

A family of five is walking through a grassy park with trees showing autumn foliage. In the foreground, a young girl in a patterned sweater and a woman in a white jacket are walking together. In the background, a man, a woman, and a child are walking, with the child sitting on the man's shoulders.

# 2018 Community Health Needs Assessment Report

## Primary Service Area: Custer County, Montana

### Sponsored by:

- Holy Rosary Healthcare

### In Collaboration with:

- Montana DPHHS Public Health and Safety Division
- Montana Healthcare Foundation

### In Cooperation with the Community Health Alliance:

- Billings Clinic Miles City
- Miles Community College
- Montana Health Network
- oneHealth Custer County Public Health



# **CUSTER COUNTY COMMUNITY HEALTH ASSESSMENT 2018**



**This project made possible with funding provided through a grant from the Montana DPHHS Public Health & Safety Division and the Montana Healthcare Foundation and the resources of organizations represented in the Community Health Alliance.**

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## **Foreword**

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### **Community Defined for This Assessment**

The study area for the survey effort (referred to as Custer County in this report), Custer County is the common patient base among the collