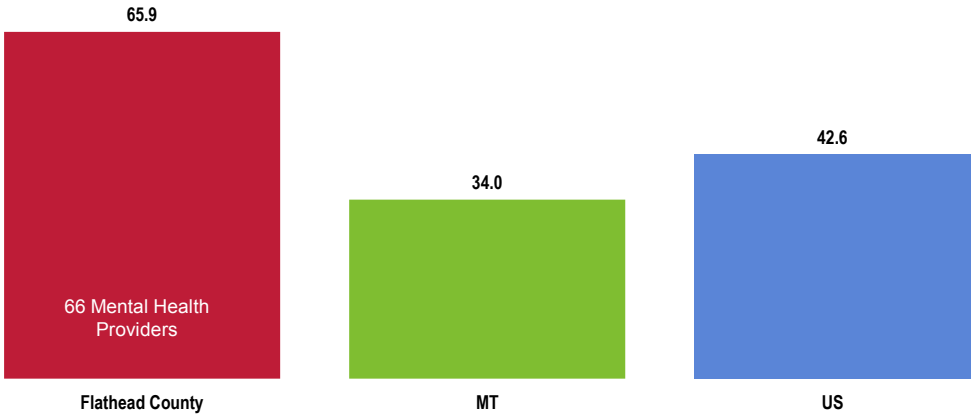
## Mental Health Providers

**In Flathead County in 2020, there were 65.9 mental health providers for every 100,000 population.**

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

## Access to Mental Health Providers

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




Sources: University of Wisconsin Population Health Institute, County Health Rankings.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

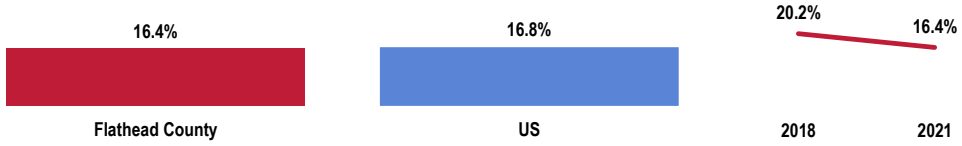
Notes: This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

## Currently Receiving Treatment

### Currently Receiving Mental Health Treatment

Flathead County

Among respondents ever diagnosed with a depressive disorder, 57% are currently receiving treatment.




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 94-95]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
"Treatment" can include taking medications for mental health.

## Difficulty Accessing Mental Health Services

**A total of 4.7% of Flathead County adults report a time in the past year when they needed mental health services but were not able to get them.**

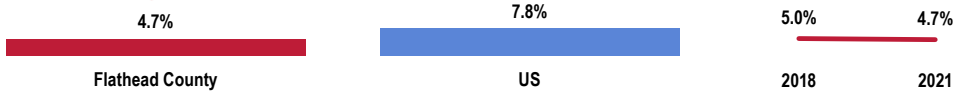
BENCHMARK ► Better than the national finding.

DISPARITY ► Reported more often among women and adults age 45 to 64. Appears to be higher

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

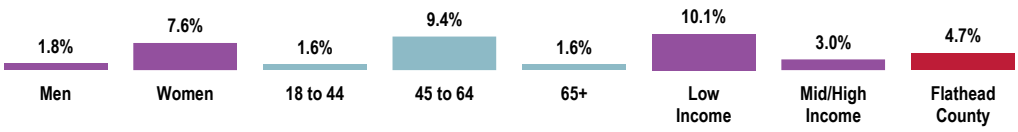
Flathead County

Among the small sample of those reporting difficulties, Medicaid issues and cost were predominant reasons given, along with offices not accepting new patients.



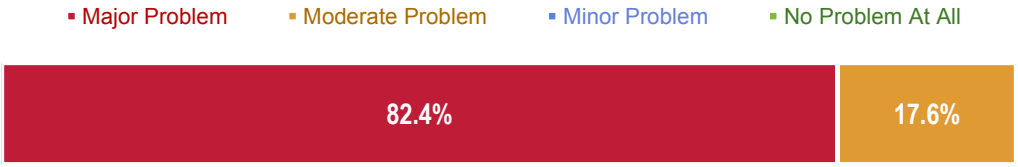

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 95,303]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

## Unable to Get Mental Health Services When Needed in the Past Year
(Flathead County, 2021)




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

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




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

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

### Access to Care/Services

> Access to care, health insurance, limited number of providers, and lack of case management. – Public Health Representative
>
> Mental health services are limited. There are often long waits for services. The systems do not seem to be working well together to connect referrals through a streamlined system of care. There are limited options for substance use treatment, in particular for residential care. There are few options for transitional or supportive housing to move people to a lower level of care with wrap around supports. Mental health professionals are limited with limited ability to respond where they are needed. Care is expensive, many lack adequate insurance for care. Co-pays and deductibles are high even when individuals have insurance or they have to pay out of network to see their preferred provider. – Public Health Representative

> It can be very difficult to get an appointment with providers quickly. There is an emphasis on medication with little to no personalized care. Mental health facilities like pathways are difficult to get admitted to and often are not very helpful. – Social Services Provider

### Contributing Factors

> Stigma, lack of resources, and expense. – Public Health Representative
>
> Stigma. We have limited in patient services that are affordable. We have high rates of suicide. We have a lot of people trying to address this problem, but they are not getting anything done. They just meet and talk in circles. – Other Health Provider
>
> Getting access to mental health care. Educating law enforcement about mental health. Educating the community about maternal child mental health. – Public Health Representative

### Senior Population

> For everyone, access to services seems to be the biggest hurdle, but for older adults there are some added challenges. Older adults, their families and others (including health and social service professionals) may attribute mental health concerns/symptoms as part of normal aging rather than treatable conditions. Generationally, older adults may be more reluctant to acknowledge difficulties or ask for help. Health concerns common to older adults like chronic conditions, stroke and dementia and even some medications (or medication interactions) can have mental health implications. Older adults experience some unique age-related stressors as well, such as decreased mobility, vision or hearing loss, loss of spouse/family/friends, change in living situations or loss of independence, social isolation and loneliness, etc. that can affect mental health and should be considered in treatment. – Social Services Provider
>
> For older adults, social isolation is a driver of poor physical and mental health outcomes as well as cognitive decline. It increases the risk of dementia, increases the likelihood of needing personal care and can even lead to premature death. It was prevalent in our community before, but COVID has exacerbated the issue in ways we are just now beginning to uncover. – Social Services Provider

### Incidence/Prevalence

> So many unmet needs, so much untreated mental illness. – Social Services Provider
>
> This is one of our highest priorities and areas of need. Mental health challenges make it difficult to engage patients in any other aspects of their care. – Public Health Representative

### Follow-Up/Support

> Getting a return call and follow-up from providers. Access to appropriate services. Providers are difficult to get responses from. There are many times when calls go un-returned and this is difficult because other non-mental health service providers are then in a real dilemma trying to coordinate appropriate care services. It can unnecessarily cause a person to decline with mental or behavioral health issues, when a 'light-touch' approach may have initially been appropriate but over time the need escalated and client now in crisis. – Social Services Provider

### Affordable Care/Services

> Services are unavailable for low income and homeless individuals. – Social Services Provider

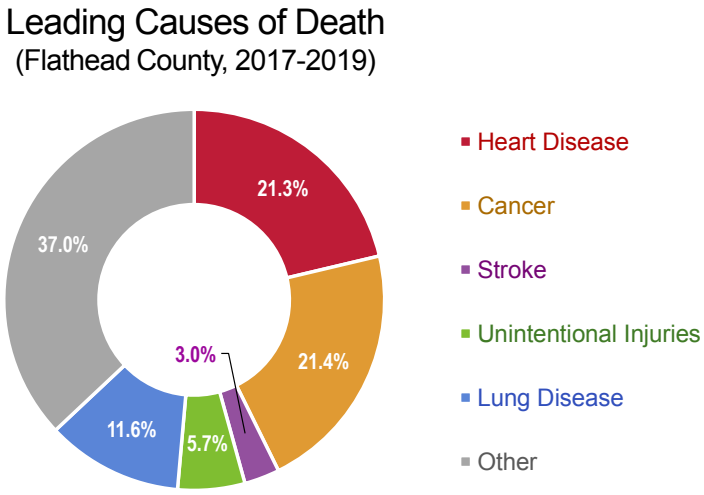
### Co-Occurrences

> Young people who have experienced trauma and have mental health care needs as a result. – Community Leader

# DEATH, DISEASE & CHRONIC CONDITIONS

# LEADING CAUSES OF DEATH

## Distribution of Deaths by Cause




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

## Age-Adjusted Death Rates for Selected Causes

### AGE-ADJUSTED DEATH RATES

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

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

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

The following chart outlines 2017-2019 annual average age-adjusted death rates per 100,000 population for selected causes of death in Flathead County.

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

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

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

| | Flathead County | Montana | US | HP2030 |
|---|---|---|---|---|
| **Diseases of the Heart** | 152.5 | 158.4 | 163.4 | 127.4* |
| **Malignant Neoplasms (Cancers)** | 136.6 | 144.7 | 149.3 | 122.7 |
| **Falls [Age 65+]** | 91.1 | 87.1 | 65.1 | 63.4 |
| **Chronic Lower Respiratory Disease (CLRD)** | 52.7 | 50.4 | 39.6 | — |
| **Unintentional Injuries** | 46.6 | 52.2 | 48.9 | 43.2 |
| **Cerebrovascular Disease (Stroke)** | 30.1 | 31.5 | 37.2 | 33.4 |
| **Intentional Self-Harm (Suicide)** | 23.8 | 26.7 | 14.0 | 12.8 |
| **Alzheimer's Disease** | 18.7 | 21.7 | 30.4 | — |
| **Firearm-Related** | 17.7 | 19.6 | 11.9 | 10.7 |
| **Pneumonia/Influenza** | 15.2 | 11.5 | 13.8 | — |
| **Motor Vehicle Deaths** | 13.0 | 16.0 | 11.3 | 10.1 |
| **Kidney Disease** | 12.7 | 9.7 | 12.9 | — |
| **Diabetes** | 11.5 | 20.2 | 21.5 | — |
| **Cirrhosis/Liver Disease** | 11.1 | 14.3 | 11.1 | 10.9 |
| **Unintentional Drug-Related Deaths** | 10.9 | 9.8 | 18.8 | — |
| **Homicide/Legal Intervention** | 2.9 | 3.5 | 5.6 | 5.5 |

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.
Note: *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

# CARDIOVASCULAR DISEASE

## ABOUT HEART DISEASE & STROKE

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

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

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

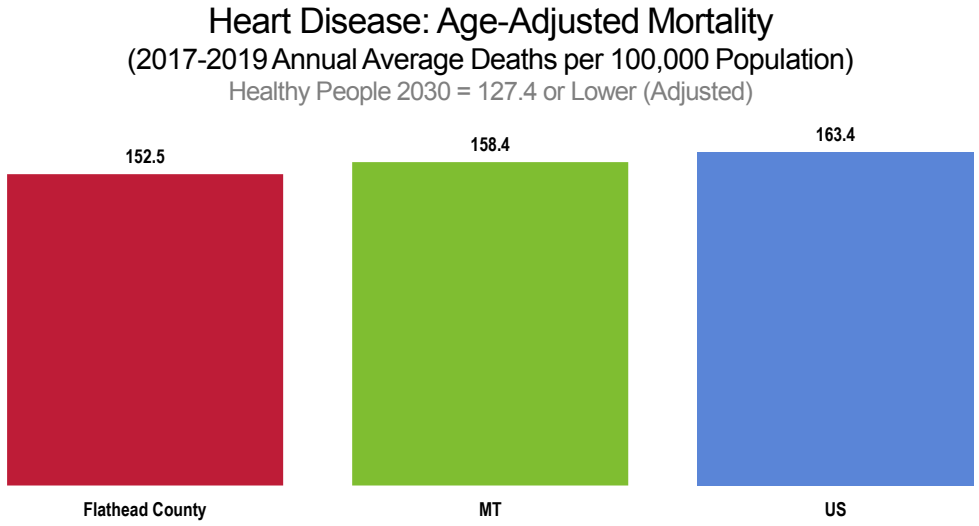
# Age-Adjusted Heart Disease & Stroke Deaths

## Heart Disease Deaths

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

**Between 2017 and 2019, there was an annual average age-adjusted heart disease mortality rate of 152.5 deaths per 100,000 population in Flathead County.**

BENCHMARK ► Fails to satisfy the HP2030 target of 127.4 or lower (as adjusted to account for all




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

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

## Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 151.6 | 146.0 | 144.9 | 138.1 | 143.6 | 144.1 | 149.1 | 152.5 |
| MT | 154.0 | 154.1 | 151.0 | 152.6 | 152.7 | 155.1 | 157.5 | 158.4 |
| US | 191.6 | 188.5 | 169.1 | 168.4 | 167.0 | 166.3 | 164.7 | 163.4 |

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

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

## Stroke Deaths

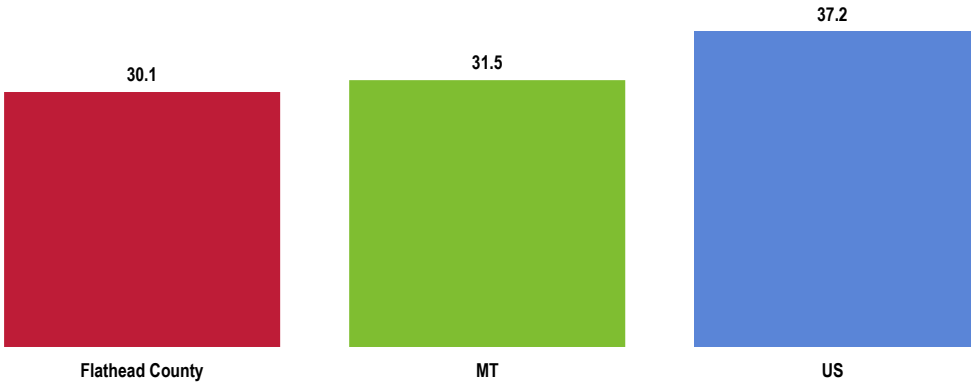
**Between 2017 and 2019, there was an annual average age-adjusted stroke mortality rate of 30.1 deaths per 100,000 population in Flathead County.**

BENCHMARK ► More favorable than the US mortality rate. Satisfies the HP2030 target of 33.4 or lower.

## Stroke: Age-Adjusted Mortality

(2017-2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower




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

## Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 40.5 | 33.9 | 37.9 | 39.4 | 40.5 | 38.2 | 34.9 | 30.1 |
| MT | 37.6 | 36.2 | 35.7 | 35.9 | 34.2 | 34.0 | 32.7 | 31.5 |
| US | 41.8 | 40.9 | 36.5 | 36.8 | 37.1 | 37.5 | 37.3 | 37.2 |

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

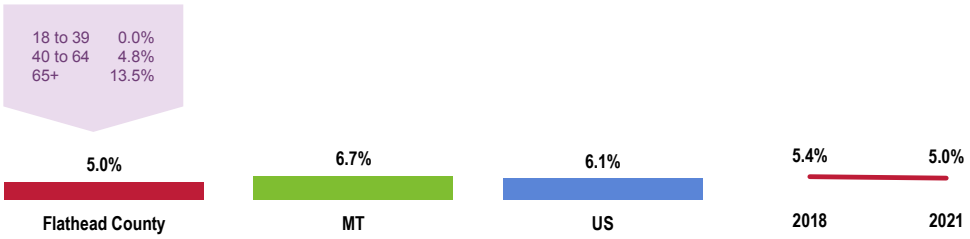
# Prevalence of Heart Disease & Stroke

## Prevalence of Heart Disease

**A total of 5.0% of surveyed adults report that they suffer from or have been diagnosed with**

## Prevalence of Heart Disease

Flathead County

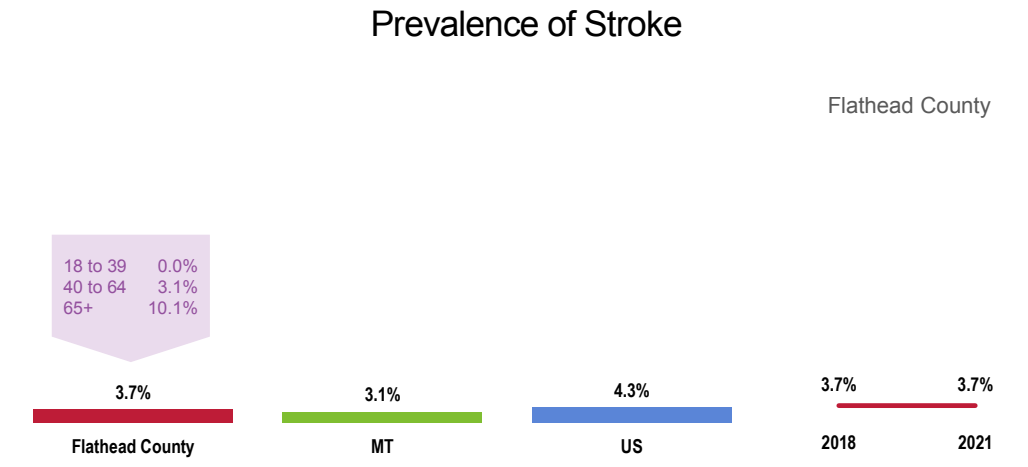



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 114]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.

Notes: Asked of all respondents.
Includes diagnoses of heart attack, angina, or coronary heart disease.

## Prevalence of Stroke

**A total of 3.7% of surveyed adults report that they suffer from or have been diagnosed with**




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

# Cardiovascular Risk Factors

## Blood Pressure & Cholesterol

**A total of 32.8% of Flathead County adults have been told by a health professional at some point that their blood pressure was high.**

BENCHMARK ► Fails to satisfy the HP2030 target of 27.7% or lower.

**A total of 31.0% of adults have been told by a health professional that their cholesterol level was high.**

## Prevalence of High Blood Pressure

Healthy People 2030 = 27.7% or Lower


## Prevalence of High Blood Cholesterol


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

## Prevalence of High Blood Pressure (Flathead County)

Healthy People 2030 = 27.4% or Lower


## Prevalence of High Blood Cholesterol (Flathead County)


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 35, 36]
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents.

## Total Cardiovascular Risk

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

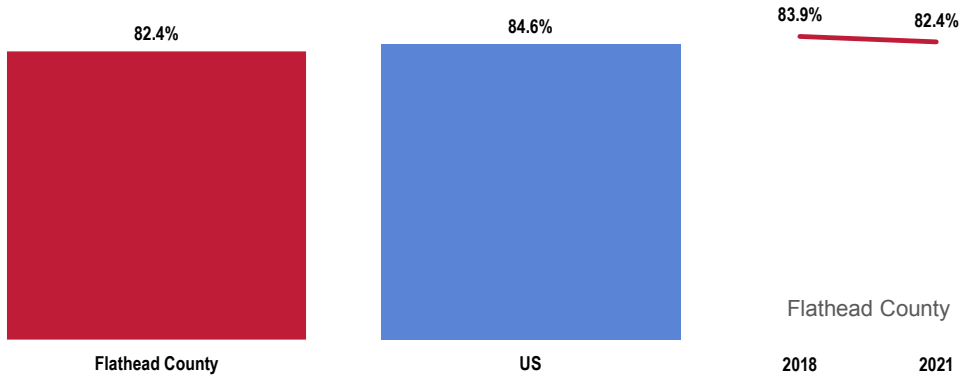
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

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

**A total of 82.4% of Flathead County adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.**

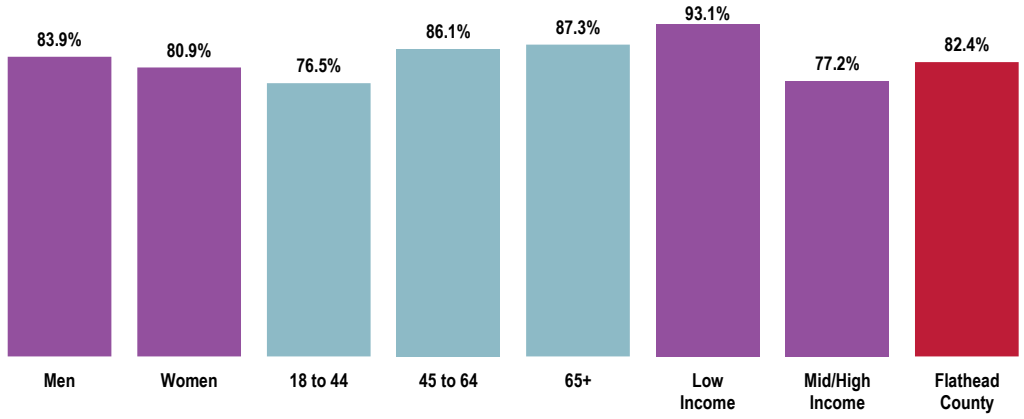
RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

### Present One or More Cardiovascular Risks or Behaviors



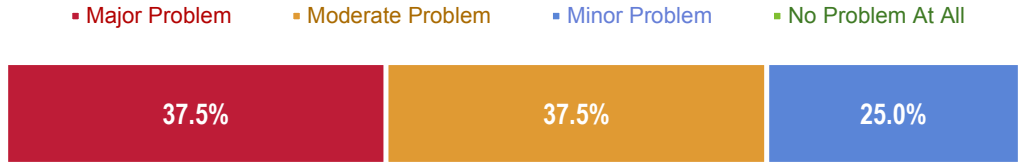

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 115]
2020 PRC National Health Survey, PRC, Inc.
Notes: Reflects all respondents.
Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

## Present One or More Cardiovascular Risks or Behaviors
(Flathead County, 2021)




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

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




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

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

### Aging Population

> These are health conditions that most typically affect older adults, and older adults represent a large percentage of our population. Almost 30% of Flathead residents are 60 or older and almost 20% are 65 or older. Stroke in particular may result in a need for ongoing supportive services and long-term care (home and community or facility-based), which can be scarce and costly. – Social Services Provider

### Co-Occurrences

> High rate of obesity and high blood pressure leading to these two diseases. – Public Health Representative

### Leading Cause of Death

> It kills a lot of people. – Public Health Representative

# CANCER

## ABOUT CANCER

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

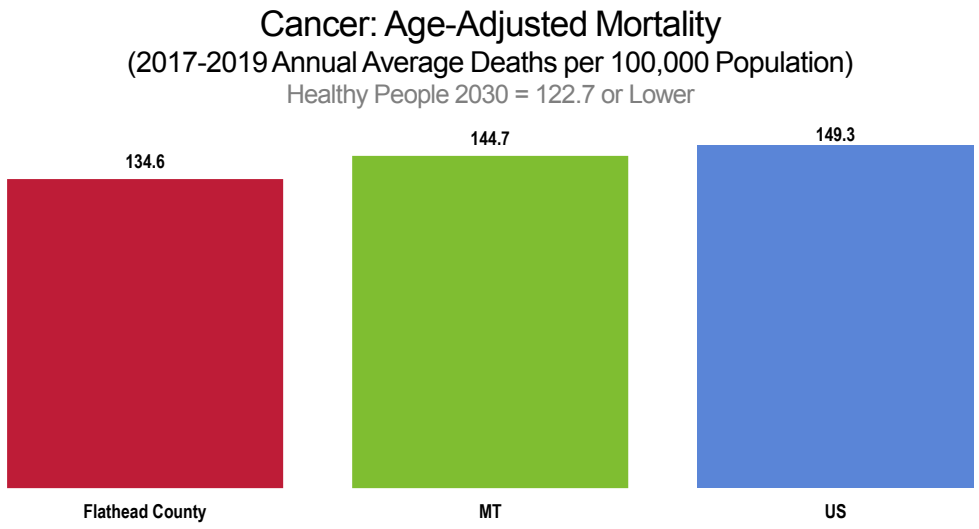
Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote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

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

# Age-Adjusted Cancer Deaths

## All Cancer Deaths

**Between 2017 and 2019, there was an annual average age-adjusted cancer mortality rate of 134.6 deaths per 100,000 population in Flathead County.**




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

## Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 122.7 or Lower

| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 156.1 | 148.0 | 160.3 | 164.6 | 163.2 | 148.5 | 132.7 | 134.6 |
| MT | 160.3 | 158.0 | 155.2 | 155.8 | 153.0 | 151.8 | 146.4 | 144.7 |
| US | 174.8 | 171.6 | 163.6 | 161.0 | 158.5 | 155.6 | 152.5 | 149.3 |

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

## Cancer Deaths by Site

**Lung cancer is by far the leading cause of cancer deaths in Flathead County.**

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

BENCHMARK

Lung Cancer ► Lower than the national rate.

Prostate Cancer ► Lower than the state rate.

Female Breast Cancer ► Lower than both state and national rates

## Age-Adjusted Cancer Death Rates by Site

(2017-2019 Annual Average Deaths per 100,000 Population)

| | Flathead County | Montana | US | HP2030 |
|---|---|---|---|---|
| **ALL CANCERS** | **134.6** | **144.7** | **149.3** | **122.7** |
| **Lung Cancer** | **27.7** | **30.4** | **34.9** | **25.1** |
| **Prostate Cancer** | **17.8** | **22.0** | **18.6** | **16.9** |
| **Female Breast Cancer** | **15.7** | **18.3** | **19.7** | **15.3** |
| **Colorectal Cancer** | **9.6** | **12.5** | **13.4** | **8.9** |

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

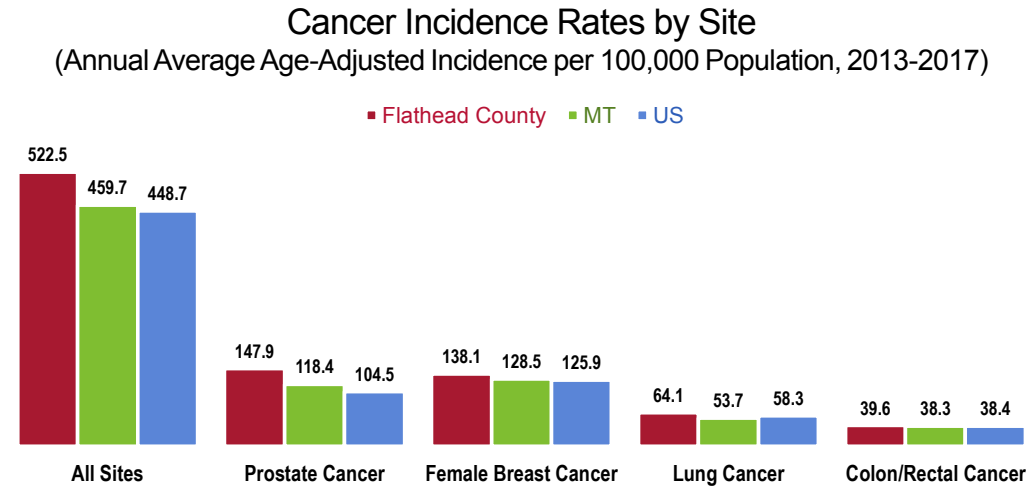
# Cancer Incidence

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

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

BENCHMARK

Prostate Cancer ► Higher than both state and national rates.




Sources: State Cancer Profiles.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

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

# Prevalence of Cancer

**A total of 10.0% of surveyed Flathead County adults report having ever been diagnosed with cancer. The most common types include skin cancer, colorectal cancer, and lung cancer.**

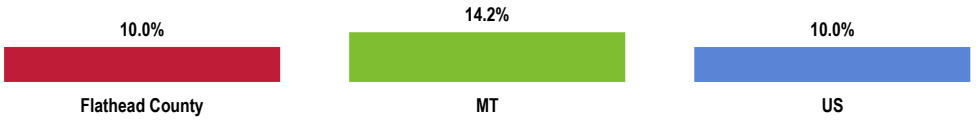
BENCHMARK ► More favorable than the statewide percentage.

DISPARITY ► Higher among adults age 65 and older.

## Prevalence of Cancer

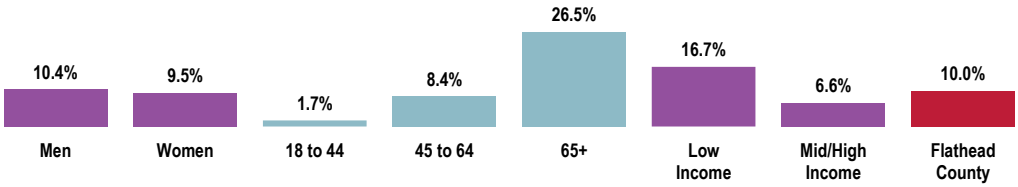
The most common types of cancers cited locally include:

1) Skin Cancer 16.3%
2) Colorectal Cancer 14.1%
3) Lung Cancer 8.4%




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 25-26]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control

## Prevalence of Cancer
(Flathead County, 2021)




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

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

## ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

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

# Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.
Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear/HPV testing); and colorectal cancer (colonoscopy/sigmoidoscopy and fecal occult blood testing).

## FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 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 aged 21 to 29 years. For women aged 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 50 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.

**Among women age 50-74, 64.7% have had a mammogram within the past 2 years.**

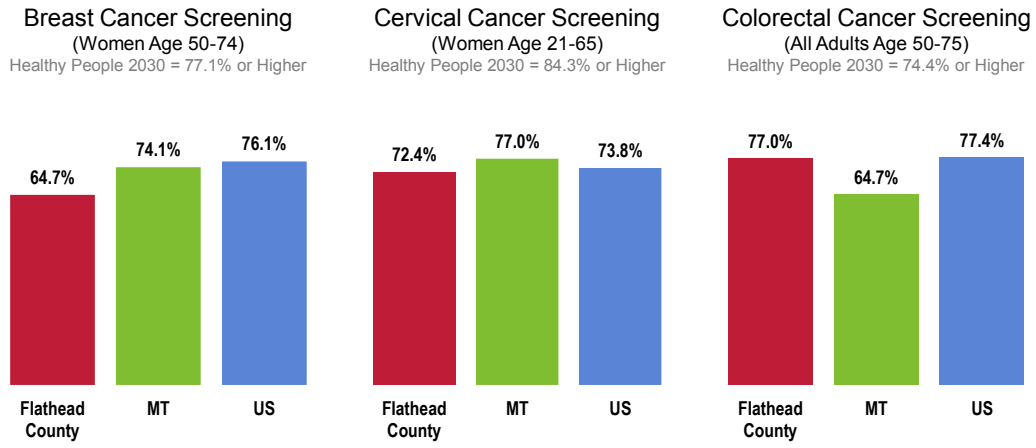
BENCHMARK ► Lower than state and national percentages. Fails to satisfy the HP2030 target of 77.1% or higher.

**Among Flathead County women age 21 to 65, 72.4% have had appropriate cervical cancer screening.**

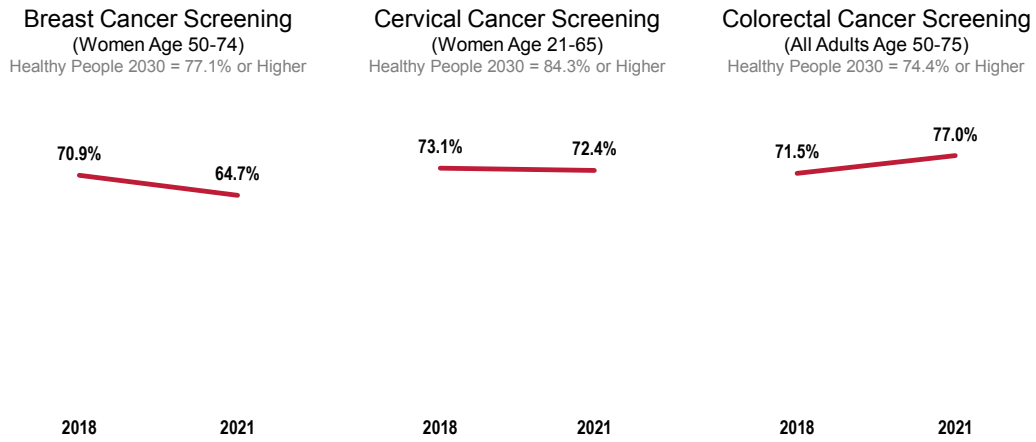
BENCHMARK ► Fails to satisfy the HP2030 target of 84.3% or higher.

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65. Women 21 to 65 with hysterectomy are excluded.

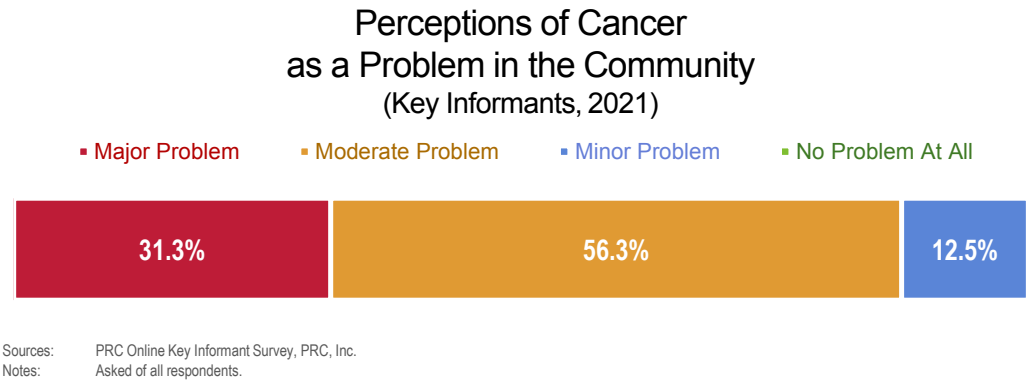
"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 116-118]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Montana data




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 116-118]
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Each indicator is shown among the gender and/or age group specified.




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

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

## Incidence/Prevalence

> Cancer continues to be on the rise. Many go to facilities outside of the Flathead to receive care. There is a lot occurring in the Artificial Intelligence/genomics space outside of Montana but not available in Montana. We continue to take a one-size fits all approach to cancer treatment with surgery, chemotherapy and radiation. With the last 15 months of the pandemic, many individuals are showing up to their primary care provider with more advanced cancers due to missed screenings and appointments since the start of the pandemic. – Public Health Representative
>
> I know many people who have cancer and I am under the impression that our county has a fairly high rate of cancer per capita. – Public Health Representative

## Vulnerable Populations

> Low income families lack access to screening and education on signs and symptoms. – 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.

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

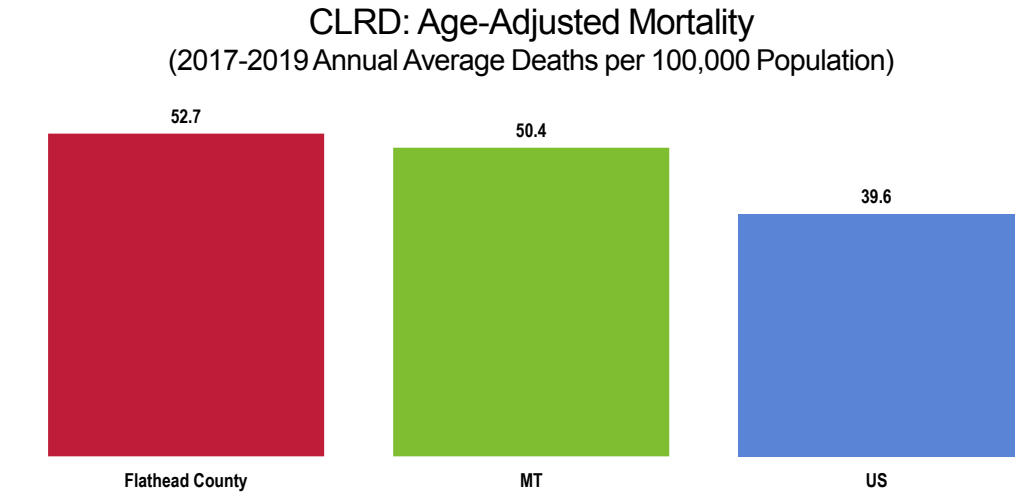
– Healthy People 2030 (https://health.gov/healthypeople)

# Age-Adjusted Respiratory Disease Deaths

## Chronic Lower Respiratory Disease Deaths (CLRD)

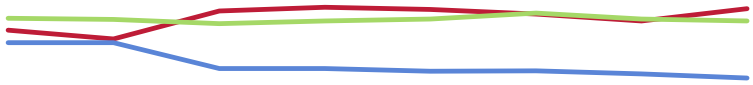
**Between 2017 and 2019, there was an annual average age-adjusted CLRD mortality rate of 52.7 deaths per 100,000 population in Flathead County.**

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




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

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



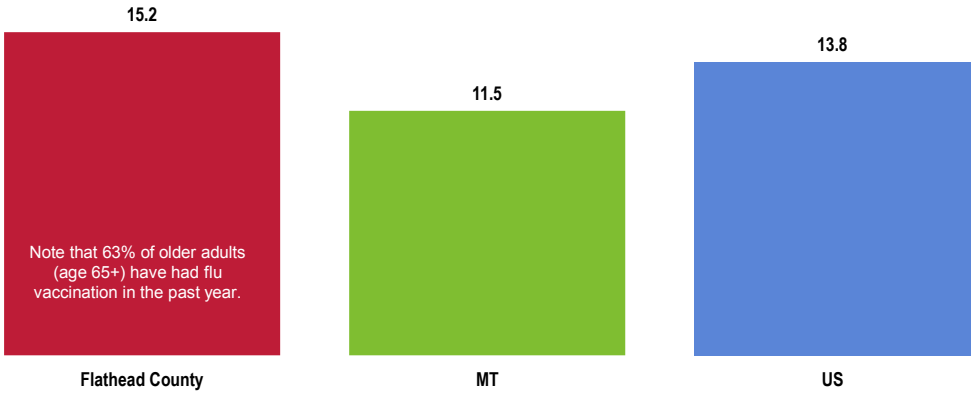
| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 48.7 | 47.0 | 52.3 | 53.0 | 52.6 | 51.7 | 50.4 | 52.7 |
| MT | 50.9 | 50.7 | 49.9 | 50.4 | 50.8 | 51.9 | 50.8 | 50.4 |
| US | 46.3 | 46.3 | 41.4 | 41.4 | 40.9 | 41.0 | 40.4 | 39.6 |

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

## Pneumonia/Influenza Deaths

**Between 2017 and 2019, Flathead County reported an annual average age-adjusted pneumonia influenza mortality rate of 15.2 deaths per 100,000 population.**

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




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

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

| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 14.6 | 14.3 | 17.4 | 16.3 | 14.0 | 14.5 | 14.7 | 15.2 |
| MT | 12.9 | 13.8 | 14.1 | 14.6 | 12.8 | 12.7 | 11.7 | 11.5 |
| US | 15.8 | 16.1 | 15.1 | 15.4 | 14.6 | 14.3 | 14.2 | 13.8 |

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

# Prevalence of Respiratory Disease

## Asthma

### Adults

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

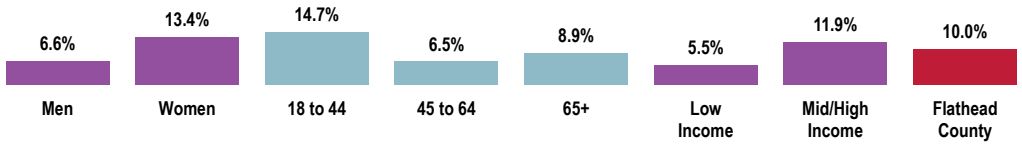
**A total of 10.0% of Flathead County adults currently suffer from asthma.**

### Prevalence of Asthma

Flathead County


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 119]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.

### Prevalence of Asthma
(Flathead County, 2021)

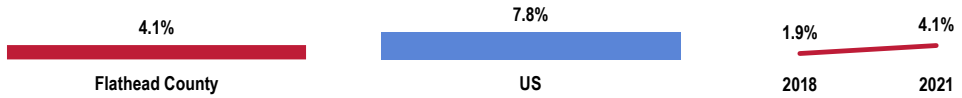



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: Asked of all respondents.
Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Children

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

Flathead County




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 120]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.
Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

## Chronic Obstructive Pulmonary Disease (COPD)

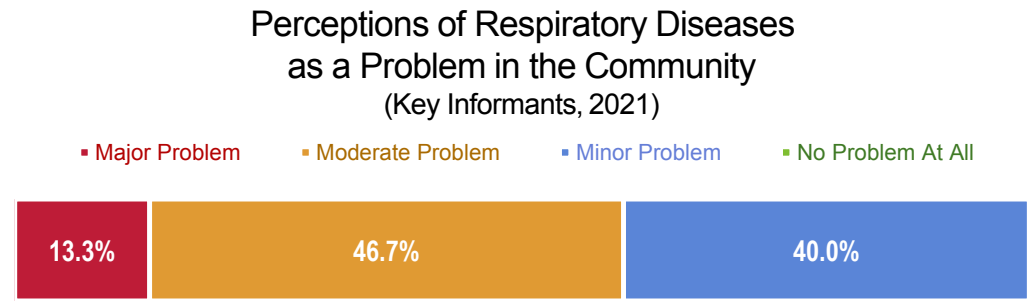
Note: COPD includes lung diseases such as emphysema and chronic bronchitis.

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

Flathead County

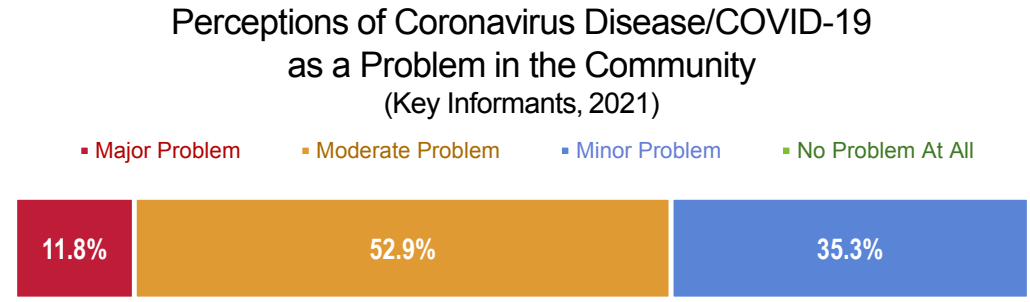

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 23]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

## Key Informant Input: Respiratory Disease




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

## Key Informant Input: Coronavirus Disease/COVID-19




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

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

### Limited Restrictions

> It has had widespread effects in the Flathead with ample opportunity to spread due to the limitations with COVID-19 restrictions. COVID-19 should be handled by public health professionals and medical professionals who are trained to limit the spread of the disease with support from the Governor and local elected officials. – Public Health Representative

# INJURY & VIOLENCE

## ABOUT INJURY & VIOLENCE

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

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

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

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

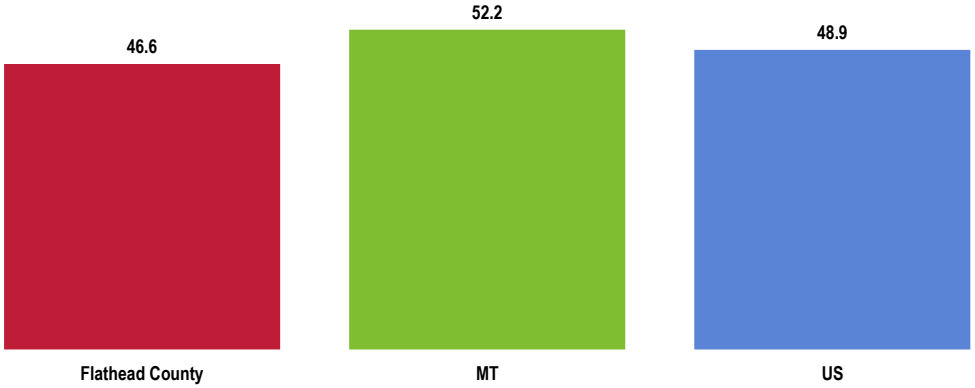
– Healthy People 2030 (https://health.gov/healthypeople)

# Unintentional Injury

## Age-Adjusted Unintentional Injury Deaths

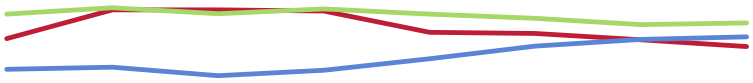
**Between 2017 and 2019, there was an annual average age-adjusted unintentional injury mortality rate of 46.6 deaths per 100,000 population in Flathead County.**

## Unintentional Injuries: Age-Adjusted Mortality
(2017-2019 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower




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

## Unintentional Injuries: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower

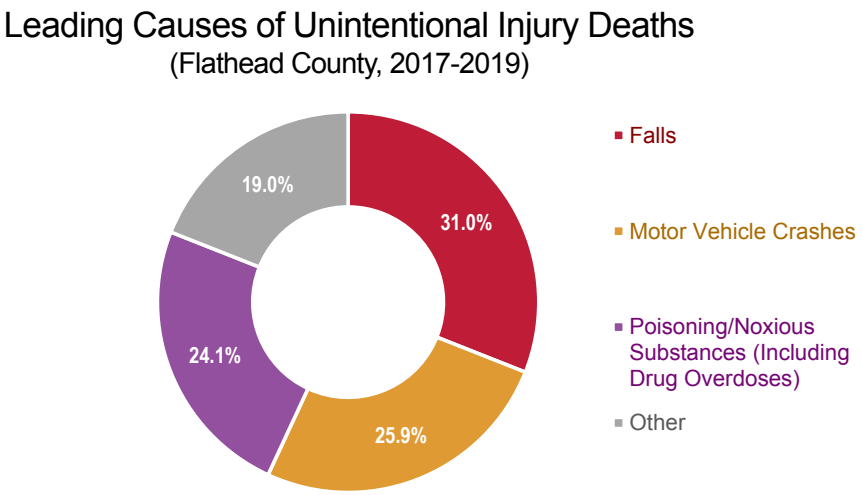


| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 48.5 | 55.3 | 55.3 | 55.0 | 50.0 | 49.7 | 48.2 | 46.6 |
| MT | 54.3 | 55.8 | 54.4 | 55.5 | 54.3 | 53.3 | 51.8 | 52.2 |
| US | 41.2 | 41.7 | 39.7 | 41.0 | 43.7 | 46.7 | 48.3 | 48.9 |

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

## Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.




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

## Falls

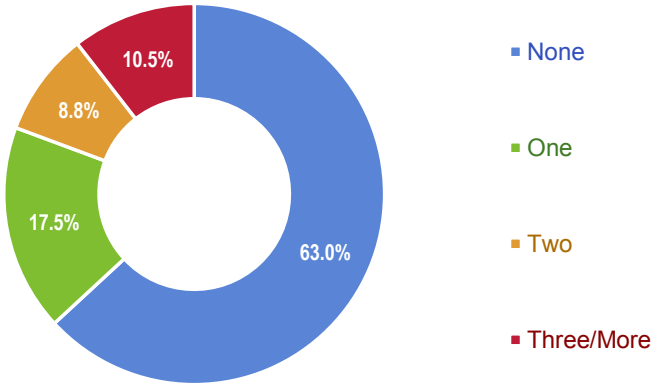
### ABOUT FALLS

Falls are the leading cause of fatal and nonfatal injuries for persons aged ≥65 years …. Even when those injuries are minor, they can seriously affect older adults' quality of life by inducing a fear of falling, which can lead to self-imposed activity restrictions, social isolation, and depression.

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

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

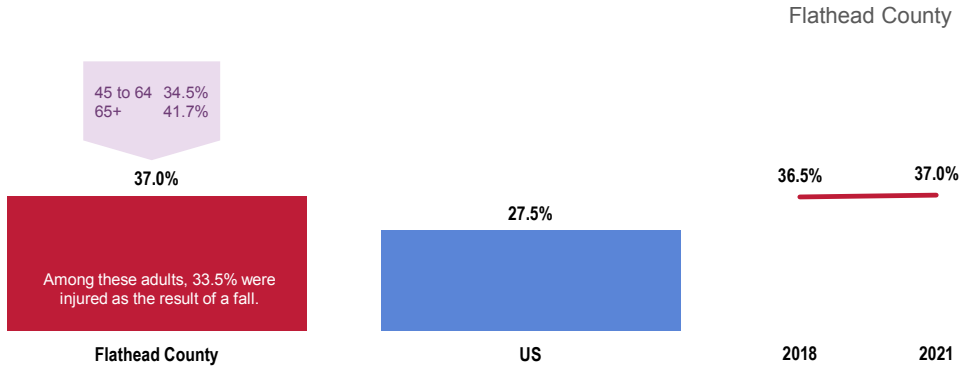
## Number of Falls in Past 12 Months
(Adults Age 45 and Older; Flathead County, 2021)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: Asked of all respondents age 45+.

**However, 37.0% have experienced a fall at least once in the past year.**

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



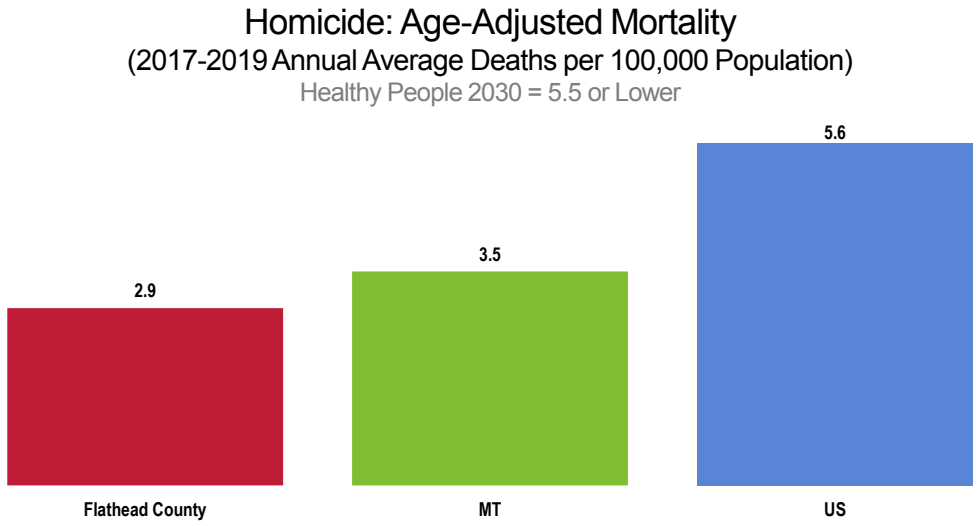

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 304-305]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of those respondents age 45 and older.

# Intentional Injury (Violence)

## Age-Adjusted Homicide Deaths

**In Flathead County, there were 2.9 homicides per 100,000 population (2017-2019 annual**

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




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

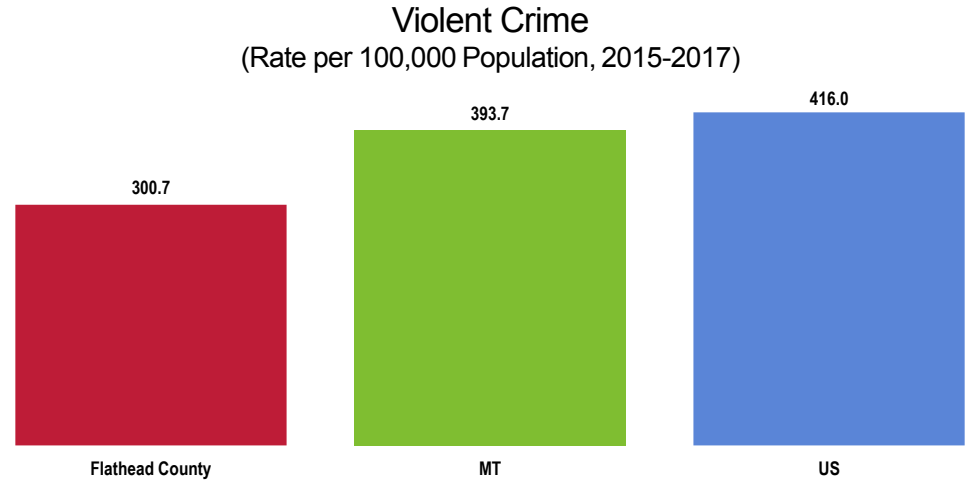
## Violent Crime

### Violent Crime Rates

**E**

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

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




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

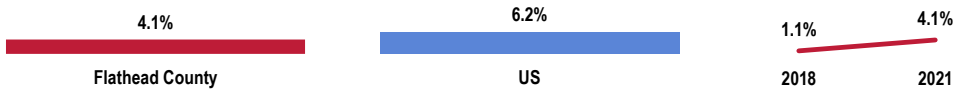
Notes: This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
Participation by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

## Community Violence

**A total of 4.1% of surveyed Flathead County adults acknowledge being the victim of a violent crime in the area in the past five years.**

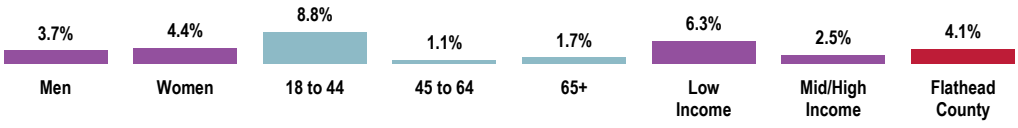
### Victim of a Violent Crime in the Past Five Years

Flathead County




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

### Victim of a Violent Crime in the Past Five Years
(Flathead County, 2021)

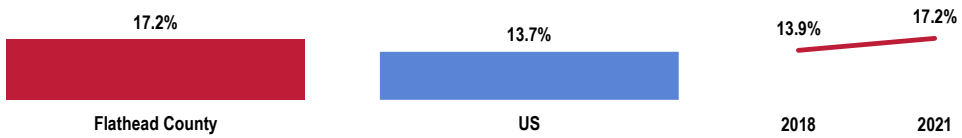



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 38]
Notes: Asked of all respondents.

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

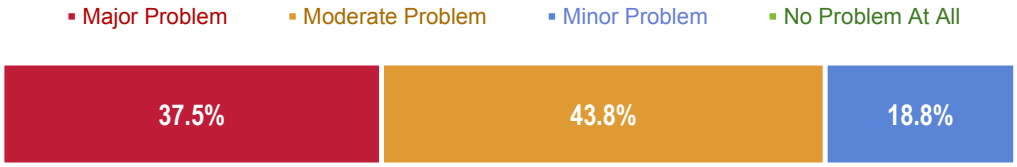
## Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

Flathead County




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 39]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

## Perceptions of Injury and Violence as a Problem in the Community
(Key Informants, 2021)




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

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

### Incidence/Prevalence

> Violence continues to rise. We have seen increases in homicides. – Public Health Representative
>
> One in four women are victimized by IPV in their lifetime. – Social Services Provider

### Co-Occurrences

> Substance use and mental health issues contribute to most injuries and violence in Flathead County. – Public Health Representative

### Domestic/Family Violence

> Domestic violence is a major problem in our community. Lack of intervention by law enforcement and district courts have left victims of domestic violence to fend for themselves. – Social Services Provider

# DIABETES

## ABOUT DIABETES

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

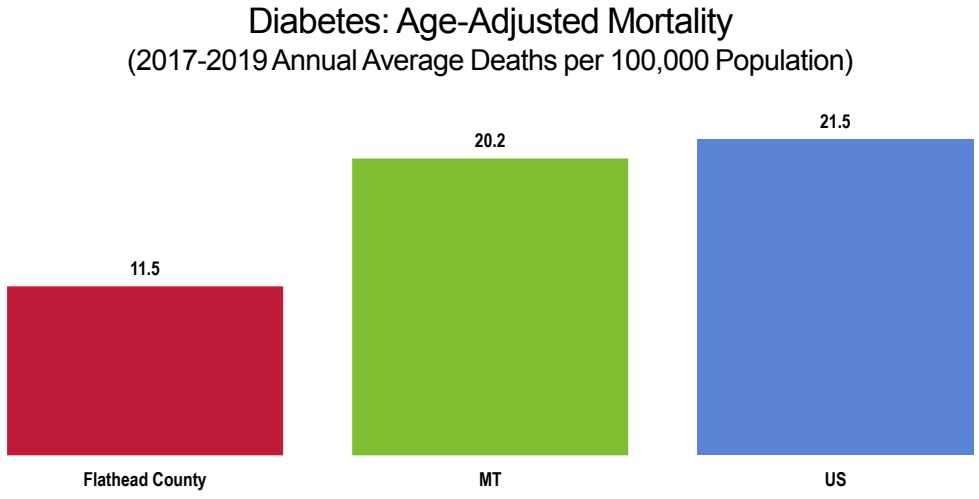
Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity,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

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

## Age-Adjusted Diabetes Deaths

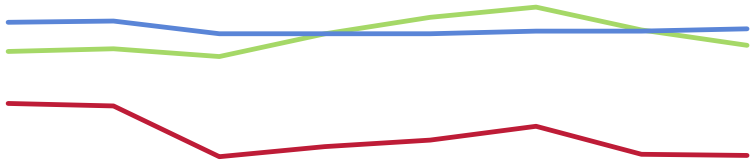
**Between 2017 and 2019, there was an annual average age-adjusted diabetes mortality rate of 11.5 deaths per 100,000 population in Flathead County.**

BENCHMARK ► Lower than state and US rates.




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

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



| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 15.6 | 15.4 | 11.4 | 12.2 | 12.7 | 13.8 | 11.6 | 11.5 |
| MT | 19.7 | 19.9 | 19.3 | 21.1 | 22.4 | 23.2 | 21.4 | 20.2 |
| US | 22 | 22.1 | 21.1 | 21.1 | 21.1 | 21.3 | 21.3 | 21.5 |

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

# Prevalence of Diabetes

**A total of 8.7% of Flathead County adults report having been diagnosed with diabetes.**

## Prevalence of Diabetes

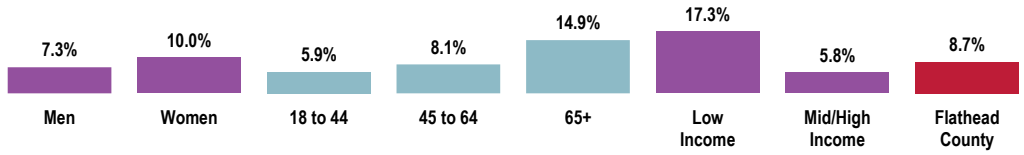
Another 8.6% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

Flathead County


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

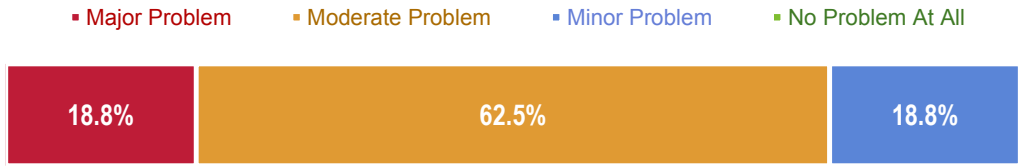
## Prevalence of Diabetes
(Flathead County, 2021)

Note that among adults who have not been diagnosed with diabetes, 43.7% report having had their blood sugar level tested within the past three years.




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

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




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

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

### Access to Care/Services

> Access to healthcare services and prevention measures. – Public Health Representative
>
> It is a maze for patients to get the care, medications and equipment they need to manage their diabetes. Frequently they have to navigate multiple providers and programs and just give up. – Public Health Representative

### Contributing Factors

> How expensive the medication can be and how expensive diabetic food is. The limited diabetic food options at the food bank. Education. – Public Health Representative

### Disease Management

> Managing their sugars and education. – Public Health Representative

# KIDNEY DISEASE

## ABOUT KIDNEY DISEASE

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

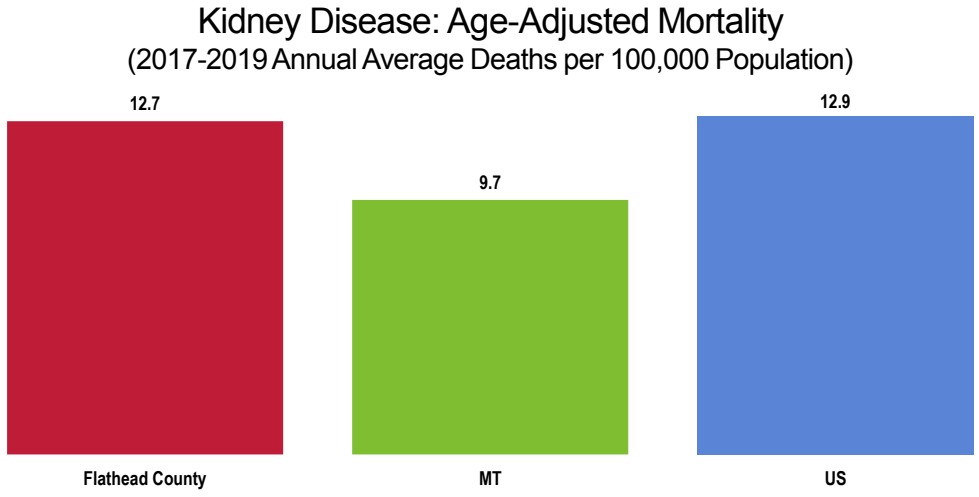
Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve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

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

## Age-Adjusted Kidney Disease Deaths

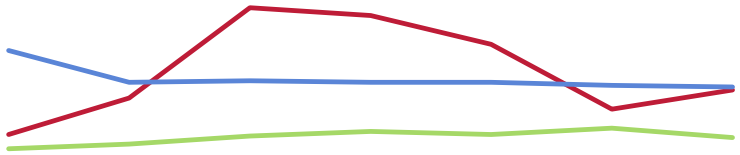
**Between 2017 and 2019, there was an annual average age-adjusted kidney disease mortality rate of 12.7 deaths per 100,000 population in Flathead County.**

BENCHMARK ► Higher than found across the state.




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

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

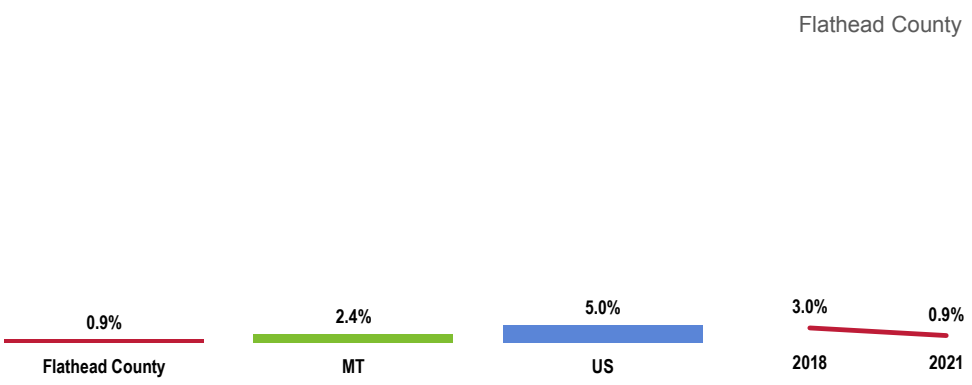


| | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|
| Flathead County | 9.9 | 12.2 | 17.9 | 17.4 | 15.6 | 11.5 | 12.7 |
| MT | 9.0 | 9.3 | 9.8 | 10.1 | 9.9 | 10.3 | 9.7 |
| US | 15.2 | 13.2 | 13.3 | 13.2 | 13.2 | 13.0 | 12.9 |

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

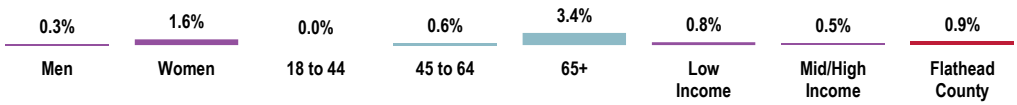
# Prevalence of Kidney Disease

## Prevalence of Kidney Disease




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 24]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

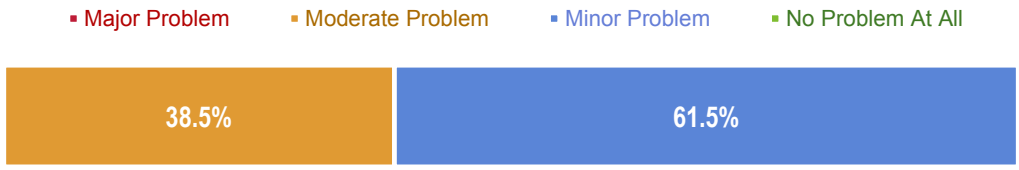
## Prevalence of Kidney Disease
(Flathead County, 2021)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 24]
Notes: Asked of all respondents.

# Key Informant Input: Kidney Disease

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




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

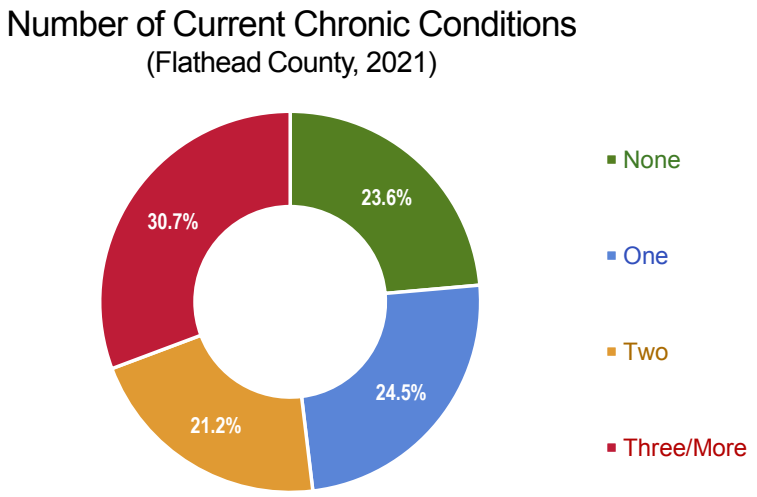
# POTENTIALLY DISABLING CONDITIONS

## Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

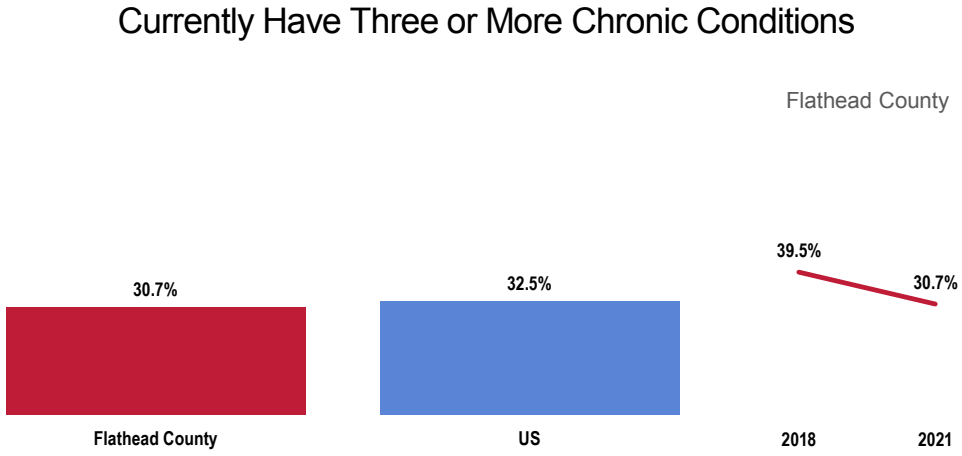
- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.



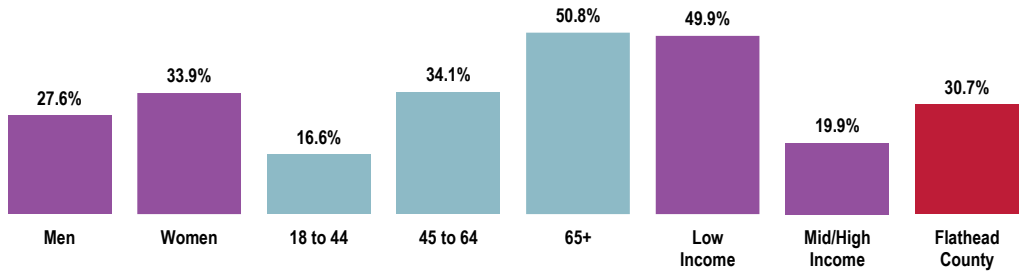

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: Asked of all respondents.
In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity,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

**In fact, 30.7% of Flathead County adults report having three or more chronic conditions.**




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

## Currently Have Three or More Chronic Conditions
(Flathead County, 2021)




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

# Activity Limitations

### ABOUT DISABILITY & HEALTH

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

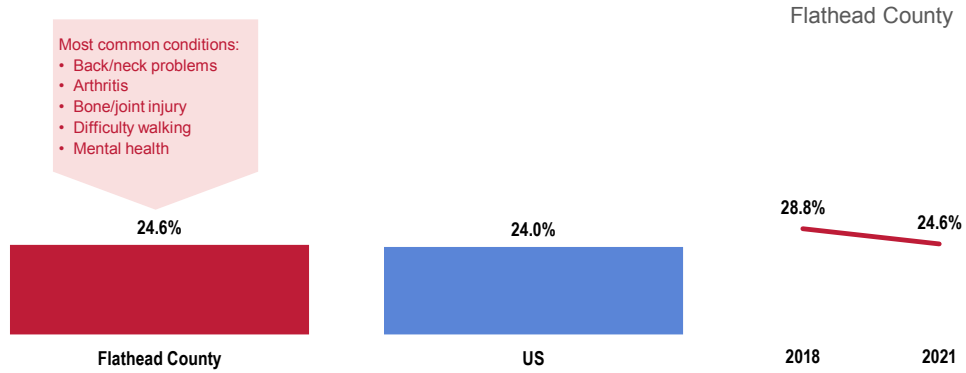
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life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

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

**A total of 24.6% of Flathead County adults are limited in some way in some activities due to a physical, mental, or emotional problem.**

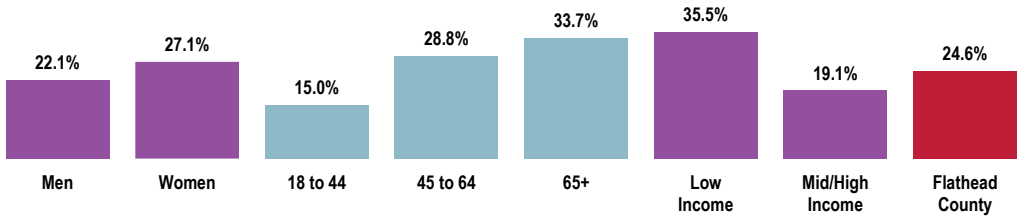
DISPARITY ► Higher among adults age 45 and older and lower-income respondents.

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




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 96-97]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

## Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem
(Flathead County, 2021)




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

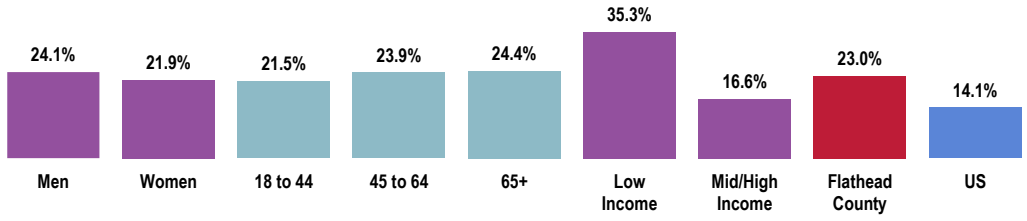
# Chronic Pain

**A total of 23.0% of Flathead County adults experience high-impact chronic pain, meaning physical pain that has limited their life or work activities "every day" or "most days" during the past six months.**

BENCHMARK ► Less favorable than the national finding. Fails to satisfy the HP2030 target of 7.0% or lower.

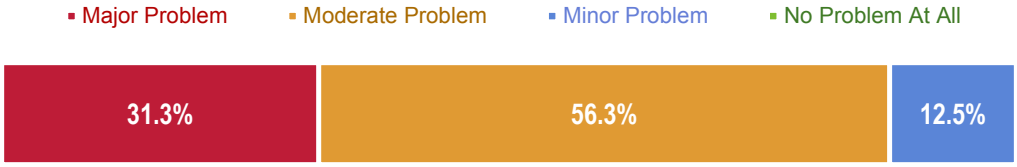
DISPARITY ► Higher among those with lower incomes.

## Experience High-Impact Chronic Pain
(Flathead County, 2021)
Healthy People 2030 = 7.0% or Lower




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 37]
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents.
High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

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




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

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

## Incidence/Prevalence

> I know many people who suffer from chronic pain. – Public Health Representative
>
> We see a high volume of this patients in our clinic. Many are seeking disability due to their chronic pain issues. – Public Health Representative

## Contributing Factors

> Lack of resources. Limited resources for alternative pain management to medication. In the winter, public walkways/parking lots are not cleared well enough for people to use them who depend upon wheelchairs, walkers, canes or other mobility devices. – Public Health Representative

## Access to Care/Services

> This category describes a high number of patients seeking out services. Folks with limited resources receive diminished support and treatment. – Social Services Provider

# Alzheimer's Disease

## ABOUT DEMENTIA

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

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

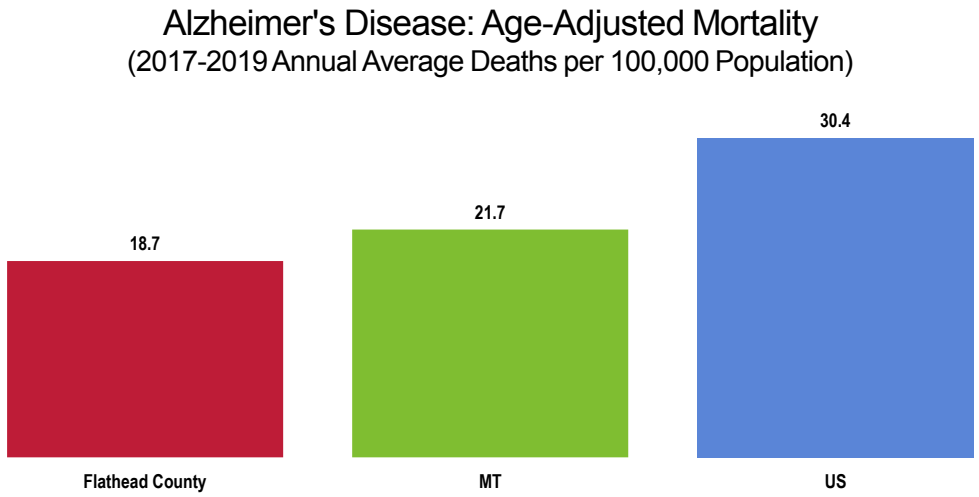
While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address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

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

## Age-Adjusted Alzheimer's Disease Deaths

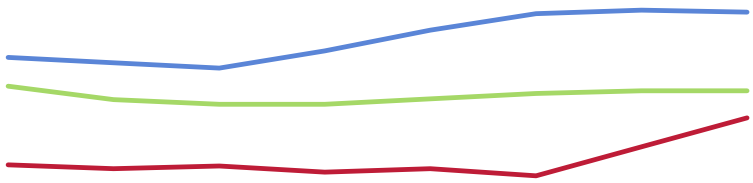
**Between 2017 and 2019, there was an annual average age-adjusted Alzheimer's disease mortality rate of 18.7 deaths per 100,000 population in Flathead County.**

BENCHMARK ► Lower than was found across the state and nation.




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

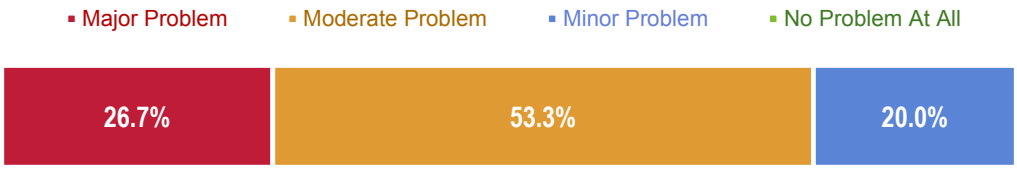
## Alzheimer's Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 13.5 | 13.1 | 13.4 | 12.7 | 13.1 | 12.3 | 15.5 | 18.7 |
| MT | 22.2 | 20.7 | 20.2 | 20.2 | 20.8 | 21.4 | 21.7 | 21.7 |
| US | 25.4 | 24.8 | 24.2 | 26.1 | 28.4 | 30.2 | 30.6 | 30.4 |

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

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




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

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

### Aging Population

> Flathead has a growing aging population, and the prevalence of Alzheimer's and related dementias is growing along with it. It is the 6th leading cause of death in Montana. Individuals with dementia and their families struggle to identify, access and afford supportive services and care. – Social Services Provider

### Awareness/Education

> Access to information is limited at times. I have worked in geriatric care within the community in the past and felt that the system was pretty clean, but recently am navigating care for a family member with dementia and it has not been a smooth process. For instance, the interface between clinical services and home care seems to be broken. – Social Services Provider

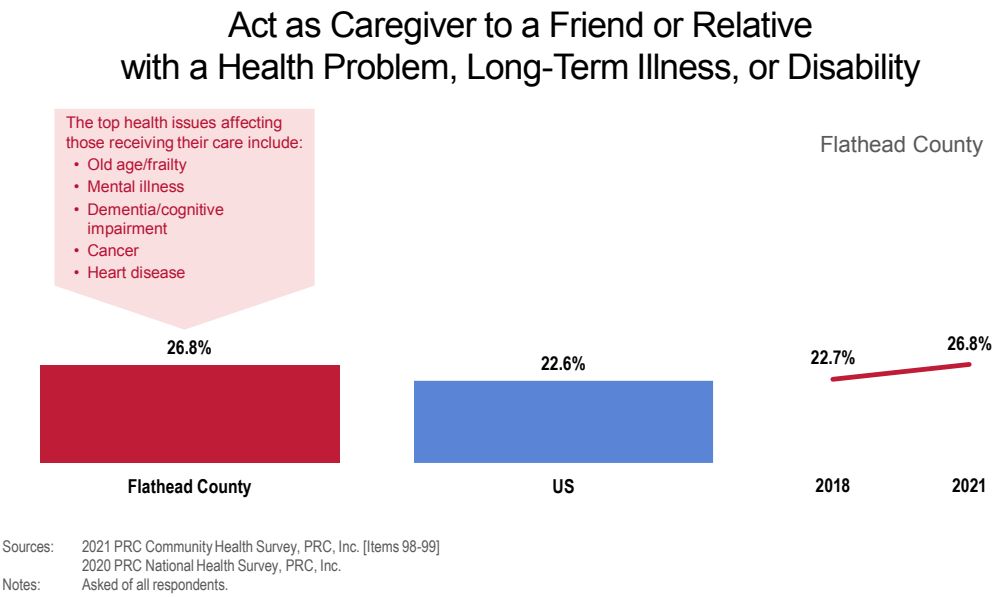
### Incidence/Prevalence

> I know many folks in our area as well as across the country with Alzheimer's and dementia. – Public Health Representative

### Access to Care/Services

> Support services for families and caregivers are limited and not cost effective. – Public Health Representative

## Caregiving




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 98-99]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

# BIRTHS

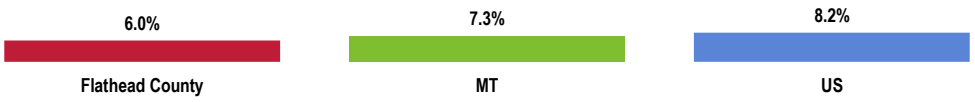
# BIRTH OUTCOMES & RISKS

## Low-Weight Births

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

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

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




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

## Infant Mortality

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

**Between 2017 and 2019, there was an annual average of 4.7 infant deaths per 1,000 live births.**

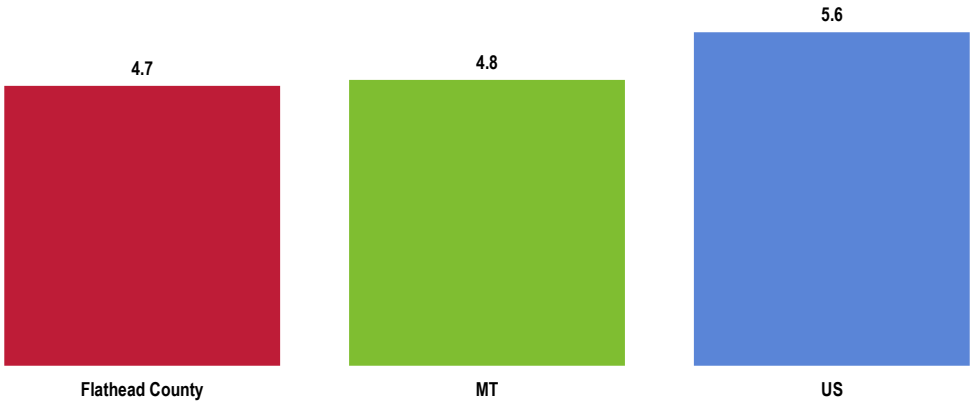
BENCHMARK ► Below the national rate.

TREND ► Fluctuating considerably, showing no clear trend.

## Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2017-2019)

Healthy People 2030 = 5.0 or Lower



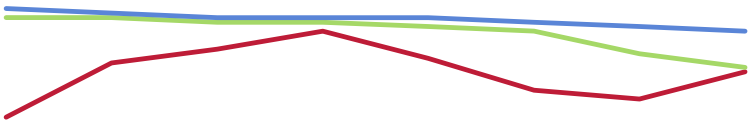

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

## Infant Mortality Trends

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

Healthy People 2030 = 5.0 or Lower



| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 3.7 | 4.9 | 5.2 | 5.6 | 5.0 | 4.3 | 4.1 | 4.7 |
| MT | 5.9 | 5.9 | 5.8 | 5.8 | 5.7 | 5.6 | 5.1 | 4.8 |
| US | 6.1 | 6.0 | 5.9 | 5.9 | 5.9 | 5.8 | 5.7 | 5.6 |

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2021.
Centers for Disease Control and Prevention, National Center for Health Statistics.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes: Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

# FAMILY PLANNING

## ABOUT FAMILY PLANNING

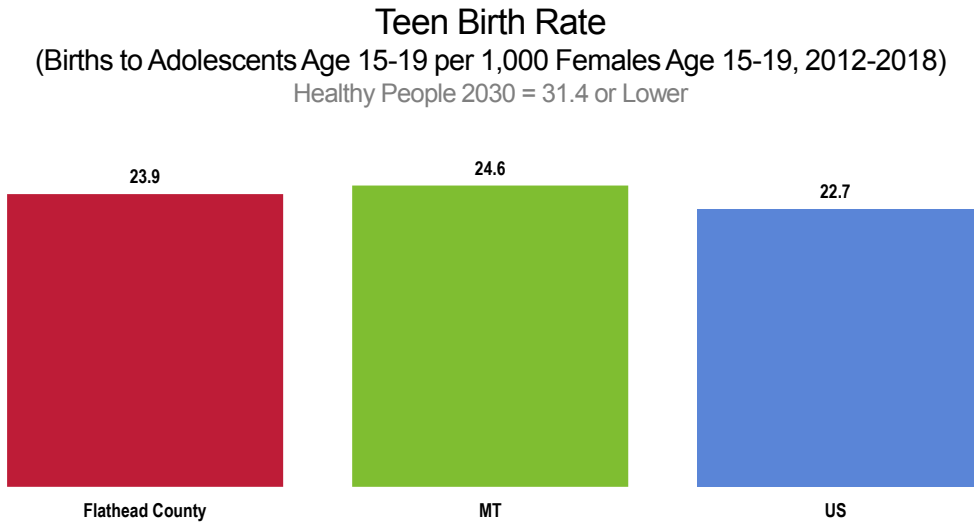
Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical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

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

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

## Births to Adolescent Mothers

**Between 2012 and 2018, there were 23.9 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in Flathead County.**

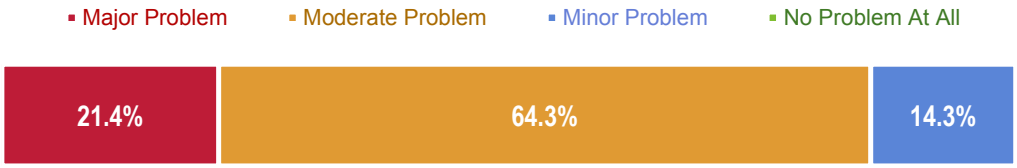



Sources: Centers for Disease Control and Prevention, National Vital Statistics System.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. August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

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

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

(Key Informants, 2021)




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

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

### Policy/Legislation

> Sex Ed and family planning services are under assault from our state legislature. – Social Services Provider

### Prevention/Screenings

> Infant health and family planning in Flathead County are major issues because of limited access to preventative measures. – Public Health Representative

### Stable Housing

> Failure to thrive due to lack of stable housing. – Social Services Provider

### Teen Pregnancy

> We have many teen pregnancies in Flathead County, which can be higher risk at times. That's the concern. – Public Health Representative

# MODIFIABLE HEALTH RISKS

# NUTRITION

## ABOUT NUTRITION & HEALTHY EATING

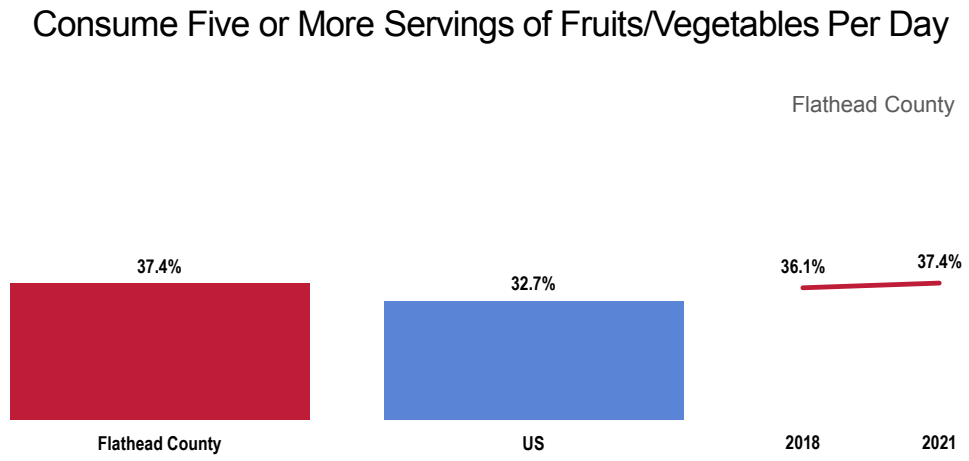
Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy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

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

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

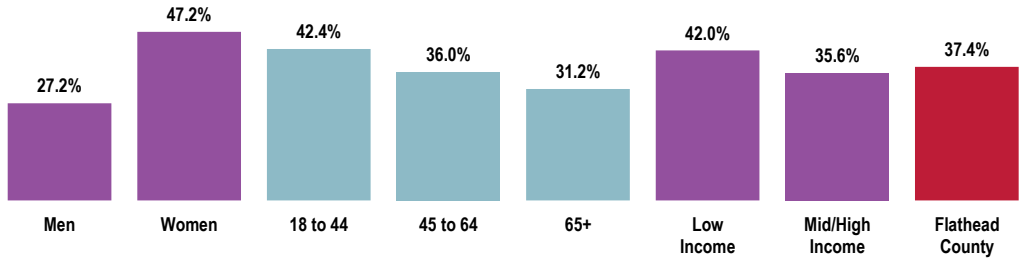
## Daily Recommendation of Fruits/Vegetables

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




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 125]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
For this issue, respondents were asked to recall their food intake on the previous day.

## Consume Five or More Servings of Fruits/Vegetables Per Day
(Flathead County, 2021)



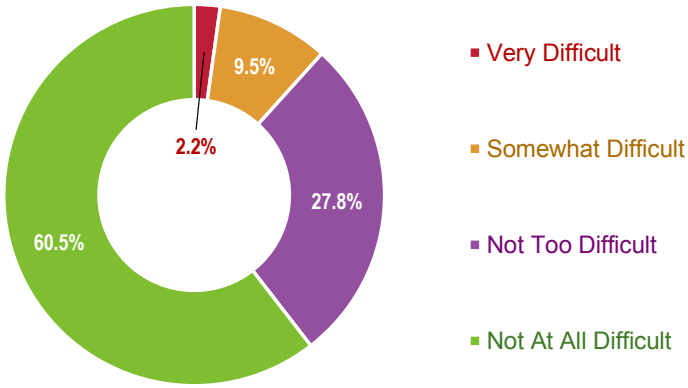

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 125]
Notes: Asked of all respondents.
For this issue, respondents were asked to recall their food intake on the previous day.

# Difficulty Accessing Fresh Produce

Respondents were asked: "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

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

## Level of Difficulty Finding Fresh Produce at an Affordable Price
(Flathead County, 2021)



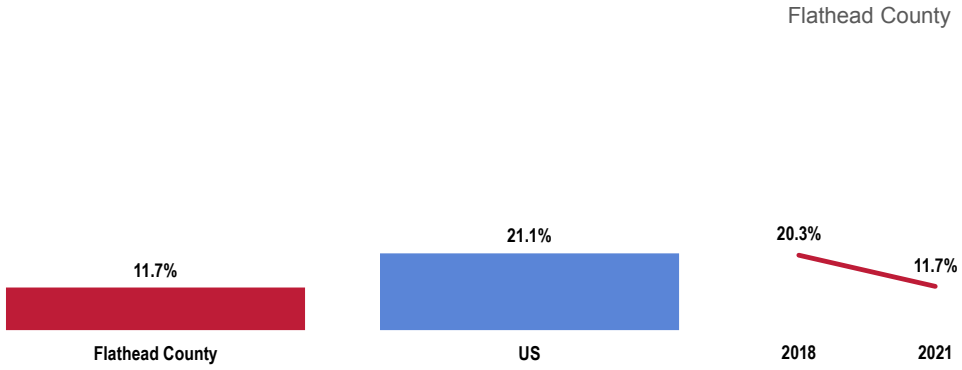

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: Asked of all respondents.

**However, 11.7% of Flathead County adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.**

BENCHMARK ► Well below that found across the US.

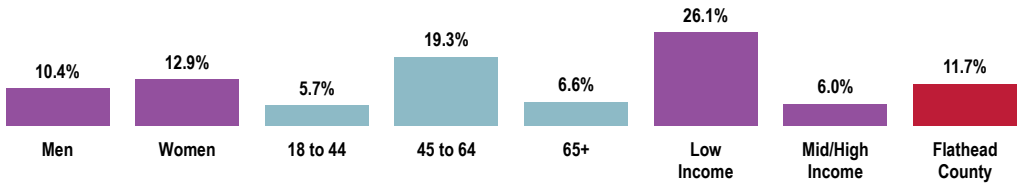
TREND ► A significant improvement since 2018.

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




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

## Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(Flathead County, 2021)




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

# PHYSICAL ACTIVITY

## ABOUT PHYSICAL ACTIVITY

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

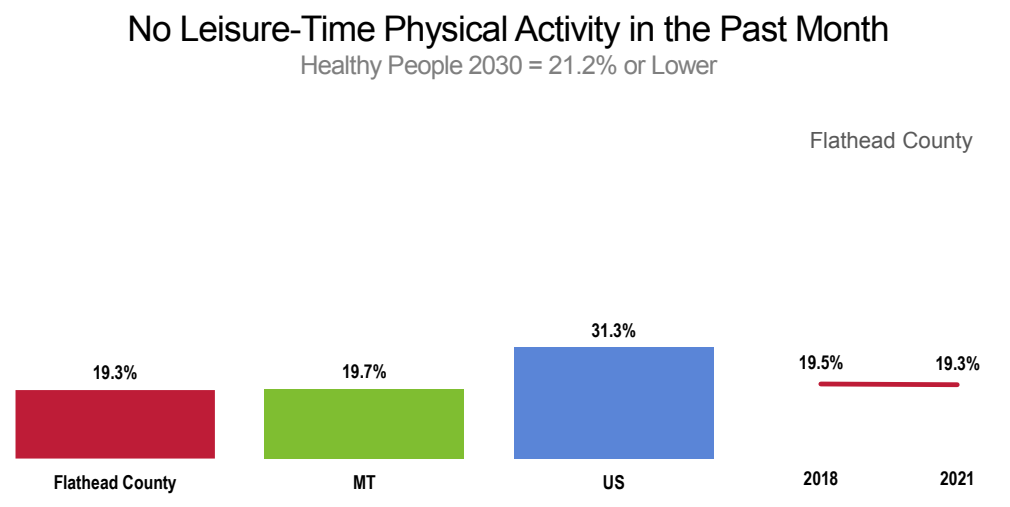
Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

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

## Leisure-Time Physical Activity

**A total of 19.3% of Flathead County adults report no leisure-time physical activity in the past**

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.




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

# Activity Levels

## Adults

### ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

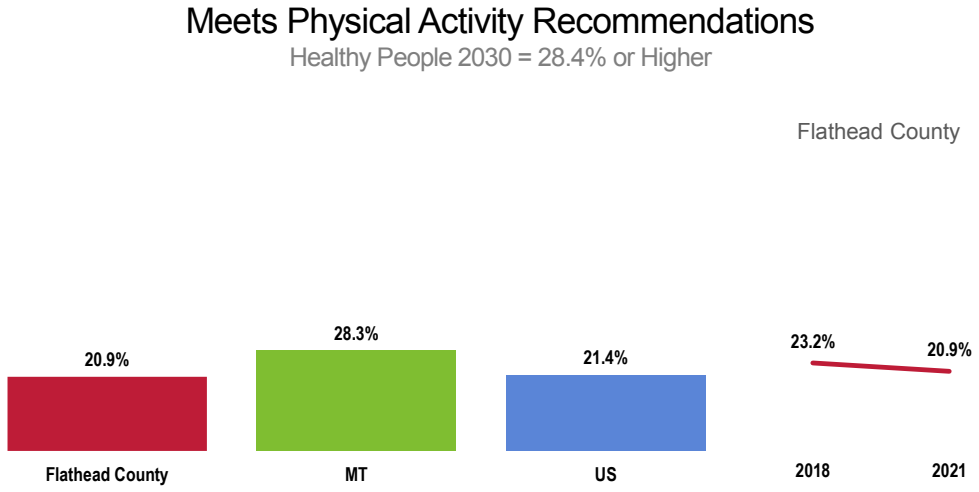
**A total of 20.9% of Flathead County adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).**

BENCHMARK ► Less favorable than the statewide percentage. Fails to meet the HP2030 target of 28.4% or higher.

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activities:

**Aerobic** activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

**Strengthening** activity is at least 2 sessions per week of exercise designed to strengthen muscles.



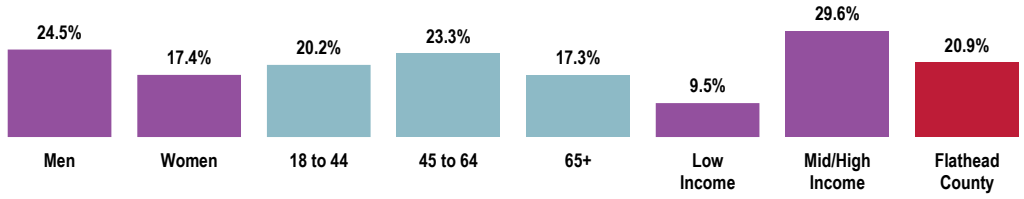

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 126]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.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

Notes: Asked of all respondents.
Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

## Meets Physical Activity Recommendations

(Flathead County, 2021)

Healthy People 2030 = 28.4% or Higher




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

Notes: Asked of all respondents.
Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

# Children

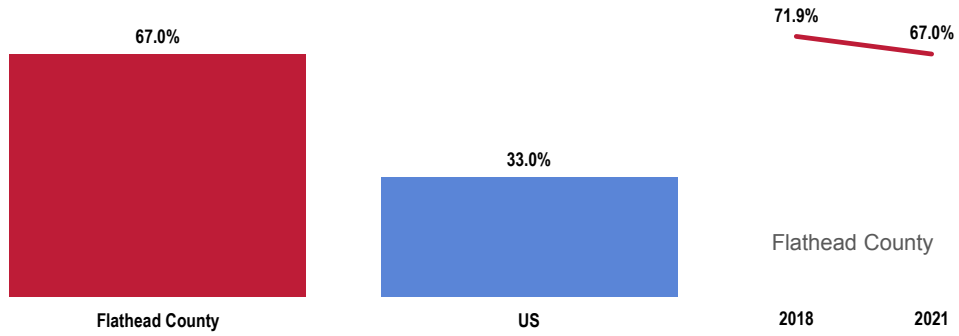
### CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

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

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

## Child Is Physically Active for One or More Hours per Day

(Parents of Children Age 2-17)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 109]
2020 PRC National Health Survey, PRC, Inc.

Notes: Asked of all respondents with children age 2-17 at home.
Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

# Access to Physical Activity

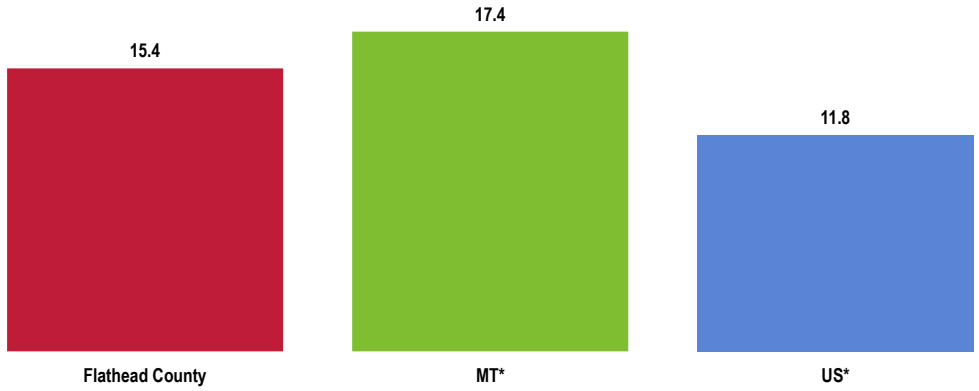
**In 2018, there were 15.4 recreation/fitness facilities for every 100,000 population in Flathead**

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

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

## Population With Recreation & Fitness Facility Access

(Number of Recreation & Fitness Facilities per 100,000 Population, 2018)




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 February 2021 via SparkMap (sparkmap.org).

Notes: Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.
*State and national rates reflect 2017 data.

# 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.

## Adult Weight Status

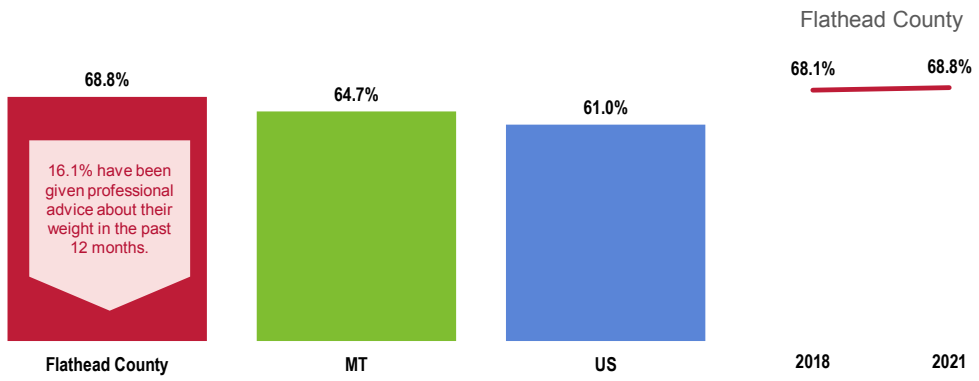
| CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI | BMI ($kg/m^2$) |
|---|---|
| Underweight | <18.5 |
| Normal | 18.5 – 24.9 |
| Overweight | 25.0 – 29.9 |
| Obese | ≥30.0 |

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

## Overweight Status

Here, "overweight" includes those respondents with a BMI value ≥25.

### Prevalence of Total Overweight (Overweight and Obese)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 128, 302]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.

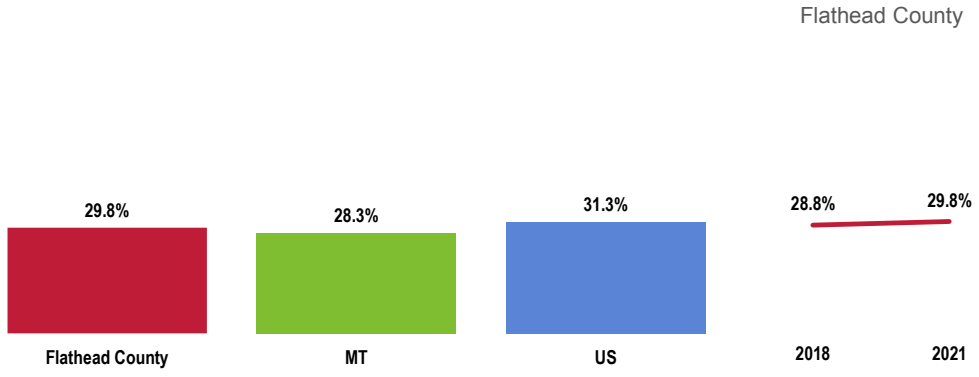
Notes: Based on reported heights and weights, asked of all respondents.
The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Note that 16.1% of overweight adults have been given advice about their weight by a health professional in the past year (while over 80% have not).

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

### Prevalence of Obesity

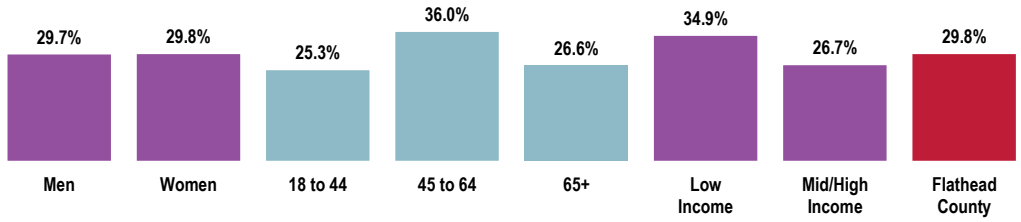
Healthy People 2030 = 36.0% or Lower




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes: Based on reported heights and weights, asked of all respondents.
The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

## Prevalence of Obesity
(Flathead County, 2021)
Healthy People 2030 = 36.0% or Lower

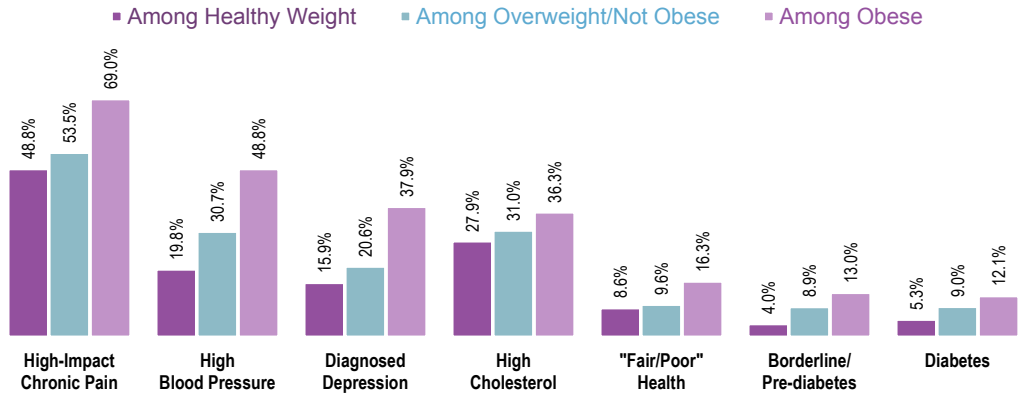



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Based on reported heights and weights, asked of all respondents.
The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

## Relationship of Overweight With Other Health Issues

The correlation between overweight and various health issues cannot be disputed.

### Relationship of Overweight With Other Health Issues
(Flathead County, 2021)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
Notes: Based on reported heights and weights, asked of all respondents.

# Children's Weight Status

## ABOUT WEIGHT STATUS IN CHILDREN & TEENS

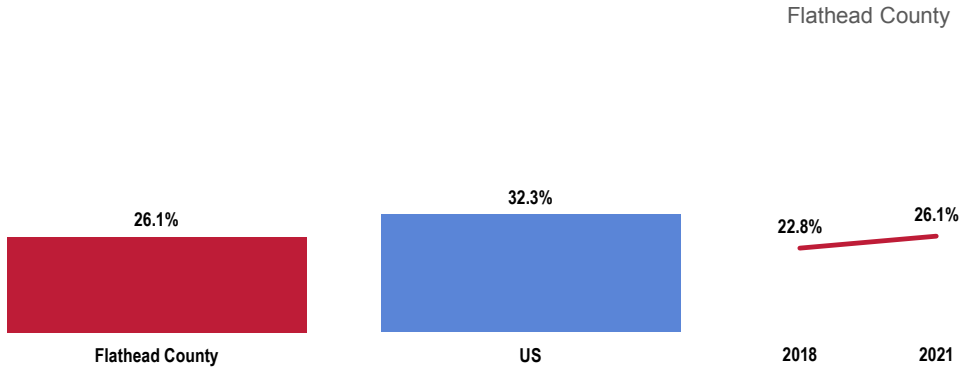
In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

– Centers for Disease Control and Prevention

### Prevalence of Overweight in Children
(Parents of Children Age 5-17)



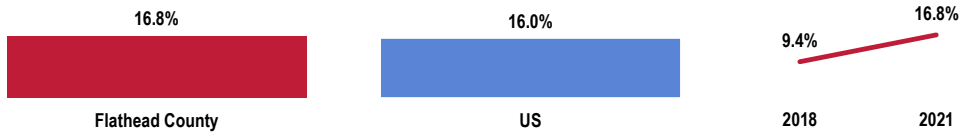

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 131]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents with children age 5-17 at home.
Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

**The childhood overweight prevalence above includes 16.8% of area children age 5 to 17 who are obese (≥95th percentile).**

BENCHMARK ▶ Similar to the HP2030 target of 15.5% or lower

## Prevalence of Obesity in Children
(Children Age 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)
Healthy People 2030 = 15.5% or Lower

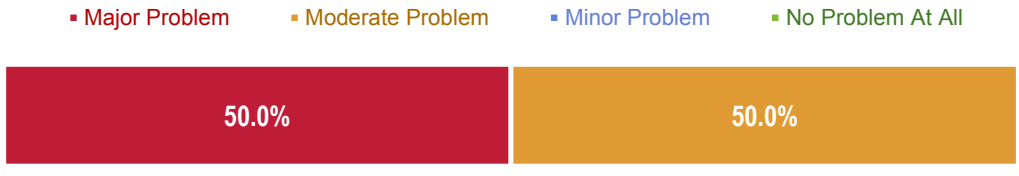
Flathead County




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 131]
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents with children age 5-17 at home.
Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

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

### Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2021)




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

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

### Contributing Factors

> The healthy choice is not always the affordable choice when it comes to nutrition. Many people do not have access to nutritious foods. Many also do not know about nutritious foods and how to prepare them. Physical activity has been a particular problem this past year as more people have spend the year in isolation, lock down, in front of a computer. There are many parts of our County that do not have sidewalks for safe walking, there are an increase in bike paths but some still lack connectivity without traveling on a busy street/highway. – Public Health Representative

> Cost of living, food, Long cold winters, and limited affordable indoor activities. – Public Health Representative

### Nutrition

> Our public schools serve privatized fast food. – Social Services Provider

> People being able to stick to a good nutritional diet and get the proper exercise. – Public Health Representative

### Obesity

> The three largest categories of mortality in the US (cancer, heart disease, COVID) all have one factor in common: obesity. As long as fast food and soda are cheap, it will be a challenge to get people to take responsibility for their health. School nutrition programs and getting quality produce to families make a difference – Social Services Provider

### Awareness/Education

> Maybe just some misinformation or misunderstanding surrounding the topic. – Social Services Provider

### Access to Affordable Healthy Food

> Access to affordable and healthy fresh food. – Community Leader

# SUBSTANCE ABUSE

## ABOUT DRUG & ALCOHOL USE

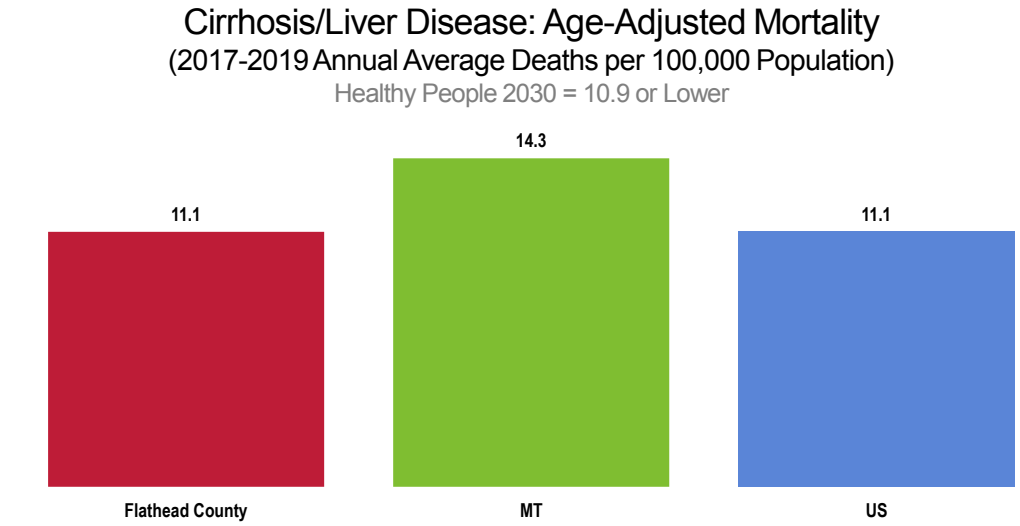
More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

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

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

## Age-Adjusted Cirrhosis/Liver Disease Deaths

**Between 2017 and 2019, Flathead County reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 11.1 deaths per 100,000 population.**

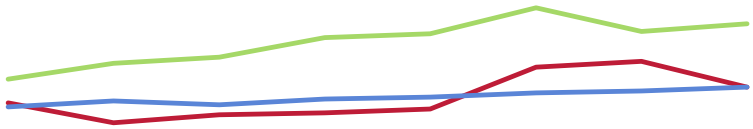



Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2021.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

## Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower



| | 2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|---|
| Flathead County | 10.3 | 9.3 | 9.7 | 9.8 | 10.0 | 12.1 | 12.4 | 11.1 |
| MT | 11.5 | 12.3 | 12.6 | 13.6 | 13.8 | 15.1 | 13.9 | 14.3 |
| US | 10.1 | 10.4 | 10.2 | 10.5 | 10.6 | 10.8 | 10.9 | 11.1 |

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

# Alcohol Use

## Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

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

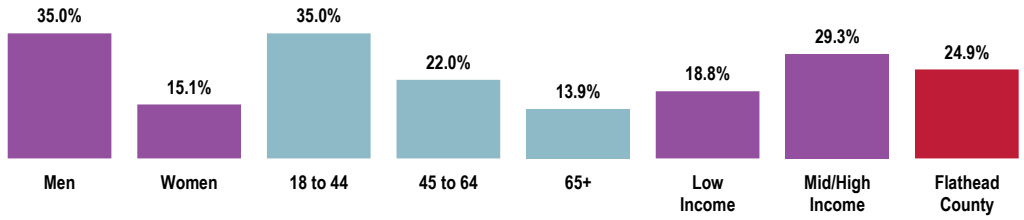
## Excessive Drinkers

Flathead County


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 136]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.

Notes: Asked of all respondents.
Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

## Excessive Drinkers
(Flathead County, 2021)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 136]
Notes: Asked of all respondents.
Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

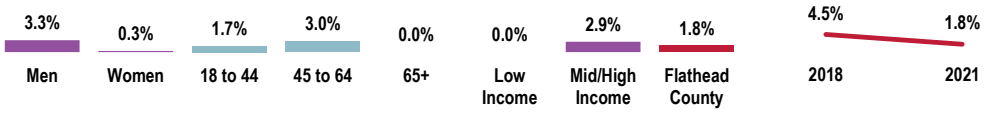
## Drinking & Driving

**A total of 1.8% of Flathead County adults acknowledge having driven a vehicle in the past month after they had perhaps too much to drink.**

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

### Have Driven in the Past Month After Perhaps Having Too Much to Drink

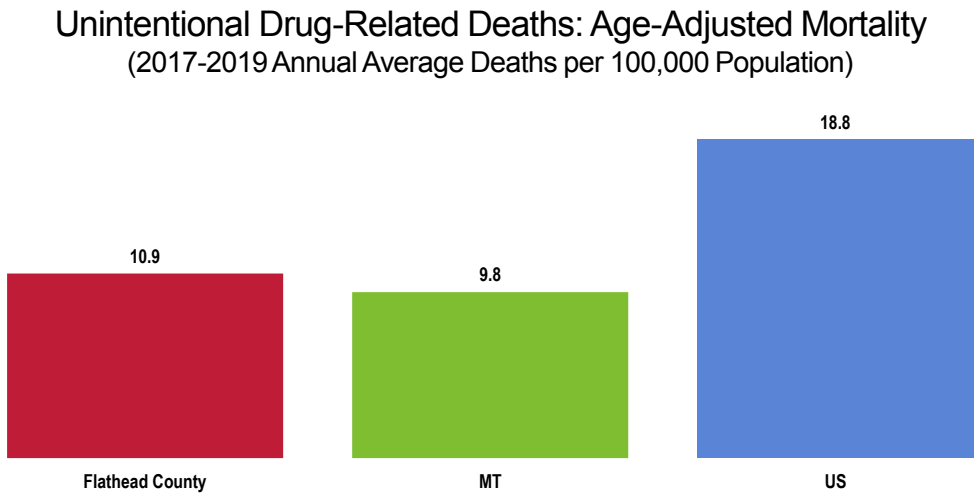
Flathead County



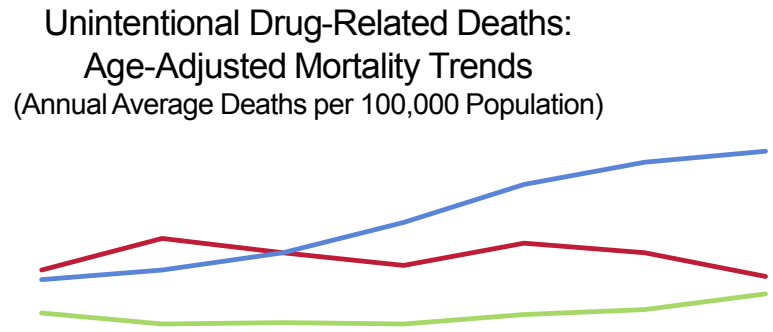

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: Asked of all respondents.

# Age-Adjusted Unintentional Drug-Related Deaths

**Between 2017 and 2019, there was an annual average age-adjusted unintentional drug-related mortality rate of 10.9 deaths per 100,000 population in Flathead County.**




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




| | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 |
|---|---|---|---|---|---|---|---|
| Flathead County | 11.3 | 13.3 | 12.4 | 11.6 | 13.0 | 12.4 | 10.9 |
| MT | 8.6 | 7.9 | 8.0 | 7.9 | 8.5 | 8.8 | 9.8 |
| US | 10.7 | 11.3 | 12.4 | 14.3 | 16.7 | 18.1 | 18.8 |

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

# Illicit Drug Use

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

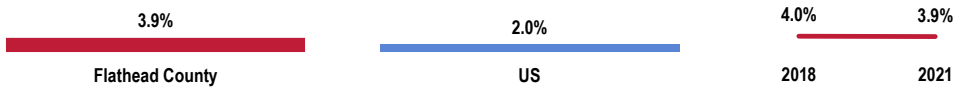
**A total of 3.9% of Flathead County adults acknowledge using an illicit drug in the past month.**

BENCHMARK ► Satisfies the HP2030 target of 12.0% or lower.

## Illicit Drug Use in the Past Month

Healthy People 2030 = 12.0% or Lower

Flathead County

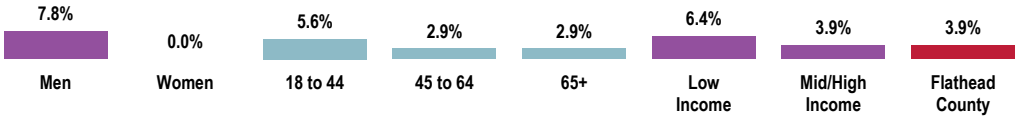



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 49]
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents.

## Illicit Drug Use in the Past Month

(Flathead County, 2021)

Healthy People 2030 = 12.0% or Lower



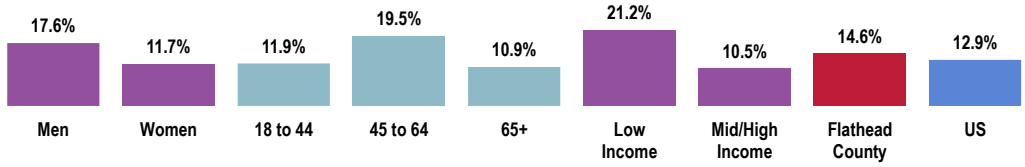

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 49]
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents.

# Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

**A total of 14.6% of Flathead County adults report using a prescription opioid drug in the past**

## Used a Prescription Opioid in the Past Year
(Flathead County, 2021)

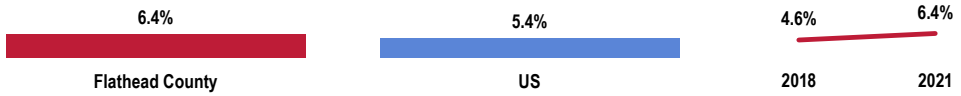



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 50]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

# Alcohol & Drug Treatment

## Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

Flathead County

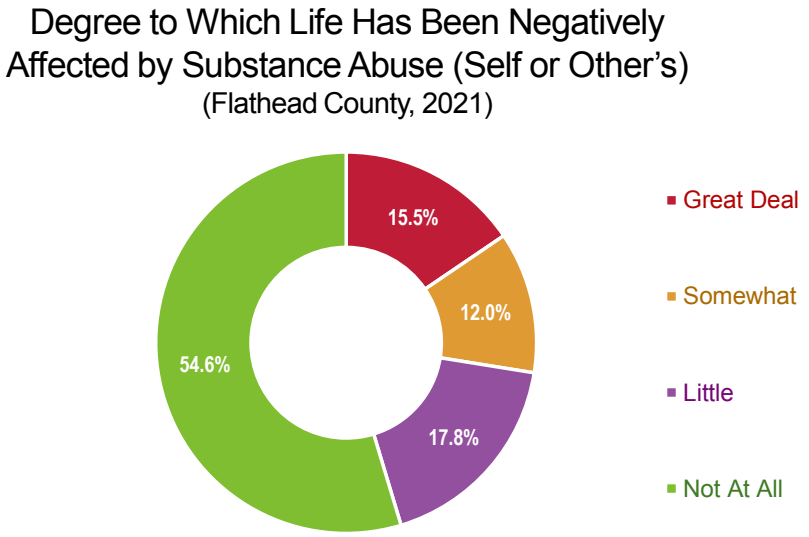



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 51]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

# Personal Impact From Substance Abuse

Area adults were also asked to what degree their lives have been impacted by substance abuse (whether their own abuse or that of another).

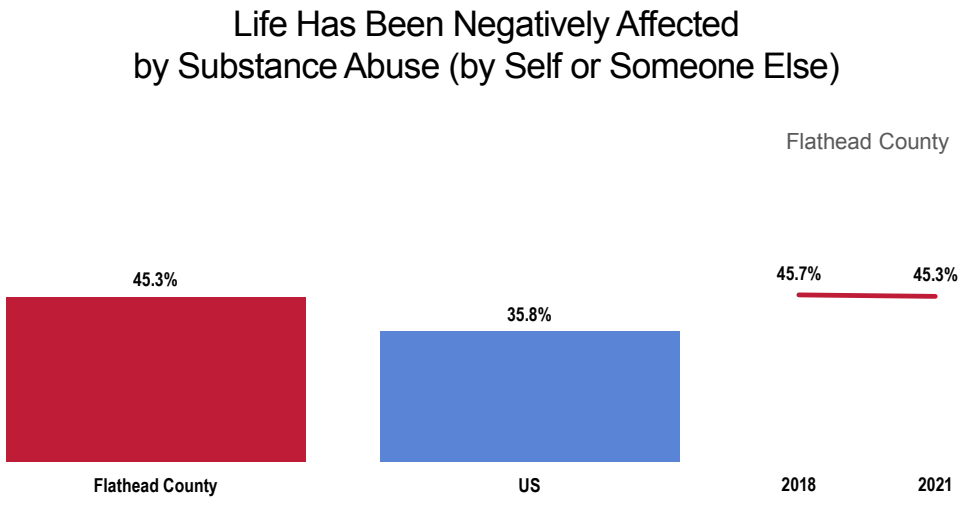
**Most Flathead County residents' lives have <u>not</u> been negatively affected by substance abuse**




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: Asked of all respondents.

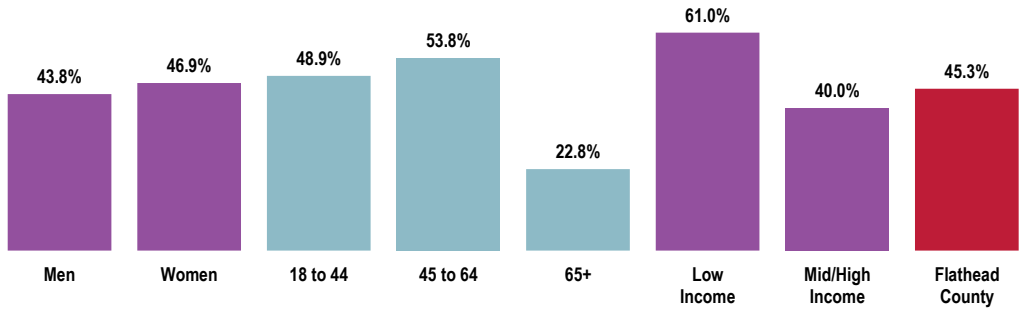
**However, 45.3% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").**

BENCHMARK ► Higher than the US percentage.




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Includes response of "a great deal," "somewhat," and "a little."

## Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)
(Flathead County, 2021)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: Asked of all respondents.
Includes response of "a great deal," "somewhat," and "a little."

## Perceptions of Substance Abuse as a Problem in the Community
(Key Informants, 2021)


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

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

### Access to Care/Services

> We have some outpatient options but very few inpatient options for those needing extended care. We lack facilities for medical detox. We have more options for medication assisted treatment for opioid use disorder but still lack options in the detention centers to offer MAT (funding is problematic...who pays for medications while in detention centers and how do they continue once out). Few options for other substance use disorders (methamphetamine). We do not have strong peer support networks in Flathead County. We have family treatment court but no other treatment court options for other Flathead County residents. – Public Health Representative
>
> No inpatient programs in the Flathead, money, time and cost required for treatment, transportation, wait times for programs. Refusal of some programs to treat Opioid disorders if the patient is using other substances, such as marijuana. – Public Health Representative

> Funding. Limited residential treatment options locally. – Social Services Provider
>
> Pathways says on their website and marketing materials that it can be used as a detox center, in my experience working with individuals with substance abuse issues, they turn them away every time and these folks are left with a hefty ER bill and no treatment, or worse the ER doc send them away with benzos which they end up hooked on. Drugs are a major issue in our community. – Social Services Provider

### Lack of Providers

> Limited number of providers, limited amount of health insurance coverage for treatment. – Public Health Representative
>
> Lack of quality providers. – Social Services Provider

### Denial/Stigma

> Stigma. Lack of resources. Lack of affordable treatment options. Providers not meeting users where they are at. People are not willing to see the problem. People complain about the problem but will not do anything to solve it. – Other Health Provider

### Impact on Quality of Life

> Falling a close second to mental health, substance use complicates every aspect of our patient's lives and inhibits their ability to seek and engage in care. – Public Health Representative

### Parental Influence

> Young people being exposed to and having access to substances as a result of use in the home by an adult or older household member. – Community Leader

### Follow-Up/Support

> People having the support they need. – Public Health Representative

## Most Problematic Substances

Key informants (who rated this as a “major problem”) clearly identified **alcohol** as causing the most problems in the community, followed by **methamphetamine/other amphetamines** and **heroin/other opioids**.

| SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Abuse as a “Major Problem”) | |
|---|---|
| Alcohol | 60.0% |
| Methamphetamines or Other Amphetamines | 20.0% |
| Heroin or Other Opioids | 20.0% |

# TOBACCO USE

## ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

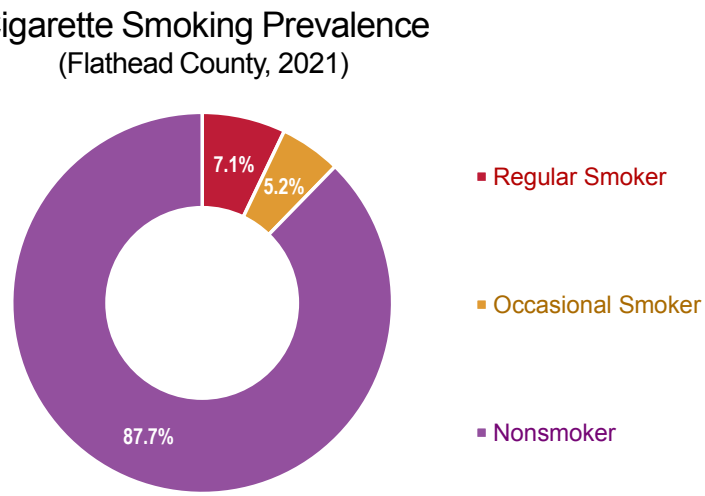
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including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

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

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

# Cigarette Smoking

## Cigarette Smoking Prevalence



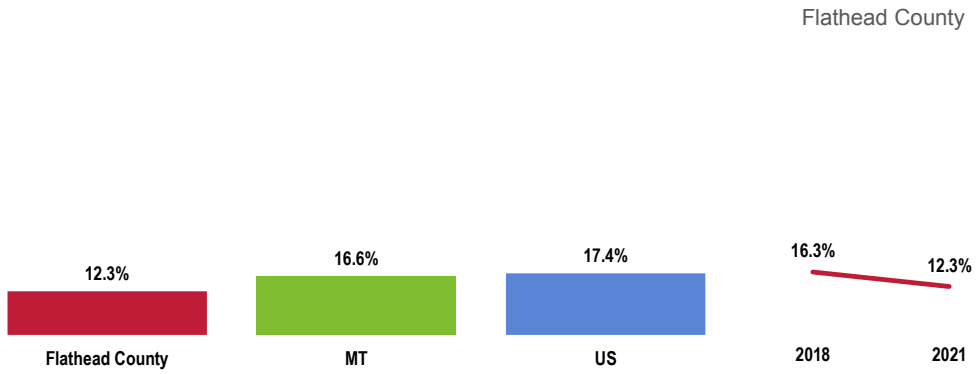

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: Asked of all respondents.

Note the following findings related to cigarette smoking prevalence in Flathead County.

BENCHMARK ► Smoking is significantly less prevalent among county respondents when compared to the state and nation. However, the county percentage fails to satisfy the HP2030 target of 5.0% or lower.

## Current Smokers

Healthy People 2030 = 5.0% or Lower



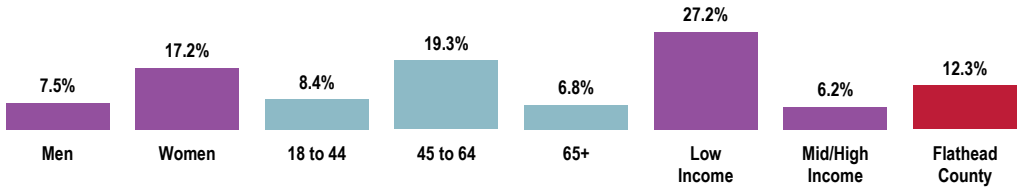

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes: Asked of all respondents.
Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

## Current Smokers

(Flathead County, 2021)

Healthy People 2030 = 5.0% or Lower



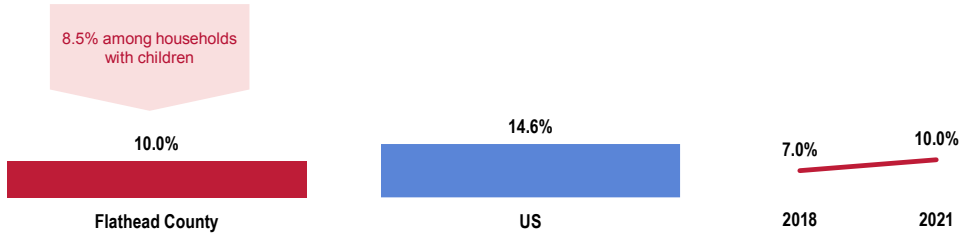

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes: Asked of all respondents.
Includes regular and occasion smokers (every day and some days).

## Environmental Tobacco Smoke

### Member of Household Smokes at Home

Flathead County

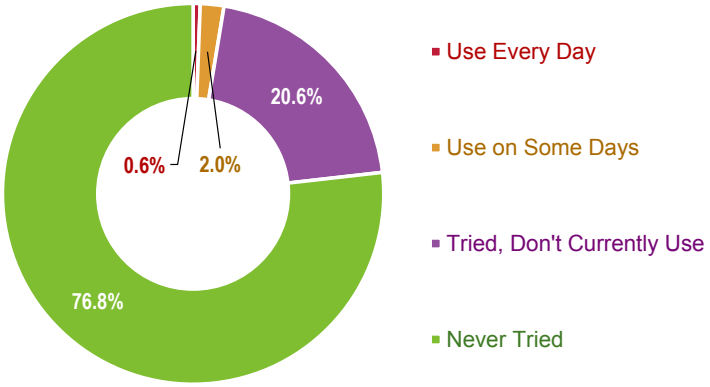



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
"Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

# Other Tobacco Use

## Use of Vaping Products

### Use of Vaping Products
(Flathead County, 2021)

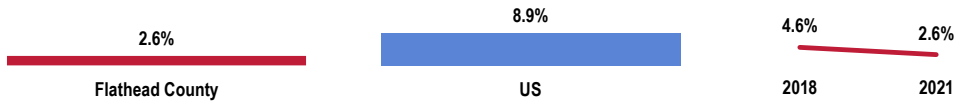



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
Notes: Asked of all respondents.

**However, 2.6% currently use vaping products either regularly (every day) or occasionally (on**

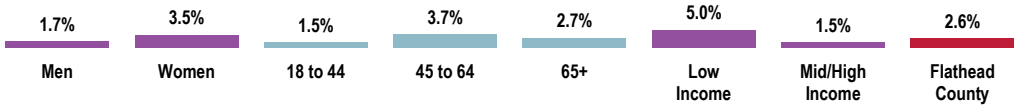
## Currently Use Vaping Products
(Every Day or on Some Days)

Flathead County



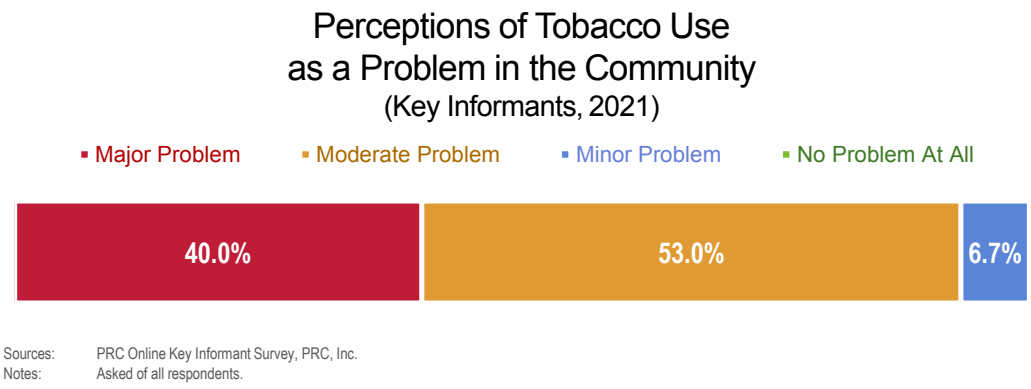

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
2020 PRC National Health Survey, PRC, Inc.
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2019 Montana data

## Currently Use Vaping Products
(Flathead County, 2021)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
Notes: Asked of all respondents.
Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

# Key Informant Input: Tobacco Use




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

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

## E-Cigarettes

> Young people vaping is increasing rapidly. – Community Leader
>
> Many people are vaping now, thinking it is okay. – Public Health Representative

## Easy Access

> Not many people use actual tobacco. It's the nicotine or salt nicotine products that are more prevalent. Easy access, vape shops not carding minors are creating addictions for our young people. – Social Services Provider

## Co-Occurrences

> The amount of people sick due to related illness. – Public Health Representative

## Incidence/Prevalence

> Isn't it a major problem in every community? – Social Services Provider

# SEXUAL HEALTH

## ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

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

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

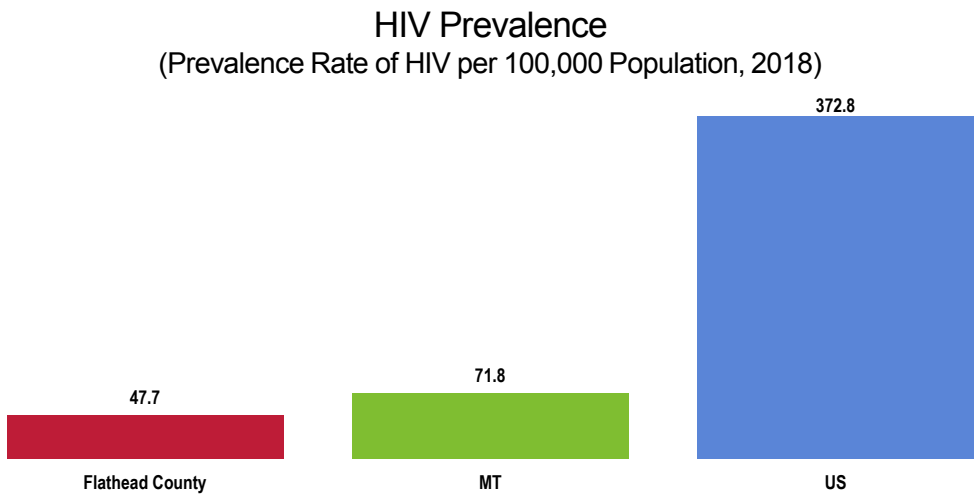
Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the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

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

# HIV

## HIV Prevalence

**In 2018, there was a prevalence of 47.7 HIV cases per 100,000 population in Flathead County.**




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 February 2021 via SparkMap (sparkmap.org).

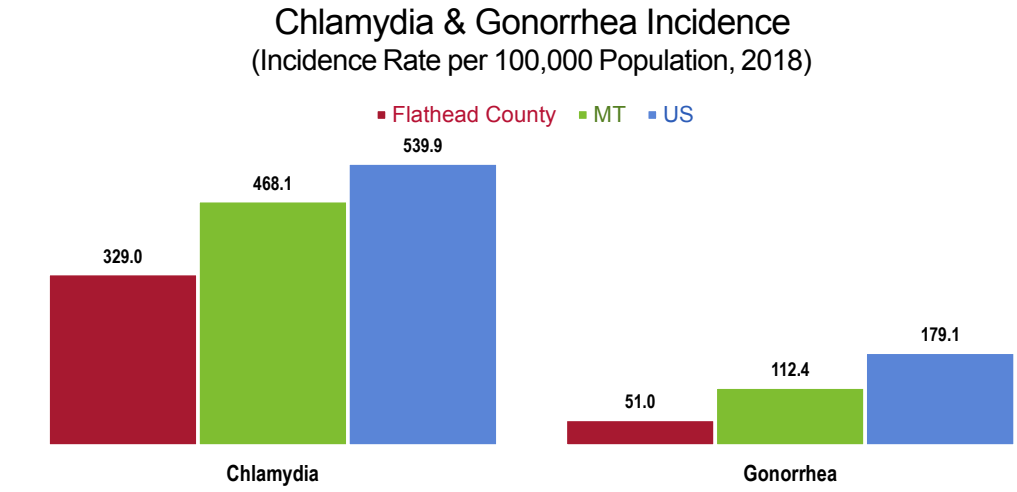
Notes: This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

# Sexually Transmitted Infections (STIs)

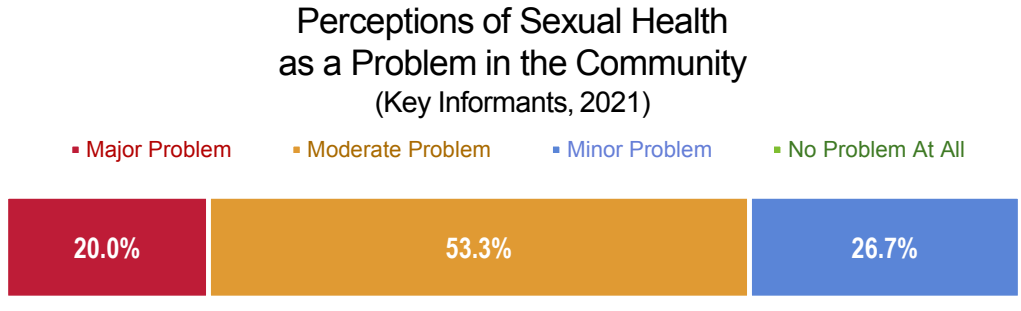
## Chlamydia & Gonorrhea

**In 2018, the chlamydia incidence rate in Flathead County was 329.0 cases per 100,000 population.**

**The Flathead County gonorrhea incidence rate in 2018 was 51.0 cases per 100,000 population.**




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 February 2021 via SparkMap (sparkmap.org).
Notes: This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.




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

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

### Contributing Factors

> Stigma. Lack of community support around prevention, and education. Religious influence discourages access to care. Limited funding. Limited support from County Commissioners and the State Government for programs that are trying to address this issue. – Other Health Provider

### Youth

> Our schools are not doing their part to educate students on safe sex. Lack of understanding on reproductive systems and safe sex with the younger generation. Working with youth most of them have had chlamydia or another STI at least once. – Social Services Provider

### Denial/Stigma

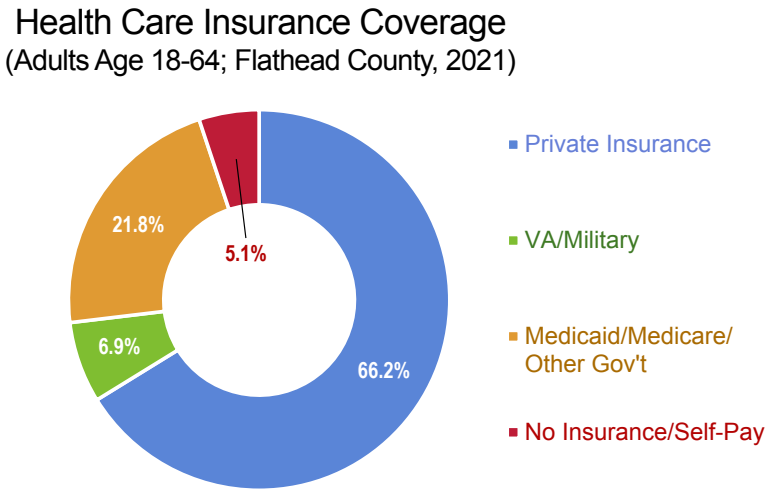
> Stigma, access to care, and cultural beliefs. – Public Health Representative

# ACCESS TO HEALTH CARE

# HEALTH INSURANCE COVERAGE

## Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
Notes: Reflects respondents age 18 to 64.

## Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

**Among adults age 18 to 64, 5.1% report having no insurance coverage for health care expenses.**

BENCHMARK ► More favorable than state and national findings.

TREND ► A significant decrease from 2018.

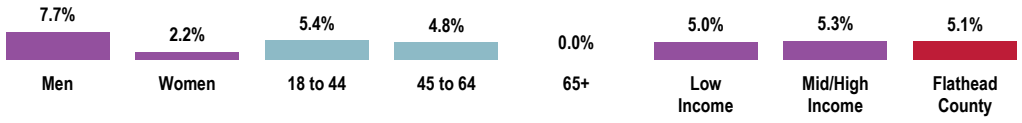
DISPARITY ► Higher among male respondents.

## Lack of Health Care Insurance Coverage
(Adults Age 18-64)
Healthy People 2030 = 7.9% or Lower

Flathead County


Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents under the age of 65.

## Lack of Health Care Insurance Coverage
(Adults Age 18-64; Flathead County, 2021)
Healthy People 2030 = 7.9% or Lower




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents under the age of 65.

# DIFFICULTIES ACCESSING HEALTH CARE

## ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

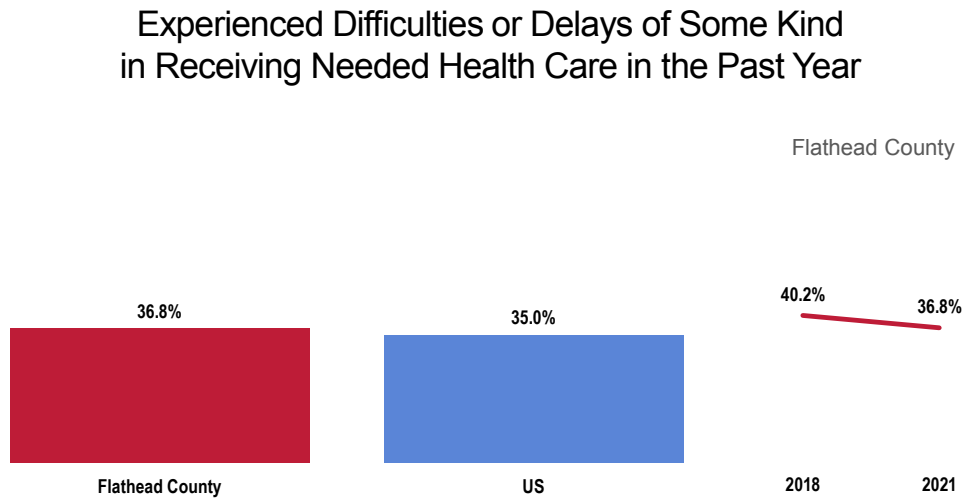
Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication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

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

## Difficulties Accessing Services

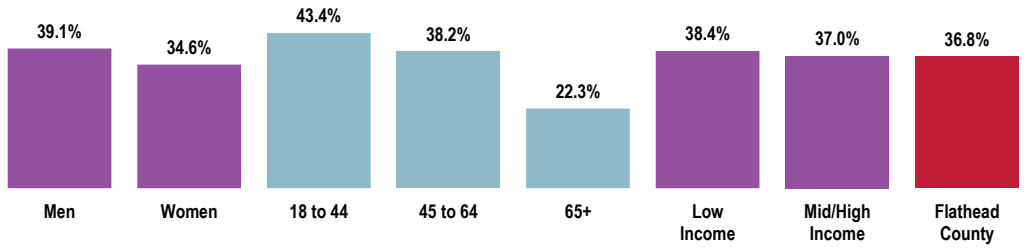
This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

**A total of 36.8% of Flathead County adults report some type of difficulty or delay in obtaining health care services in the past year.**




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.
Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

## Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Flathead County, 2021)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
Notes: Asked of all respondents.
Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

# Barriers to Health Care Access

**Of the tested barriers, appointment availability impacted the greatest share of Flathead County adults.**

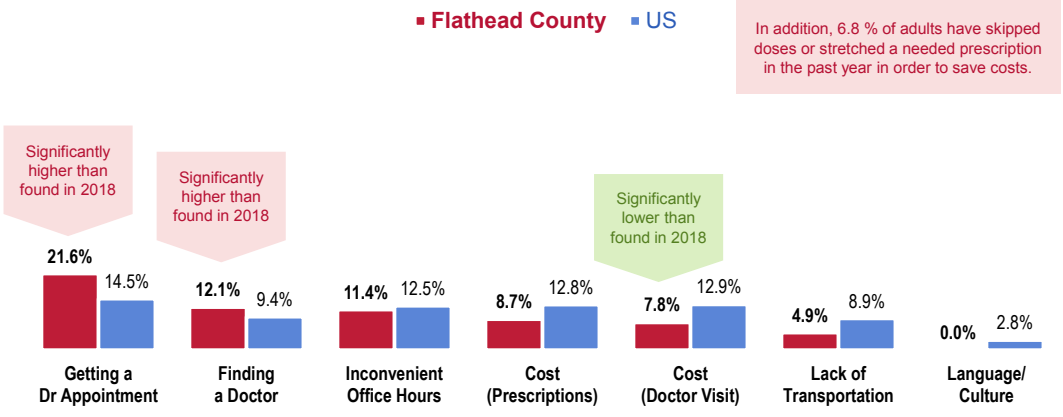
BENCHMARK ► While the barriers of cost (physician visits and prescriptions), transportation, and language affect lower shares of county adults than they do Americans nationwide, the barrier of appointment availability is much more prevalent locally than found nationally.

TREND ► Note the significant improvement in **cost of doctor visits** as a barrier to local adults; on the

To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

## Barriers to Access Have Prevented Medical Care in the Past Year



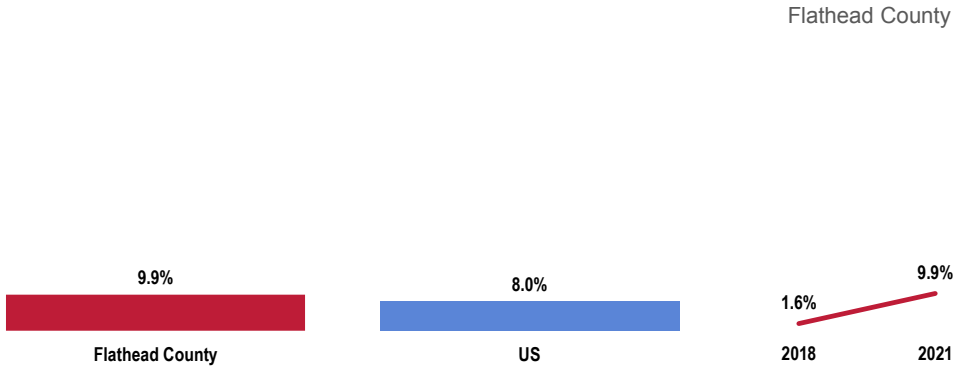

Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 7-14]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

# Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

**A total of 9.9% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.**

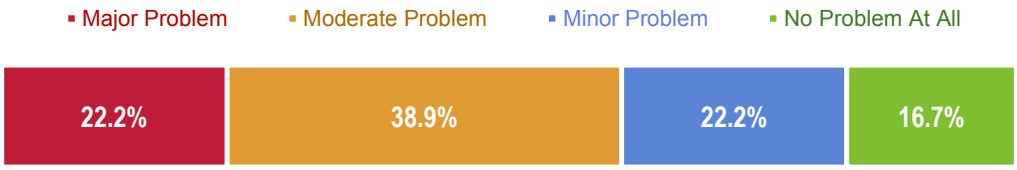
## Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 104]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.

## Key Informant Input: Access to Health Care Services

## Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants, 2021)




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

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

## Contributing Factors

> Money, transportation, knowledge of when it is appropriate to seek medical attention. – Public Health Representative
>
> Transportation, lack of insurance/money, general community distrust of KRMC, the almost KRMC monopoly, how unaffordable medications are, wait times, and a culture built to avoid preventative care. – Public Health Representative

## Access to Care/Services

> As our community continues to grow, there are long wait times for many appointments, in particular specialty appointments (mental health, cardiology, substance use treatment). There continue to be access issues for individuals in our most rural areas as well as access issues for those with no or inadequate insurance coverage. – Public Health Representative

# PRIMARY CARE SERVICES

## ABOUT PREVENTIVE CARE

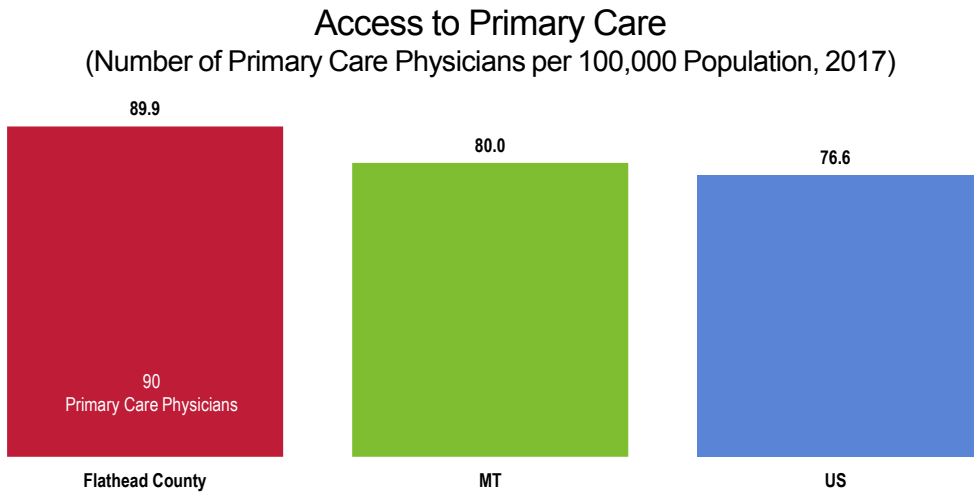
Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

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

## Access to Primary Care




Sources: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2021 via SparkMap (sparkmap.org).

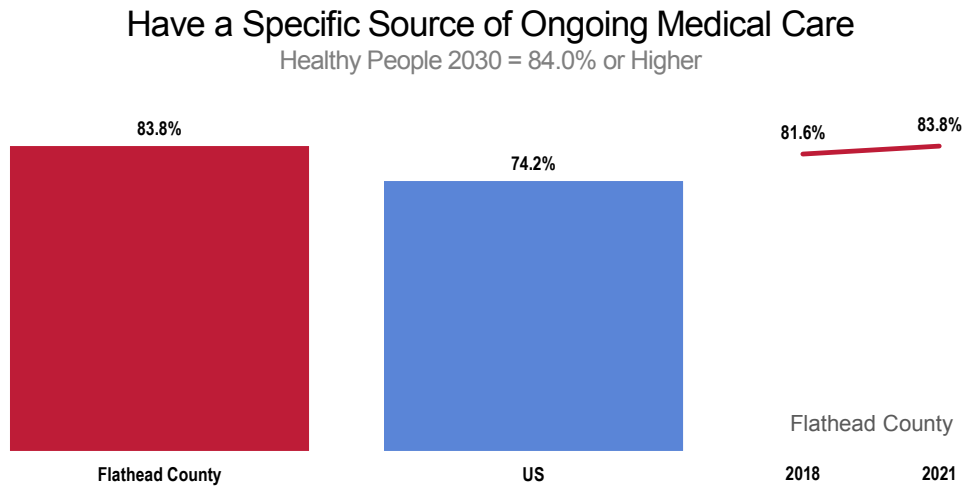
Notes: Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

# Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

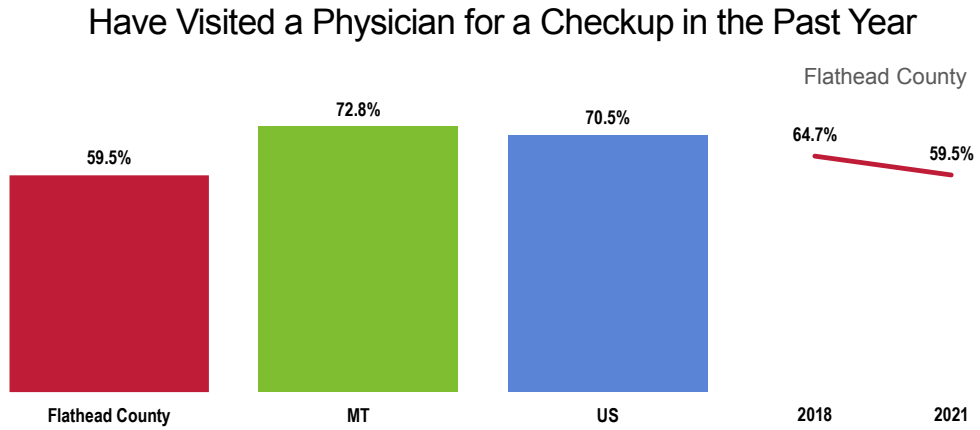
**A total of 83.8% of Flathead County adults were determined to have a specific source of**




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 139]
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents.

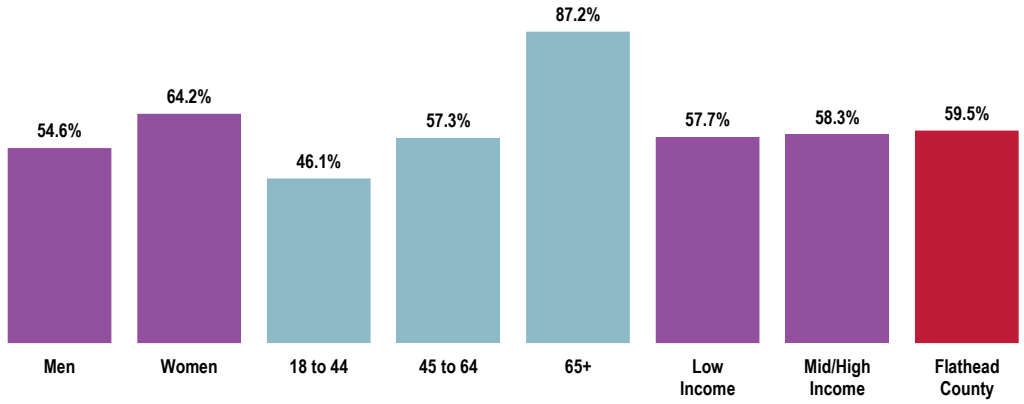
# Utilization of Primary Care Services

## Adults




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 18]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

## Have Visited a Physician for a Checkup in the Past Year
(Flathead County, 2021)

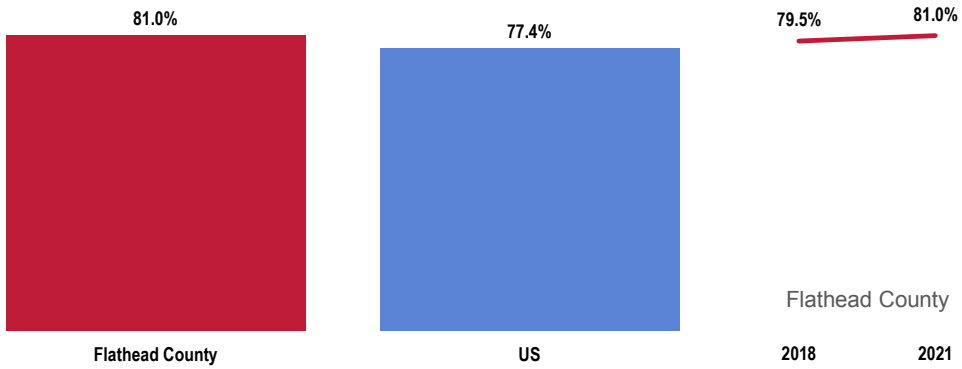



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 18]
Notes: Asked of all respondents.

## Children

**Among surveyed parents, 81.0% report that their child has had a routine checkup in the past**

## Child Has Visited a Physician for a Routine Checkup in the Past Year
(Parents of Children 0-17)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 105]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents with children 0 to 17 in the household.

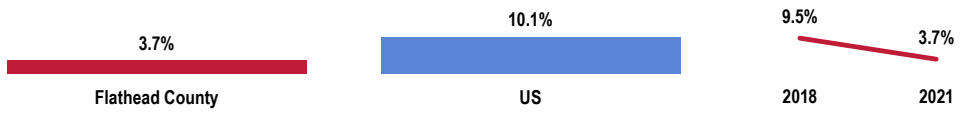
# EMERGENCY ROOM UTILIZATION

**A total of 3.7% of Flathead County adults have gone to a hospital emergency room more than once in the past year about their own health.**

BENCHMARK ► Lower than the US percentage.

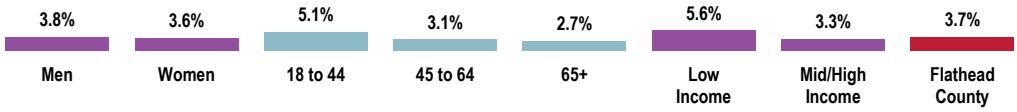
## Have Used a Hospital Emergency Room More Than Once in the Past Year

Flathead County




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 22]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

## Have Used a Hospital Emergency Room More Than Once in the Past Year
(Flathead County, 2021)




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 22]
Notes: Asked of all respondents.

# ORAL HEALTH

## ABOUT ORAL HEALTH

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

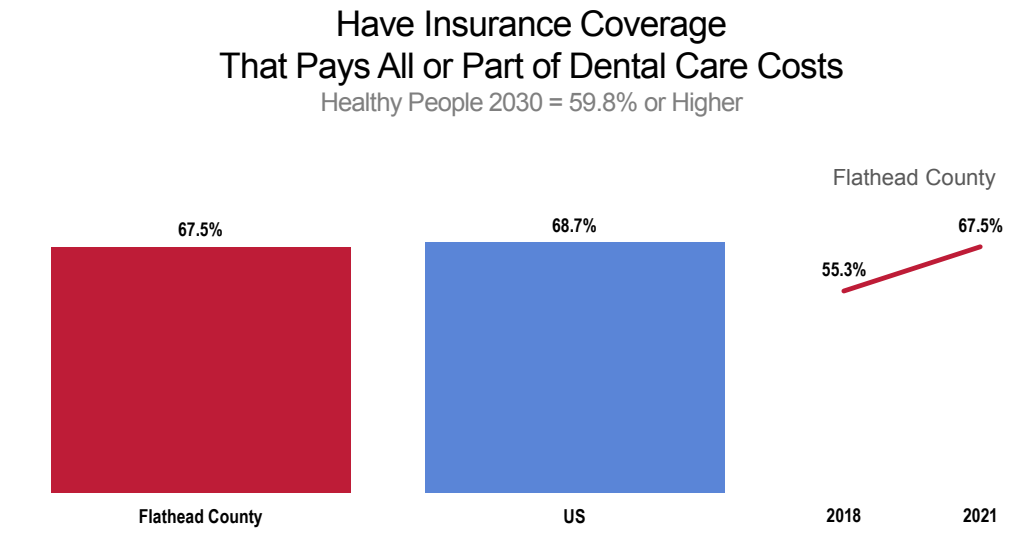
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

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

## Dental Insurance

**Over two-thirds of Flathead County adults (67.5%) have dental insurance that covers all or part of their dental care costs.**

BENCHMARK ► Satisfies the HP2030 target of 59.8% or higher.




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 21]
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents.

# Dental Care

## Adults

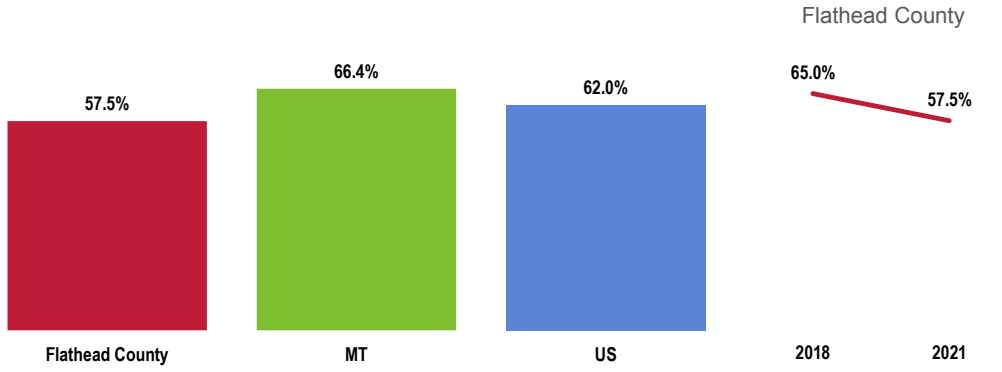
**A total of 57.5% of Flathead County adults have visited a dentist or dental clinic (for any reason) in the past year.**

BENCHMARK ► Lower than the statewide percentage. Satisfies the HP2030 target.

TREND ► Marks a significant decrease from 2018.

### Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher

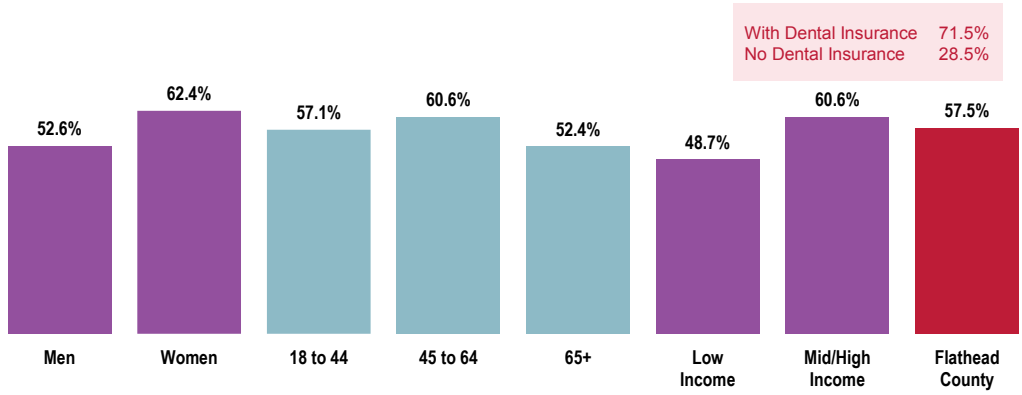



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Montana data.
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

### Have Visited a Dentist or Dental Clinic Within the Past Year

(Flathead County, 2021)

Healthy People 2030 = 45.0% or Higher

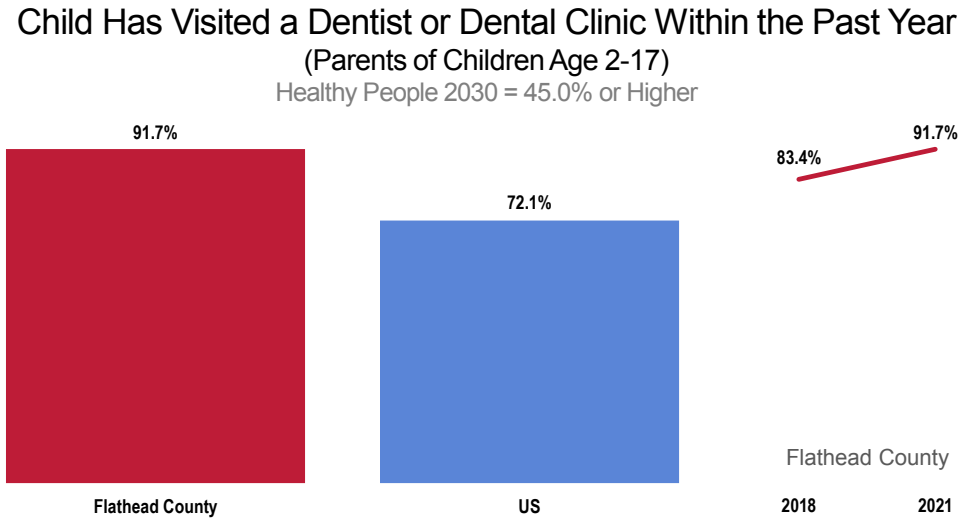



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents.

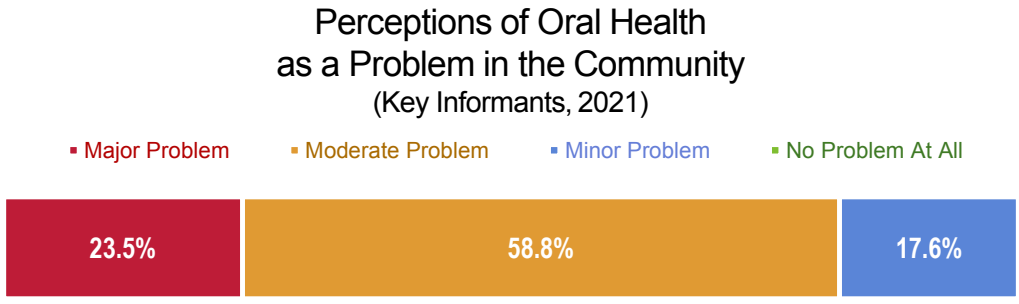
## Children

**A total of 91.7% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.**

BENCHMARK ► More favorable than the national finding. Satisfies the HP2030 target of 45.0% or




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 108]
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents with children age 2 through 17.




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

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

## Access to Care/Services

> Working with at risk teens, many of them have major dental problems when they come to our program. Limitations of Medicaid providers and overall cost for dental care is a major obstacle. – Social Services Provider

> Access to providers to address preventative and emergent dental situations. Lack of early childhood interaction with dentists. So great that the schools have the sealant programs. – Social Services Provider

## Affordable Care/Services

> There are limited providers offering oral health services that are affordable. Even patients with insurance end up paying high out of pocket expenses. This causes them to neglect their oral health. – Other Health Provider

## Contributing Factors

> Cost of dental care and fear of dentists. – Public Health Representative

# VISION CARE

**A total of 46.5% of Flathead County residents had an eye exam in the past two years during which their pupils were dilated.**

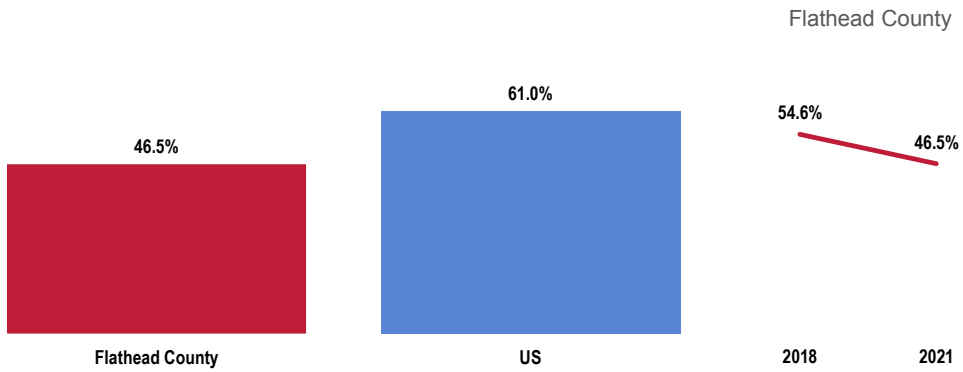
BENCHMARK ► Less favorable than the US finding. Fails to satisfy the HP2030 goal of 61.1% or higher.

TREND ► Marks a significant decrease since 2018.

DISPARITY ► Lower among adults younger than 65 and adults with lower incomes

## Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

Healthy People 2030 = 61.1% or Higher

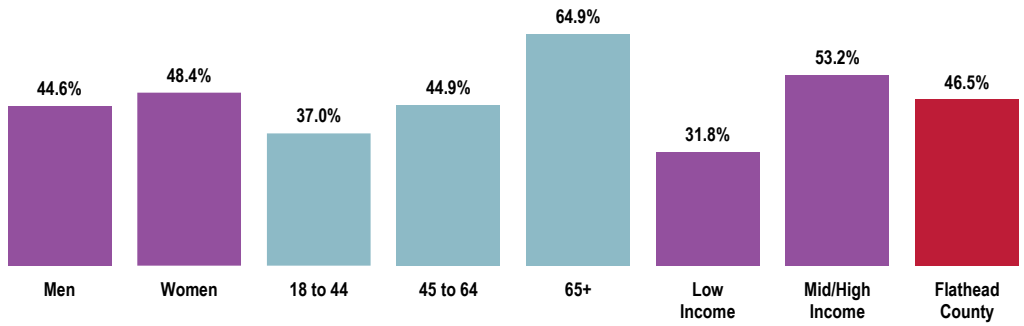



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 19]
2020 PRC National Health Survey, PRC, Inc.
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents.

## Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(Flathead County, 2021)

Healthy People 2030 = 61.1% or Higher

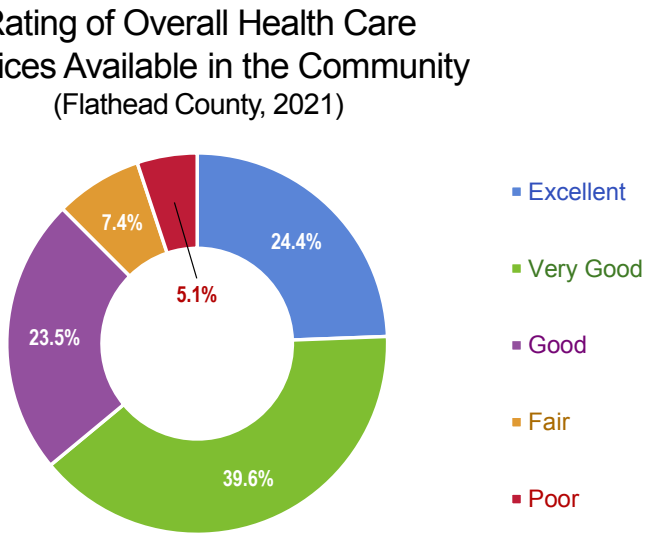



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 19]
US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: Asked of all respondents.

# LOCAL RESOURCES

# PERCEPTIONS OF LOCAL HEALTH CARE SERVICES

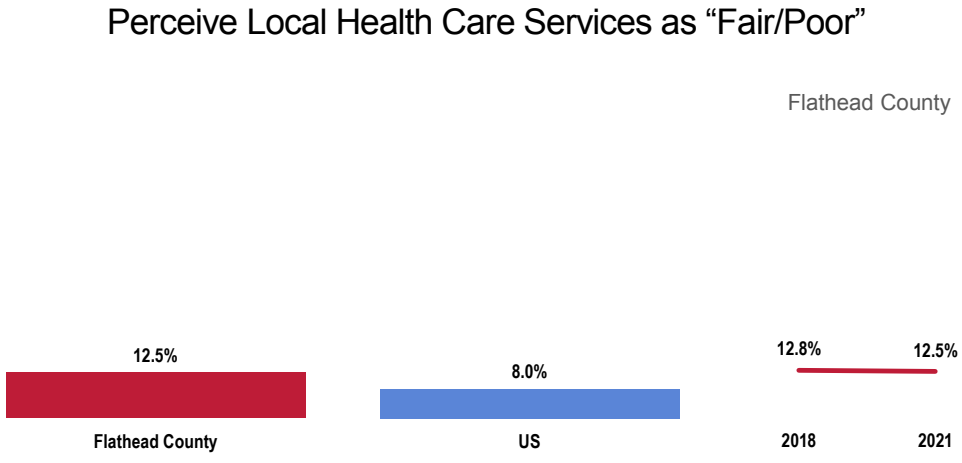
**Most Flathead County adults rate the overall health care services available in their community as "excellent" or "very good."**




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: Asked of all respondents.

**However, 12.5% of residents characterize local health care services as "fair" or "poor."**

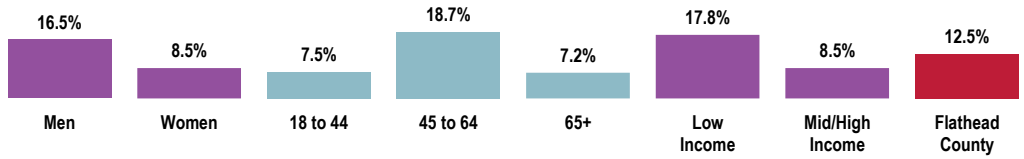
BENCHMARK ▶ Less favorable than the US percentage




Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
2020 PRC National Health Survey, PRC, Inc.
Notes: Asked of all respondents.

## Perceive Local Health Care Services as "Fair/Poor"
(Flathead County, 2021)

| | |
|---|---|
| With Access Difficulty | 84.1% |
| No Access Difficulty | 15.9% |

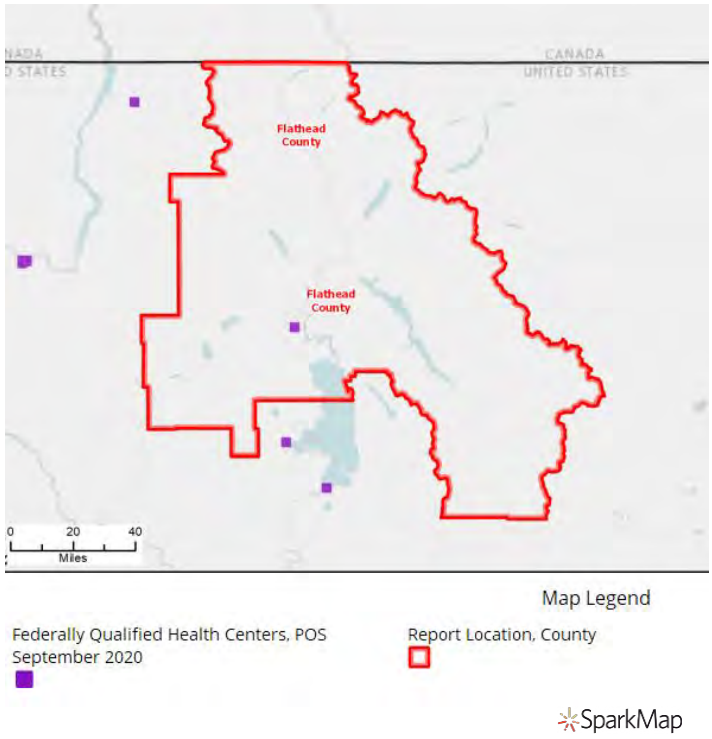



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: Asked of all respondents.

# HEALTH CARE RESOURCES & FACILITIES

## Federally Qualified Health Centers (FQHCs)

**The following map details Federally Qualified Health Centers (FQHCs) within Flathead County as of September 2020.**



# Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

### Access to Health Care Services

- Assist Transport Service
- Co-Responder Program
- County Needle Exchange Program
- Doctor's Offices
- Eagle Transit
- Family Planning
- Greater Valley Health Center
- Logan Health – Whitefish (dba North Valley Hospital)
- Shepherd's Hand
- Telehealth
- Western Montana Mental Health Center

### Cancer

- Flathead Cancer Aid Services
- Flathead County Health Department
- Health Department
- Infusion Clinic
- Logan Health – Whitefish (dba North Valley Hospital)
- Logan Health Medical Center (dba Kalispell Regional Medical Center)
- Mobile Mammography Unit
- Wings Regional Cancer Support

### Coronavirus

- Flathead County Health Department
- Greater Valley Health Center
- Logan Health – Whitefish (dba North Valley Hospital)
- Logan Health Medical Center (dba Kalispell Regional Medical Center)

### Dementia/Alzheimer's Disease

- Adult Protective Services
- Agency on Aging
- Alzheimer's Association
- Alzheimer's Support Group
- Doctor's Offices
- Flathead County Agency on Aging
- Immanuel Lutheran
- Support Groups

### Diabetes

- 340 (B)
- Agency on Aging
- DPP
- Greater Valley Health Center
- Health Center
- Logan Health Medical Center (dba Kalispell Regional Medical Center)
- Medication Assistance Programs
- Montana Children's Hospital
- Montana Youth Diabetes Alliance

### Disabilities

- Community Health
- Flathead County Agency on Aging
- Home Health Care
- Logan Health
- Logan Health – Whitefish (dba North Valley Hospital)
- Pain Center
- Physical and Occupational Therapists
- Shepherd's Hand
- Summit Independent Living
- Wellness Center

### Infant Health and Family Planning

- All Families Healthcare
- Clear Choice Clinic
- Community Health
- Flathead County Health Department
- Flathead Family Planning
- Health Department
- Hope Pregnancy
- Nurturing Center
- WIC

### Heart Disease

- Cardiac Rehab
- Doctor's Offices
- Flathead County Agency on Aging
- Flathead County Health Department

### Injury and Violence

- Abbie Shelter
- Child Protective Services
- Flathead County Health Department
- Judges
- Law Enforcement
- Prosecutors
- School System
- The Refuge

### Mental Health

- Community Health
- Co-Responder Program
- Crisis Co-Responder
- Doctor's Offices
- Family Born
- Greater Valley Health Center
- Gateway
- Intermountain
- Maternal Mental Health Coalition
- NAMI
- Newman Center
- PACT
- Pathways
- Private Practice Counselors
- Resource Group for PPD
- School System
- Sunburst
- Sweetgrass Psychological Services
- Warm Line
- Western Montana Mental Health Center

### Nutrition, Physical Activity, and Weight

- Community Health
- Farmer's Market
- Farmhands
- Fitness Centers/Gyms
- Food Bank
- Gateway
- Hospitals
- Logan Health Medical Center (dba Kalispell Regional Medical Center)
- MSU Extension Office
- Parks and Recreation
- School System
- Summit
- Support Groups
- WIC

### Oral Health

- Donated Dental
- Greater Valley Health Center
- Health Department
- Restoration Dental
- School System

### Sexual Health

- Doctor's Offices
- Greater Valley Health Center
- Flathead Family Planning
- Health Department

### Substance Abuse

- AA/NA
- Alpine
- Alpine Glow
- Community Medical Services
- Community Methadone Services
- Doctor's Offices
- Greater Valley Health Center
- Flathead Family Treatment Court
- Flathead Syringe Exchange
- Gateway
- Glacier Hope Homes
- Oxytocin
- Pathways
- School System

### Tobacco Use

- Health Department
- Quit Line
- School System

# APPENDICES: EVALUATION OF PAST ACTIVITIES

KALISPELL REGIONAL HEALTHCARE

# Kalispell Regional Healthcare and North Valley Hospital 2019 – 2022 Joint Implementation Plan in Response to the 2019 Flathead County Community Health Needs Assessment

As a result of the research and recommendations that appear in the 2019 Flathead County Community Health Needs Assessment and further exploration with hospital administrators, staff, and Boards of Directors, the following strategies, will guide the organizations in addressing the community's identified health needs over the next three years. These strategies were approved by the North Valley Hospital Board of Directors on June 25, 2019 and by the Kalispell Regional Healthcare Board of Trustees on June 27, 2019.

## *Comprehensive Care*

### 1. Mental Health and Substance Abuse:

Kalispell Regional Healthcare is committed to continuing the provision of mental health care through many existing services and activities including:

1. Pathways Treatment Center for acute mental health and substance abuse patients (adolescents and adults), and outpatient support groups for those discharged from Pathways Treatment Center.
2. Integrated Behavioral Health in nine primary care practices.
3. Comprehensive school-based treatment and mental health services for Bigfork, Columbia Falls, Kalispell, Somers/Lakeside, and Whitefish school districts.
4. The Newman Center, an outpatient mental health clinic.
5. Funding for a consortium of community members for mental health professionals/crisis response.
6. Funding for local transportation to/from medical appointments.

To augment these services, Kalispell Regional Healthcare and North Valley Hospital will:

## a. Alcohol and Tobacco Use

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Implement Tobacco Screening for every inpatient & outpatient | Increased identification, education and support services for patients impacted by alcohol and tobacco use. | • Costs for developing educational materials for patients and families as well as education and training materials for employees and providers.<br>• Resources at The Summit<br>• KRH Nurse Navigation team | • MT Tobacco Quit Line<br>• NVH Care Coordination team | The Primary Care Service Line developed and implemented a standardized workflows for Medical Assistants rooming patients for screening of tobacco. This was not completed for the inpatient arena |
| **2.** Develop a care pathway for education and support of patients who use alcohol or tobacco | Increased staff and provider knowledge related to importance of screening as well as resources available to support patients and their families in a team based approach to treatment and cessation. | | | This was not developed due to EMR capabilities during this time frame. The organization is now using ZYNX software for Care Pathway development and standing orders. |

| | | | | |
|---|---|---|---|---|
| 3. Educate providers and implement SBIRT (Screening, Brief Intervention, and Referral to Treatment) for every inpatient/outpatient | Patient identification, education and referral as necessary to access the appropriate treatment. | | | SBIRT TRAINING completed with Maternal Care providers thru National council BH/Virn a Little LCSW/LAC 2021 Logan Health participated in Community collaborative with School District 5 and Lindeman Education, Montana Healthcare Foundation to SBIRT screen all adolescents and train teaching staff and counselors 20-20-9-2021 |
| **4.** Provide education and communication around Tobacco-Free Campus | Improved patient engagement and continuous messaging in support of patient smoking cessation. | | | Signage is up in the Primary Care Practices and staff have been educated |

**b. Opioid Use and Medication Assisted Therapy**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Work with NVH to implement system-wide opioid policy, which includes patient contracts to assure patient safety, education, monitoring, compliance, and monitoring of opioid utilization | Create consistency for treatment of patients across the KRH system. Help prevent potential drug diversion. | • Cost of staffing hours to support initiatives and task force development and participation.<br>• Cost for continued education to staff and providers regarding awareness and alternative treatment options. | • Flathead County Health Department<br>• Independent Medical Groups in the Flathead Valley<br>Flathead Valley Chemical Dependency<br>• Alpenglow Medical<br>• Dickerson Counseling<br>• Primary Care Physicians<br>• Schools<br>• Local TV & Radio<br>• Law Enforcement<br>• First Responders | A joint policy and implementation of the policy "Prescription Of Long Term Opioids"<br>  <br>Long term Opioid policy.pdf<br>Utilizing our Business Clinical Analytics capabilities a Dashboard is being created to Monitor the requirements set forth in this policy. |

| | | | | |
|---|---|---|---|---|
| 2. Conduct provider education around prescribing practices | Build bonds between primary care and an additional pain care option for patients. | • Cost for providing community education to include marketing and staffing hours | | Education was completed for The implementation of the Policy through Medical Staff meetings, Departmental meetings. Currently we are in process of a dashboard to track all the requirements of this policy for Provider follow up. |
| 3. Include Physical Therapy and Occupational Therapy in the treatment plan | Cultivate stronger collaboration for alternative treatment options utilizing therapy services. | | | This did formally occur. Informally PT has been involved In providing alternatives to narcotics for years. |
| 4. Improve access to medication assisted treatment & associated opioid treatment modalities | More resources for patient care options. | | | Nothing new was developed however we continue to refer to the Montana Treatment Center for Pain as needed. Participating in state initiative Meadowlark dealing with maternal OUD and early intervention. Hired Care coordinator for maternal care screenings and referrals for MAT |
| 5. Develop community communications on the scope and impact of the opioid epidemic | Expand community awareness and understanding regarding the gravity and detriments of the opioid epidemic. | | | This did not occur primarily due to the COVID 19 outbreak of 2020 and its lingering effects. |

**c. Suicide Prevention**

***Kalispell Regional Healthcare will:***

| *Action* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Implement PHQ9 depression screening for inpatients and ambulatory outpatients | Increased identification of needs for support and treatment of depression and suicide. | • Costs related to education and training materials for staff and providers | • Nate Chute Foundation<br>• NVH Foundation | Primary Care screening has significantly improved. Now working on other ambulatory clinics.<br>Inpatient is screening all patients who present in the ED and all those that are admitted to the hospital. Currently working on a campaign to ensure patients are also being screened in specialty clinics and other outpatient areas<br>Implemented depression and CCSR in Maternal care ambulatory. Partnered with the State of MT, HRSA, and community to address Post partum Depression and SUD issues in pregnant woman, aka Meadowlark |
| 2. Develop systematic pathway to connect patients with support and services they need | Increased staff and provider awareness of patients struggling with depression or suicidal ideation and resources available for their support and treatment. | | | Struggled with IBH resources in every clinic- however have developed pathway for patients with depression and SI. Organization-wide campaign around depression and suicide-risk screening of patients across |

| | | | | |
|---|---|---|---|---|
| | | | | the continuum. Talking about this topic frequently and meeting with teams to ensure patients are being screened and the staff and providers have the appropriate resources to provide interventions. |
| 3. Increase collaboration with community partners to support patient needs | Enhanced relationships with community partners to provide support services to patients. | | | Developed better relationships with independent and county sponsored resources to support patients and families. Formed BH Collaborative with NVH, County and first responders 9-20 to current. Meet monthly RN navigators participate in the NW Coalition group, which meets monthly. This group provides education to members of the group to new or available resources. It also provides a networking opportunity so all agencies are connected to better serve the community. Patriciates in Community Crisis response team ndtraining meeting monthly with law enforcement, 2 ER's, Veterans, and Youth Court |

## 2. Chronic Disease Management and Prevention

Kalispell Regional Healthcare has invested and will continue to invest in many programs and services to treat some of the most prevalent causes of death in our county including:

1. Participation in the Comprehensive Primary Care Plus (CPC+) program in partnership with Medicare, Medicaid, Blue CrossBlue Shield, Pacific Source and Allegiance to prevent and manage chronic diseases through a care coordination activities.
2. A comprehensive cardiovascular program that includes interventional cardiology, heart surgery, electrophysiology, cardiac rehabilitation, a heart failure clinic and prevention education.
3. A comprehensive cancer program that includes medical oncology, surgical oncology, radiation oncology, supportive care and preventive screenings.
4. A Neuroscience & Spine Institute that includes neurosurgery, neurology, and a stroke program.
5. A Diabetes Care and Prevention Center that provides group education, one-on-one counseling and chronic disease management education.
6. The Journey to Wellness program to assist patients with gestational diabetes care and individuals with chronic health conditions/challenges.
7. The Healthy Measures program to facilitate corporate wellness, both at Kalispell Regional Healthcare and other employers throughout the region.
8. Mammograms to women in financial need through the Save a Sister free mammography initiative to lessen the impact of breast cancer in our community. The cost of mammograms is covered for underserved community members and education is provided on the importance of screening mammograms.
9. Spring into Safety Campaign.
10. Education of school staff, parents and children on the dangers of smoking and e-cigarettes.

**a. Respiratory Disease**

*Kalispell Regional Healthcare will:*

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Educate primary care providers within KRH network on use of Low Dose CT scan for lung cancer screening | Identify more people at an earlier stage of lung cancer and thereby improve survival rates. | • Costs for pulmonary and radiology staff educating primary care<br>• Costs for training and time of clinic staff | | Educational resources were provided via lecture and written according to Dr. Adam Smith, Primary Care Service Line Medical Director. |
| 2. Increase sleep apnea screening within KRH Network | Improve identification of patients who suffer from Sleep apnea and their quality of life and related comorbidities. | | | Provider education has occurred in the medical group as well as hospital department meetings. |

**b. Cancer**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Provide classes such as Cooking for Wellness and Advance Care to youth and adults affected by cancer | Additional tools to address holistic needs to help ensure optimal care and outcomes. | • Costs associated with education materials and staff labor hour.<br>• Cancer Support and Survivorship Program<br>• Save a Sister Initiative | | This was not accomplished due to COVID quarantine requirements in the valley for the majority of 2020-2021 |

**c. Heart Disease**

*Kalispell Regional Healthcare will:*

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Standardize hypertension screening within network clinical settings | Improve hypertension screening and care across the network. | • Costs associated with staffing for education and participation in community events<br>• Costs related to educational materials for staff, providers and patients | • The Summit and Occupational Health | ALL clinical staff (MAs, RNs, LPNs) had education and competency validation on taking an accurate set of vital signs. Part of that training was the AHA guidelines of taking a blood pressure including having the patient sit for 5 minutes with feet uncrossed, etc. |
| 2. In conjunction with the Healthy Measures program, implement a program for follow up of abnormal findings | Improve the health and wellness of our KRH employees with potential health cost savings. | | | This was not accomplished. The benefit plan did not change in 2020 and then by 2021, we had spent so much time in COVID crisis, this fell off the radar. |
| 3. Offer community events to increase engagement | Greater healthcare compliance in the community. | | | This was not accomplished due to COVID quarantine requirements in the valley for the majority of 2020-2021 |

**d. Diabetes**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Develop cross continuum diabetes screening strategies per American Diabetes Association criteria in ambulatory, inpatient and community settings | Identify people with diabetes and those at risk for diabetes. | • Diabetes Education and Prevention Department | • Area Hospitalists and Primary Care providers<br>• NW Specialists (Endocrinology) telehealth/remote site providers<br>• Diabetes Self-Management Education multi-sites (Libby, Ronan) | Better screening and education for providers was undertaken and delivered. In addition KRH began required screening our own employees and establishing PCP for our own employees to decrease their deductible. |
| 2. Build stronger/more engaged community diabetes advisory committee | Improved identification of needs for healthcare providers and patients with regards to diabetes management. | | | Have connected Primary Care with specialty resources. Provided education to our Primary Care clinicians. Available Diabetes education in all Primary Care sites. |
| 3. Create a Primary Care Diabetes Pathway to connect patients with diabetes to support and resources they need | Support patients and their families using consistent diabetes education across locations. | | | Pathway is in place-with standardized protocol and order set for referrals.<br>Primary Care Navigators are regularly reviewing the HgA1C Registry to watch for any patient A1Cs that are greater than nine. They will then contact the patient and get them information and request referrals for nutrition/diabetes education. |

## 3. Access to Care

Kalispell Regional Healthcare has invested and will continue to invest in many programs and services to improve access to care including:

1. Ongoing evaluation of the need for additional providers in the areas we serve.
2. A trauma prevention program that includes school presentations and a helmet safety program through the Save the Brain initiative and the Emergency Room. Over 1,000 helmets are given away annually at Spring into Safety Day.
3. Financial scholarships provided through the Kalispell Regional Healthcare Foundation to patients for fitness center memberships, weight loss programs, wellness programs, and other prevention activities
4. The Healthy Measures program to facilitate corporate wellness, both at Kalispell Regional Healthcare and other employers throughout the region.
5. Free mammograms to women in financial need through the Save a Sister initiative.
6. Funding for local transportation to/from medical appointments via Eagle Transit, Northern Transit, and ASSIST. Leadership representation on the Eagle Transit Board of Directors.
7. Same-day availability in primary care practices.
8. Primary care extended hours including continuity and walk-in primary care services.
9. Financial Assistance and Sliding Fee Scale Programs to aid patients who do not have the capability to pay for healthcare services.
10. Outreach to schools on education that includes oral hygiene.
11. Tracking "third next available" appointments, a measure from CMS to help us understand patient access to a given provider, as well as their clinic in general.

To augment these services, Kalispell Regional Healthcare and North Valley Hospital will:

**Expand Number of Primary and Specialty Care Providers**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH/NVH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Develop a Healthcare Access Committee | Measure and evaluate unmet needs and opportunities to optimize access to healthcare. | • Cost related to committee and implementation staff time | | This was not accomplished primarily due to continuous focus on the COVID-19 breakout situation. |

**Health Insurance and Affordable Care**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Support continued for Medicaid Expansion coverage and appropriate funding levels | Greater insured coverage of area families. | • Staff advocacy efforts<br>• Administrative and board support for innovation and disruption to traditional payment models | • Montana Hospital Association<br>• Flathead City-County Health Department<br>• Payers, Employers and providers across Montana | Continue to work towards this effort but nothing new has been initiated |
| 2. Work with employers and payers to establish innovative, rural value-based payment models | Improve access and quality; minimize cost increases. | | | KRH joined an ACO at the start of 2021. We continued with our CPC+ contract that ends in 2021. We continue to have quarterly meetings with our payer partners, developing more value based contracts. |

**a. Oral Health Care**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | |
|---|---|---|---|---|
| 1. Refer oral health needs for underserved community members to organizations offering free or discounted oral health services | Help facilitate a greater number of families obtaining oral health care. | • Financial support for Shepherd's Hand Clinic<br>• Primary care clinic care coordinators | • Shepherd's Hand Clinic<br>• Flathead Community Health Center | This was not accomplished primarily due to continuous focus on the COVID-19 breakout situation. |

**b. Appropriate Use of the Emergency Room**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | |
|---|---|---|---|---|
| 1. Develop educational materials for providers, staff, patients and their families around appropriate access to points of care | Help decrease inappropriate and more expensive emergency department usage when other options are available to the patient based on their medical need. | • Costs associated with staff and provider labor expenses | • Flathead City-County Health Department | Using some in our Electronic Medical Record- well child, vaccinations, COVID resources. |
| | | • Costs associated with educational materials for staff, providers and the community | • Area primary care and urgent care clinics | |
| 2. Support Medicaid Expansion efforts | Due to the availability of healthcare insurance, encourage the appropriate usage of primary care and urgent care vs. the emergency room for non-emergent care needs. | | | Continue to work towards this effort but nothing new has been initiated |

**c. Locations and Hours of Service**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Evaluate appropriate location of services based on patient experience and access needs | Create improved access and more appropriate access for patients as needed. | • Potential costs would include labor and building improvements and/or capital projects. | | KRH/Logan Health deployed the use of a National Consultant (Guidehouse) who assisted us with improved access in all Medical specialties. This remains ongoing work. |

## *Social Determinants of Health (SDoH)*

### 1. Environmental Determinants:

Kalispell Regional Healthcare recognizes the importance of social determinants of health and wellbeing for our community members and will continue to provide:

1. Financial Assistance and sliding fee scale programs to aid patients who do not have the capability to pay for healthcare services.
2. Support for other non-profits who work to alleviate challenges related to SDoH.
3. Support for Eagle Transit and the Northern Transit to provide public transportation to healthcare facilities.
4. Design and implementation of Food Rx programs for patients screened as food insecure; support and partnership with other non- profits who specialize in providing food resources to the food insecure.
5. Support for ASSIST in regional transportation and short term housing needs for patients.
6. Organizational involvement in the development of community walking/biking paths in all Flathead County cities/areas.
7. Engagement with local area organizations and governments on active transportation initiatives.
8. Complex Care Navigation addressing job/resume assistance, educational opportunity development, facilitation of proper insurance coverage, assisting with SDoH barriers of a personal nature, addressing housing options, collaborating with area housing authorities, transportation coordination and food access assistance.
9. The use of two new ASSIST vans purchased by KRH Foundation donors.
10. Weekly delivery by the KRH Foundation Community Outreach Committee of 450 backpacks to 19 schools to address food insecurity.
11. Outreach to schools providing education on body image, tobacco use, hygiene, oral hygiene, nutrition, activity, substance abuse and healthy cooking.
12. Screening patients in the primary care setting at KRH for SDoH indicators and referral to community services as indicated in those results.

North Valley Hospital recognizes the importance of social determinants on the health and wellbeing for our community members and will continue to provide:

1. Financial assistance and sliding fee scale programs to aid patients who meet financial guidelines regarding ability to pay for healthcare services.
2. Support for other non-profits who work to alleviate challenges related to SDoH.
3. Support for Eagle Transit to provide public transportation to healthcare facilities.
4. Design and implementation of Food Rx programs for patients screened as food insecure; support and partnership with other non- profits who specialize in providing food resources to the food insecure.
5. Collaboration with the Flathead Valley Breastfeeding Coalition and Baby Friendly USA certification program to promote breastfeeding; free community classes on breastfeeding, including an ongoing weekly support group, to promote optimal family nutrition by the NVH Birth Center.

6. Financial and in-kind support for medical and dental care and free meals to the patients and guests of Shepherd's Hand Free Clinic. NVH leadership representation on the Shepherds Hand Board of Directors.

To augment these services, Kalispell Regional Healthcare and North Valley Hospital will:

**a. Poverty**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Support Shepherd's Hand Free Clinic (medical and dental) | Increase the number of patients that Shepherd's Hand can service for medical and dental care so they may build the confidence and wellbeing to pursue options for desired lifestyles. | • Financial support | • Shepherd's Hand Free Clinic | This was not accomplished primarily due to continuous focus on the COVID-19 breakout situation. |

**b. Housing**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Develop a task force for application and management of the Montana Healthcare Foundation's "Housing as Healthcare" planning grant | Regional planning to address housing needs for homeless patients and a strategic plan for future funding acquisition. | • Financial support<br>• Costs surrounding staff labor | • Community Action Partnership of NW MT<br>• Agency on Aging<br>• Tiny Home Village<br>• Flathead City-County Health Department<br>• Montana Healthcare Foundation | Jane Emmert, from ASSIST, and Katie Larsen worked in the initial set-up and management of this grant. Attached is the Summary document from the grant facilitator, Cassidy Kipp with Community Action Partnership<br>Summary.pdf |

**c. Transportation**

*Kalispell Regional Healthcare will:*

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Explore opportunities to support "blue line" growth for Eagle Transit | Improved funding to streamline patient access via public transportation using routes that bring people closer to the hospital from areas around the community including long term care facilities, apartments and assisted living facilities. | • KRH and Kalispell Regional Medical Group Leadership<br>• Possible Foundation funds (#1) | • Eagle Transit<br>• Uber<br>• ASSIST<br>• ASSIST utilizers<br>• Flathead City-County Health Department<br>• Local EMS services<br>• Community leaders | Eagle Transit changed its name and model. They now offer rides on demand, along with a few standard routes. ASSIST has worked with them to be the first choice for medical transportation and we collaborate together to more efficiently serve the community. |
| **2.** Assess feasibility of UberHealth adoption or similar program that may be supported by KRH | Streamlined and coordinated free transportation for qualified patients to and from KRH facilities for reduction in missed appointments or poor disease management. | | | The former Director of Pop Health explored this option, but it has not gained any traction largely due to cost and the need to have Ubers that can handle wheelchairs. |

| | | | | |
|---|---|---|---|---|
| 3. Support ASSIST program in coordinating specific clinic days with KRH clinics to maximize ride shares | Improved coordination to streamline transportation availability and improve resource allocation for ASSIST to maximize their time and benefit to community. | | | This option will improve when/if the hospital moves to centralized scheduling. Right now, due to COVID, ASSIST is only transporting one person at a time to reduce exposure for the riders. |
| 4. Investigate feasibility of partnership with MT DPHHS and local EMS to apply for grant funding to pilot or support growth of EMS as Community Health Worker | Provide community health care for expansion of telehealth/triage and reduction in transportation needs to healthcare facilities. | | | The changing demographic and exponential population growth in the Flathead Valley, along with COVID, has left most EMS teams over-loaded. There has not been any progress on pursuing a partnership for this concept. |

**d. Food Insecurity**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Host quarterly food drives in KRH facilities to raise food for local food banks | Expand the volume of non-perishable items available in our communities to decrease the likelihood of food scarcity being a barrier to health. | • Cost of staff time including leadership, KRH kitchen, Summit, Diabetes Prevention and Education Registered Dietitians | • Area food banks<br>• Public relations outlets<br>• Flathead Valley Community Collage<br>• Lower Valley Farms, Whitefish Stage Farms and other regional farms and famers market producers.<br>• Shepard's Hand Free Clinic | This was not accomplished primarily due to continuous focus on the COVID-19 breakout situation. |
| 2. Initiate conversations with regional growers/food producers to host farmers market at KRH hospitals on a weekly basis | Create easier access during working hours to healthy foods to encourage KRH staff, patients and visitors to eat a healthier diet while supporting the local economy. | | | This was not accomplished primarily due to continuous focus on the COVID-19 breakout situation. |
| 3. Create food access task force composed of KRH, the HealthCenter and NVH staff | Help expand on current initiatives to improve healthy food access and grow our plans and goals as an overarching organization to ensure coordinated effort in addressing food insecurity | | | This was not accomplished primarily due to continuous focus on the COVID-19 breakout situation. |

**d. Built Environment**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Support private and public development initiatives creating active transportation available in all Flathead County Communities | Help drive active transportation as a necessary good for all communities to improve patient health outcomes for chronic diseases and behavioral health issues. Improve patient ability to access healthcare services through alternative modes of transportation. | • KRH leadership time | • Montana West Economic Development Corp<br>• County and city planning boards<br>• Rails to trails initiators<br>• Bike Walk Montana<br>Eagle Transit | Early discussions were had but fell apart with the onslaught of COVID 19. No further progress has been made |
| 2. Continue goal development to improve pedestrian movement on the KRH and The HealthCenter campus | Improve patient ability to access healthcare services via optimized routes that are conducive to pedestrians. | | | This was not accomplished primarily due to continuous focus on the COVID-19 breakout situation. |

## 1. Community Resilience:

Kalispell Regional Healthcare is committed to providing care that focuses on individuals' overall wellbeing by continuing:

1. To follow its core values including "showing compassion to every person, every time."
2. Chronic Care Management program to identify barriers to health and social services and assist with navigation to community partners with expertise in the identified services.

To augment these services, Kalispell Regional Healthcare and North Valley Hospital will:

**a. Trauma Informed Care - Supporting those who have experienced traumatic events via safety, choice, collaboration, trustworthiness and empowerment**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Create consistent education for providers and care givers regarding trauma, its prevalence, and types within the KRH system | Staff development in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, and emotional safety for everyone, and that creates | • Costs associated with staff training and associated educational materials for staff, providers and the community | • Flathead City-County Health Dept.<br>• DPHHS<br>• State of MT Primary Care association<br>• Behavioral Health of Montana Association | • Adopted Aegis training for all employees and providers which looks at trauma informed care, your own bias regarding trauma, and workplace violence. Trained 25 trainers and have implemented training of all employees beginning 4.21<br>• Reviewed pediatric ER, ER safe rooms |

| | | | | |
|---|---|---|---|---|
| 2. Identify medical exams and procedures that exacerbate trauma and approach patients from a culture of safety, empowerment and healing | Engage more patients in a team-based care approach to improve their health and create a positive patient experience of empowerment. | | | |
| 3. Use community events as avenues for education and awareness | Community support via collaboration, education and awareness of trauma informed care. | | | This was not accomplished primarily due to continuous focus on the COVID-19 breakout situation. |

**b. Access to Non-Clinical Services**

***Kalispell Regional Healthcare will:***

| *Actions* | *Anticipated Impact* | *KRH Resources* | *Potential Collaborations* | *Evaluation* |
|---|---|---|---|---|
| 1. Community Resource Partners (AKA as Community Health Workers) will visit people in their homes to connect them to community resources to help them regain their health and independence. Examples: Medicaid, Food Stamps, Disability and Veteran benefits. | Financial stability to meet individuals' basic social determinant of health and insurance needs that allow them to seek the care they need. | Costs associated with Community Resource Partners' time and leased vehicles for transportation to reach people in need across the entire Flathead Valley, especially rural areas | • Agency on Aging<br>• Complex Care<br>• Community Action Partnership<br>• United Way<br>• Kalispell Veterans Center<br>• And more | KRH hired 1 CHW who is no longer employed. While in our employment, she would go out to patient's homes and help them with paperwork like applications for housing, Medicaid, etc… The organization has seen a tremendous new influx of MVP patients in the last year. Striving to intake 9/week. The influx of people into the Valley has impacted Complex Care tremendously.<br>Hired a Maternal Care coordinator to work with pregnant moms and SDOH and community resources. Also participates in the Meadowlark and works with local community team and other Meadowlark sites throughout MT |

NORTH VALLEY HOSPITAL

# Kalispell Regional Healthcare and North Valley Hospital
# 2019 – 2022 Joint Implementation Plan
# in Response to the 2019 Flathead County Community Health Needs Assessment

As a result of the research and recommendations that appear in the 2019 Flathead County Community Health Needs Assessment and further exploration with hospital administrators, staff, and Boards of Directors, the following strategies, will guide the organizations in addressing the community's identified health needs over the next three years. These strategies were approved by the North Valley Hospital Board of Directors on June 25, 2019 and by the Kalispell Regional Healthcare Board of Trustees on June 27, 2019.

## *Comprehensive Care*

**1. Mental Health and Substance Abuse:**

Kalispell Regional Healthcare is committed to continuing the provision of mental health care through many existing services and activities including:

1. Pathways Treatment Center for acute mental health and substance abuse patients (adolescents and adults), and outpatient support groups for those discharged from Pathways Treatment Center.
2. Integrated Behavioral Health in nine primary care practices.
3. Comprehensive school-based treatment and mental health services for Bigfork, Columbia Falls, Kalispell, Somers/Lakeside, and Whitefish school districts.
4. The Newman Center, an outpatient mental health clinic.
5. Funding for a consortium of community members for mental health professionals/crisis response.
6. Funding for local transportation to/from medical appointments.

North Valley Hospital is committed to continuing the provision of mental health care through many existing services and activities including:

1. North Valley Behavioral Health for outpatient psychiatric and counseling treatment for children, adolescents and adults.
2. Behavioral Health screenings and referrals at School-Based Clinics in Columbia Falls High School and Whitefish Elementary, Middle and High School.
3. Behavioral Health Telehealth Outreach Services available at Eureka Healthcare Primary Care Clinic as well as the Eureka School-Based Clinic in Eureka, MT.
4. Integrated Licensed Clinical Social Worker in the North Valley Professional Center, Columbia Falls.
5. Tobacco and alcohol screening at clinics to gauge patient alcohol and tobacco use, and refer to local resources including Montana Quit Line.
6. Support for the Montana State tobacco cessation program to reduce tobacco effects on maternal, fetal, infants, and children.
7. Participation in the Drug Free Flathead Task Force, with an emphasis on the sub-committee for Maternal, Fetal, Infant, and Pre-pregnant Women Prevention Program to make a positive impact to reduce the use of opioid and other drugs within the valley deemed dangerous by Montana Code Annotated.
8. NVH Birth Center staff member representation on the Fetal, Infant, Child, & Maternal Mortality Review Committee that reviews teen and maternal suicides for prevention potential with goals to: 1) decrease suicide rate in teens and mothers up to one-year post-partum in the valley; and 2) promote programs to assist in prevention of future situations through analysis of current occurrences.
9. NVH Birth Center participation in the Best Beginnings Community Council sub-group on Postpartum Mood Disorder (PPMD) to support education and community members that are effected by PPMD, and therefore, at greater risk for suicide.
10. PPMD workshops provided by the NVH Birth Center for community members at risk to provide a safe place for depressed and anxious clients to process their feelings and refer to specialists in our community.

To augment these services, Kalispell Regional Healthcare and North Valley Hospital will:

**a. Alcohol and Tobacco Use**

***North Valley Hospital will:***

| *Action* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Develop a care pathway for education and support of patients who use alcohol or tobacco | Increased staff and provider knowledge related to importance of screening as well as resources available to support patients and their families in a team based approach to treatment and cessation. | • Costs for developing educational materials for patients and families as well as education and training materials for employees and providers.<br>• NVH Care Coordination team | • MT Tobacco Quit Line<br>• KRH Nurse Navigation team | Care Coordinators are currently working on creating a paper care pathway with resources and algorithms. They currently have a resource guide to provide patients and families. |
| 2. Provide training to nursing staff on alcohol addiction. | Patient identification, education and referral as necessary to access the appropriate treatment. | | | SBIRT training was provided to the LCSW in the Columbia Falls clinic. |
| 3. Develop registries for care coordinators to do outreach and follow-up on prescribed programs | Timely identification of referral resources. | | | Not able to complete due to capabilities of EMR. Care Coordinators provide education and support from their patients enrolled in CCM. |

**b.**

**Opioid Use and Medication Assisted Therapy**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Work with KRH to implement system-wide opioid policy, which includes patient contracts to assure patient safety, education, monitoring, compliance, and monitoring opioid utilization | Create consistency for treatment of patients across the KRH system. Help prevent potential drug diversion. | • Cost of staffing hours to support initiatives and task force development and participation.<br>• Cost for continued education to staff, providers and the public regarding awareness and alternative treatment options.<br>• Cost of electronic prescribing software | • Flathead County Health Department<br>• Independent Medical Groups in the Flathead Valley<br>• Flathead Valley Chemical Dependency<br>• Alpenglow Medical<br>• Dickerson Counseling<br>• Primary Care Physicians<br>• Schools<br>• Law Enforcement<br>• First Responders | Clinics follow the System Opioid Policy. |
| 2. Creation of an opioid task force by NVH physical and occupational therapists to focus on collaboration with primary care and behavioral health clinicians to develop therapy alternatives to opioids when appropriate | Cultivate stronger collaboration for alternative treatment options utilizing therapy services. | | | Delayed due to Covid |

| | | | | |
|---|---|---|---|---|
| **3.** Implement electronic prescribing of controlled substances | Help prevent potential drug diversion through electronic monitoring of drug inventories, dispensing, waste etc. | • Cost for providing community education to include marketing and staffing hours | | E-scribing was implemented for controlled substances, however due to current ECW program we will eventually lose this function until we are on Meditech. |
| 4. Develop community communications on the scope and impact of the opioid epidemic | Expand community awareness and understanding regarding the gravity and detriments of the opioid epidemic. | | | Delayed due to Covid |

**c. Suicide Prevention**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Implement PHQ2 and PHQ9 depression screenings for inpatients and ambulatory outpatients | Increased identification of needs for support and treatment of depression and suicide. | • Costs related to education and training materials for staff and providers.<br>• Costs related to purchasing, accommodating and training staff for TMS equipment.<br>• Costs related to marketing and education on TMS services and treatment opportunities. | • Nate Chute Foundation<br>• KVH Foundation | NVHF raised approximately $280,000 to provide funding to the Nate Chute Foundation during the period 2019-2023. $60,000 was provided through sponsorship to NCF in 2019.<br>Completed at AWV visits and mental/behavioral health visits, and as needed bases<br>Inpatient screening includes C-SSRS screenings, which was researched and adopted by nursing shared leadership to utilize on the inpatients.<br>PHQ screening added to quality measures in provider contracts. |

| | | | | |
|---|---|---|---|---|
| 2. Develop systematic pathway to connect patients with support and services they need | Increased staff and provider awareness of patients struggling with depression or suicidal ideation and resources available for support and treatment. | | | Provide staff and patients with a list of mental health resources in Flathead county that includes adult, child, adolescent, Veteran, acute, chemical and crisis resources. |
| 3. Adopt new Transcranial Magnetic Stimulation (TMS) equipment in North Valley Behavioral Health | Provides an additional treatment option as an alternative or supplement to prescription medication treatment. | | | NVHF raised $80,000 to purchase TMS equipment with services starting in November 2019.<br>Completed and Ongoing: TMS is in place and 35+ patients completed the course, which amounts to over 1,260 treatments. NVH was instrumental in getting Montana Medicaid to recognize TMS as a legitimate payable service. Hopeful that we will add a second chair in the coming 1-2 years.<br>NVHF dedicated $22,000 to start a Behavioral Health Fund with initial focus to cover cost of TMS treatment for patients who qualified |

| | | | | |
|---|---|---|---|---|
| | | | | financially and were either uninsured or on Medicaid (which does not reimburse for TMS). Goal to raise $150,000 additionally. |
| 4. Increase collaboration with community partners to support patient needs | Enhanced relationships with community partners to provide support services to patients. | | | NVHF Working collaboratively with NCF to identify gaps and seek solutions with donors and community partners (Mental Health symposium planned for first week of April 2020) |
| 5. Provide training to all nurses regarding teen suicide | Enhanced identification and care for teen patients and their families. | | | Delayed due to Covid. |

**2. Chronic Disease Management and Prevention**

Kalispell Regional Healthcare has invested and will continue to invest in many programs and services to treat some of the most prevalent causes of death in our county including:

1. Participation in the Comprehensive Primary Care Plus (CPC+) program in partnership with Medicare, Medicaid, Blue Cross Blue Shield, Pacific Source and Allegiance to prevent and manage chronic diseases through a care coordination activities.
2. A comprehensive cardiovascular program that includes interventional cardiology, heart surgery, electrophysiology, cardiac rehabilitation, a heart failure clinic and prevention education.
3. A comprehensive cancer program that includes medical oncology, surgical oncology, radiation oncology, supportive care and preventive screenings.
4. A Neuroscience & Spine Institute that includes neurosurgery, neurology, and a stroke program.

5. A Diabetes Care and Prevention Center that provides group education, one-on-one counseling and chronic disease management education.
6. The Journey to Wellness program to assist patients with gestational diabetes care and individuals with chronic health conditions/challenges.
7. The Healthy Measures program to facilitate corporate wellness, both at Kalispell Regional Healthcare and other employers throughout the region.
8. Mammograms to women in financial need through the Save a Sister free mammography initiative to lessen the impact of breast cancer in our community. The cost of mammograms is covered for underserved community members and education is provided on the importance of screening mammograms.
9. Spring into Safety Campaign.
10. Education of school staff, parents and children on the dangers of smoking and e-cigarettes.

North Valley Hospital has invested and will continue to invest in many programs and services to treat some of the most prevalent causes of death in our county including:

1. Chronic Care Management Program to help patients navigate and improve healthcare outcomes by addressing barriers to healthcare and decreasing emergency department and inpatient utilization.
2. Asthma Education Program for hospital inpatients and outpatients.
3. 3D Mammography and participation in the KRH Save a Sister free mammography initiative.
4. Preventative breast/rectal/prostate cancer screening in the clinic setting.
5. Tele-Stroke program to identity patients that may have had a stroke and to deliver appropriate treatment.
6. Free EKG's and sleep studies for Shepherd's Hand Free Clinic patients.
7. Individualized care plans for patients with chronic diseases who are high utilizers of the Emergency Department.
8. Diabetes Prevention Program for community members.
9. Education of school staff, parents and children on the dangers of smoking and e-cigarettes.

To augment these services, Kalispell Regional Healthcare and North Valley Hospital will:

**a. Respiratory Disease**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Expand the Asthma Education Program to outpatient clinics | Help patients identify symptoms and manage their asthma. | • Cost of asthma education materials<br>• Care Coordinators | | Eureka care coordinator currently collaborating with school nurse on completing Asthma forms for school aged children. Obtained pediatric education booklets through DPHHS to provide to patients and the plan is to distribute to the clinics. |
| 2. Develop care registries of outreach services | Engage more patients in team-based care approach to connect patients to respiratory support and services they need. | | | Expanded and marketed pulmonary functioning testing capabilities. Looking to partner with Logan Kalispell and expand services. |

**b. Cancer**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Create a Cancer Care Pathway for patients with newly diagnosed cancer | Address holistic needs and provide navigation assistance to medical care teams to ensure optimal care and outcomes, address barriers to healthcare. | • Costs associated with education materials and staff labor hours | • KRH Care Navigators | Care Coordinators are actively working on creating pathways. Currently they are referred newly diagnosed patients who collaborate with community resources. |

**c. Heart Disease**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Facilitate a grant to enhance the Cardiac Rehab program | Help navigate and improve healthcare outcomes, address barriers to healthcare, increase percentage of patients attending Cardiac Rehab post hospitalization, and decrease emergency department and inpatient utilization. | • Costs associated with staffing for education and participation in community events.<br>• Costs related to educational materials and communication vehicles for staff, providers and patients. | | Obtained $9000 through North Valley Foundation to utilize for education and outreach.<br>Obtained certification through American Association of CV and pulmonary rehab in 2021. |
| 2. Develop care registries for outreach support and treatment | Engage more patients in team-based care approach to connect patients to cardiovascular support and services they need. | | | Expanded and marketed cardiac rehab services.<br>Addition of classes and staff. |
| 3. Add physical and occupational therapy exercise programs for post-rehab heart disease patients at North Valley Hospital Outpatient PT/OT | Continuation of outpatient services to maintain patients' heart health. | | | Due to covid, offered patients to utilize cardiac rehab facility ongoing after graduation to continue the exercise program. |

**d. Diabetes**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Create a Primary Care Diabetes Pathway to connect patients with diabetes to support and resources they need | Engage more patients in team-based care approach to connect patients to diabetes support and services they need. | Costs associated with clinic and physical therapy staff | | Care Coordinators are currently working on a pathway.<br>Patients are referred to hospital diabetic educator.<br>EHPC has an RN diabetic educator that works with care coordinator to enroll patients in chronic care management program. |
| **2.** Develop a program in the North Valley Physical Therapy clinic which offers physical therapy to those who would like to address their diabetes with exercise | Engage more patients in team-based care approach that incorporates physical therapy as part of their diabetes management. | | | Delayed due to covid, patients referred to Summit Medical Fitness. |

**3. Access to Care**

Kalispell Regional Healthcare has invested and will continue to invest in many programs and services to improve access to care including:

1. Ongoing evaluation of the need for additional providers in the areas we serve.
2. A trauma prevention program that includes school presentations and a helmet safety program through the Save the Brain initiative and the Emergency Room. Over 1,000 helmets are given away annually at Spring into Safety Day.
3. Financial scholarships provided through the Kalispell Regional Healthcare Foundation to patients for fitness center memberships, weight loss programs, wellness programs, and other prevention activities
4. The Healthy Measures program to facilitate corporate wellness, both at Kalispell Regional Healthcare and other employers throughout the region.
5. Free mammograms to women in financial need through the Save a Sister initiative.
6. Funding for local transportation to/from medical appointments via Eagle Transit, Northern Transit, and ASSIST. Leadership representation on the Eagle Transit Board of Directors.
7. Same-day availability in primary care practices.
8. Primary care extended hours including continuity and walk-in primary care services.
9. Financial Assistance and Sliding Fee Scale Programs to aid patients who do not have the capability to pay for healthcare services.
10. Outreach to schools on education that includes oral hygiene.
11. Tracking "third next available" appointments, a measure from CMS to help us understand patient access to a given provider, as well as their clinic in general.

North Valley Hospital has invested and will continue to invest in many programs and services to improve access to care including:

1. Ongoing evaluation of the need for additional providers in the areas we serve.
2. Tracking "third next available" appointments, a measure from CMS to help us understand patient access to a given provider, as well as their clinic in general.
3. Offering blocked "same day" appointments in primary care clinics to allow our patient population prompt availability to providers for acute needs.
4. Designation of a walk-in provider for the rural patients in Eureka that do not have nearby access to urgent care or emergency services.
5. Extended hours for primary care clinics.
6. Charity care, sliding fee scale, uninsured/under insured discounts, and payment options for those in financial need.
7. Emergency Department Acute Care Plans to help Emergency Department patients transition to external follow-up care.
8. Financial support for Eagle Transit to provide low cost transportation for patients to visit medical providers in the north Flathead.

9. Participation in Save a Sister initiative to provide free mammograms to women in financial need.
10. Participation in the Save the Brain Program that develops and promotes cohesive and coherent concussion education, evaluation and treatment system related to concussion care.

To augment these services, Kalispell Regional Healthcare and North Valley Hospital will:

**a. Expand Number of Primary and Specialty Care Providers**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *KRH/NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Identify standard for appropriate panel size for primary care providers | Identification of unmet needs via strategic analysis of primary care and specialty services. | • Costs related to staffing and provider time | • Western Montana Family Medicine Residency program<br>• WWAMI Clerkship in Psychiatry | Ongoing: Ambulatory Quality Improvement Committee has identified "access to care" as its priority improvement initiative and meets every 2 months. |
| 2. Expand relationship with Western Montana Family Medicine Residency program | Collaboration with residency programs to foster relationships with students to enhance recruitment opportunities. | | | Dr Dear-Ruel and Dr Carlson both are involved with working with residents from the Columbia Fall offices. Primary Care in Eureka is actively working with residents, and is involved with the program's development. |

**b. Health Insurance and Affordable Care**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Support continued for Medicaid Expansion coverage and appropriate funding levels | Greater insured coverage of area families. | • Staff advocacy efforts<br>• Administrative and board support for innovation and disruption to traditional payment models | • Montana Hospital Association<br>• Flathead City-County Health Department<br>• Payers, Employers and providers across Montana | Kirk Steadmon, Senior Clinic Operations Director, is interfacing with State of Montana – Medicaid to try to get them to cover TMS Treatment for adults with severe depression who qualify.<br>NVH Foundation provided assistance to 13 patients who were covered by Medicare at the time TMS was not covered by Medicaid. |
| 2. Work with employers and payers to establish innovative, rural value-based payment models | Improve access and quality; minimize cost increases. | | | North Valley Hospital joined with Kalispell Regional an Accountable Care Organization through Caravan in 2021. |

**c. Oral Health Care**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Refer oral health needs for underserved community members to organizations offering free or discounted oral health services | Help facilitate a greater number of families obtaining oral health care. | • Financial support for Shepherd's Hand Clinic<br>• Primary care clinic care coordinators | • Shepherd's Hand Clinic<br>• Flathead Community Health Center | Referrals to Shepherd's Hand clinic and participated in strategic planning meetings with them on where support services are needed. |

**d. Appropriate Use of the Emergency Room**

*North Valley Hospital will:*

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Work with KRH to develop educational materials for providers, staff, patients and their families around appropriate access to points of care | Help decrease inappropriate and more expensive emergency department usage when other options are available to the patient based on their medical need. | • Costs associated with staff and provider labor expenses<br>• Costs associated with educational materials for staff, providers and the community | • Flathead City-County Health Department<br>• Area primary care and urgent care clinics | Care Coordinators do education with patient enrolled in their program on appropriate point of care contacts. Overall education significantly was concentrated on covid testing.<br>Primary Care locations added weekend hours and walk-in capabilities to help accommodate patients whose condition does not warrant ER level care. |
| 2. Add an emergency nurse to the Care Transitions Committee | Provide insights to the committee working to help decrease inappropriate use of the emergency department. | | | Completed in 2020, committee meets quarterly. |
| 3. Support Medicaid expansion efforts | Due to the availability of healthcare insurance, encourage the appropriate usage of primary care and urgent care vs. the emergency room for non-emergent care needs. | | | Continue to educate about appropriate use of resources and signage in ED. |

**e. Locations and Hours of Service**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Evaluate appropriate location of services based on patient experience and access needs | Create improved access and more appropriate access for patients as needed. | • Potential costs would include labor and building improvements and/or capital projects. | | Ongoing: We have added access to services to include weekends and walk-ins across our primary care service line. Additionally, access was adopted by our Ambulatory Quality Committee as our focus improvement initiative. |

## *Social Determinants of Health (SDoH)*

**1. Environmental Determinants:**

Kalispell Regional Healthcare recognizes the importance of social determinants of health and wellbeing for our community members and will continue to provide:

1. Financial Assistance and sliding fee scale programs to aid patients who do not have the capability to pay for healthcare services.
2. Support for other non-profits who work to alleviate challenges related to SDoH.
3. Support for Eagle Transit and the Northern Transit to provide public transportation to healthcare facilities.
4. Design and implementation of Food Rx programs for patients screened as food insecure; support and partnership with other non-profits who specialize in providing food resources to the food insecure.
5. Support for ASSIST in regional transportation and short term housing needs for patients.
6. Organizational involvement in the development of community walking/biking paths in all Flathead County cities/areas.
7. Engagement with local area organizations and governments on active transportation initiatives.
8. Complex Care Navigation addressing job/resume assistance, educational opportunity development, facilitation of proper insurance coverage, assisting with SDoH barriers of a personal nature, addressing housing options, collaborating with area housing authorities, transportation coordination and food access assistance.
9. The use of two new ASSIST vans purchased by KRH Foundation donors.
10. Weekly delivery by the KRH Foundation Community Outreach Committee of 450 backpacks to 19 schools to address food insecurity.
11. Outreach to schools providing education on body image, tobacco use, hygiene, oral hygiene, nutrition, activity, substance abuse and healthy cooking.
12. Screening patients in the primary care setting at KRH for SDoH indicators and referral to community services as indicated in those results.

North Valley Hospital recognizes the importance of social determinants on the health and wellbeing for our community members and will continue to provide:

1. Financial assistance and sliding fee scale programs to aid patients who meet financial guidelines regarding ability to pay for healthcare services.
2. Support for other non-profits who work to alleviate challenges related to SDoH.
3. Support for Eagle Transit to provide public transportation to healthcare facilities.

4. Design and implementation of Food Rx programs for patients screened as food insecure; support and partnership with other non-profits who specialize in providing food resources to the food insecure.
5. Collaboration with the Flathead Valley Breastfeeding Coalition and Baby Friendly USA certification program to promote breastfeeding; free community classes on breastfeeding, including an ongoing weekly support group, to promote optimal family nutrition by the NVH Birth Center.
6. Financial and in-kind support for medical and dental care and free meals to the patients and guests of Shepherd's Hand Free Clinic. NVH leadership representation on the Shepherds Hand Board of Directors.

To augment these services, Kalispell Regional Healthcare and North Valley Hospital will:

**a. Poverty**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Implement screening tool for social determinants of health in the clinic setting | Identify at risk patients and align access to community resources. | • Cost of staff time<br>• 340B pharmaceutical savings redistribution | | Screening tool created in eCW, care coordinators are screening patients they work with. Inpatient screening developed in 2021 with the addition of a social worker hired. |
| 2. Implement Free Rx program for qualifying patients to receive a free short term supply of discharge medication prescriptions | Reduce hospital readmission risk and increase adherence to medication compliancy. | | | Discharge planners identify patients and provide vouchers. |

**b. Housing**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Implement screening tool for SDoH in the clinic setting | Identify at risk patients and align access to community housing resources. | • Costs surrounding staff labor time | • ASSIST<br>• Community Action Partnership<br>• Agency on Aging | Completed in ambulatory EMR. Also added to inpatient admission assessment with an automatic referral to social work if screen positive. |

**c. Transportation**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Implement screening tool for SDoH in the ambulatory setting | Identify at risk patients and align access to community transportation resources. | • Costs associated with staff time | • Eagle Transit<br>• Local taxi companies<br>• ASSIST | Completed, screening tool created in eCW and being utilized for TCM, CCM and food Rx patients. |
| 2. Support and participate in KRH's efforts in developing transportation strategies to improve access to healthcare services | Additional transportation options for patients to get to their health care services. | | | NVH continues to provide $6 per ride to Eagle Transit to support them. Voucher program with Lyft is in process. Hospital purchased and UBER app mainly to utilize in the ED. Eureka provides vouchers for a new taxi service in the area. |

**d. Food Insecurity**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Develop a Food Rx program at North Valley Professional Center in Columbia Falls | Serve 9-12 families impacting up to 48 people who are food insecure. | • Cost of staff time.<br>• Financial support to the mission of Farm Hands | • Farm Hands – Nourish the Flathead<br>• ASSIST | Completed and began enrolling patients/families in 2019. Patients are screened, enrolled in program, provided vouchers in collaboration with Farm Hands. Data is collected by care coordinator to measure the success and outcomes. |
| 2. Provide support to Farm Hands – Nourish the Flathead for Columbia Falls Backpack Assistance Program | Serve over 200 children in Columbia Falls school district impacting up to 800 people who are in financial need or food insecure through the support and collaboration with Farm Hands. | | | FHN currently providing 1,600 weekend food bags for students in District 6 while schools are closed. Plans are to increase to daily meal packages.<br>Funding from Washington Foundation re-directed to Farm Hands for the program through the Foundation. |
| 3. Implement screening tool for SDoH in the clinic setting | Identify at risk patients and align access to community food resources. | | | Complete, screening tool created in eCW. |
| 4. Participate in food access task force composed of KRH, The HealthCenter and NVH staff | Help expand on current initiatives to improve healthy food access. | | | Don't believe this was initiated due to Covid. |

**e. Built Environment**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Support private and public development initiatives creating active transportation available in all Flathead County Communities | Help drive active transportation as a necessary good for all communities to improve patient health outcomes for chronic diseases and behavioral health issues. Improve patient ability to access healthcare services through alternative modes of transportation. | • NVH leadership time | • Montana West Economic Development Corp.<br>• County and city planning boards<br>• Rails to trails initiators<br>• Bike Walk Montana<br>• Eagle Transit | Planetree Coordinator joined the Regional Transportation Board and will be working to provide better transportation options to NVH facilities |

**1. Community Resilience:**

Kalispell Regional Healthcare is committed to providing care that focuses on individuals' overall wellbeing by continuing:

1. To follow its core values including "showing compassion to every person, every time."
2. Chronic Care Management program to identify barriers to health and social services and assist with navigation to community partners with expertise in the identified services.

North Valley Hospital is committed to providing care that focuses on individuals' overall wellbeing by continuing:

1. Its culture of Planetree Patient Centered Care that focuses on caring for the mind, body and spirit in a healing environment at the hospital, NVH clinics and associated offices.
2. NVH Birth Center clinical staff training and monthly community support groups for Postpartum Mood Disorders and Perinatal Loss, weekly Mother/Baby Support groups, and collaboration with Best Beginnings Council for coordination of best practices for children in the Flathead Valley.
3. Chronic Care Management program to identify barriers to health and social services and assist with navigation to community partners with expertise in the identified services.

To augment these services, Kalispell Regional Healthcare and North Valley Hospital will:

**a. Trauma Informed Care - Supporting those who have experienced traumatic events via safety, choice, collaboration, trustworthiness and empowerment**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| 1. Explore additional options to enhance service quality and the patient experience in alignment with Planetree Patient Centered Care | Enhanced patient / caregiver partnerships that facilitate holistic care and wellbeing. | • Costs associated with educational materials, training and staff time. | • Planetree International<br>• National Institute of Child Health and Human Developments' Safe to Sleep Program | Planetree Committee meets monthly and continues to review processes and data around patient experience. |
| 2. Implement the Safe Sleep Program focusing on sleep related infant deaths to promote health and safety of infants up to 1 year of age | Educate families on ways to help reduce SIDS, the leading cause of death among babies between 1 month and 1 year of age. | | | Initiated in 2018 and have implemented all the requirements but have not applied for certification due to Covid and the education that is required. |

**b. Access to Non-Clinical Services**

***North Valley Hospital will:***

| *Actions* | *Anticipated Impact* | *NVH Resources* | *Potential Collaborations* | *Results* |
|---|---|---|---|---|
| **1.** Expand Chronic Care Management program to identify barriers to health care for hospital and clinic patients and assist them with navigation to needed non-clinical services | Help patients obtain the non-clinical assistance they need as a foundation for overall health and wellbeing. | • Costs associated with Care Management time and any creation of corresponding patient information | • ASSIST<br>• Agency on Aging<br>• Flathead City-County Health Department<br>• Community Action Partnership<br>• United Way<br>• Kalispell Veterans Center<br>• Samaritan House & more | In process, CCM program established, patients enrolled and care coordinators/director attend monthly community meetings with clinical and non clinical services in the community. With joining the Accountable Care Organization, utilizing data to target high risk/high cost patients. |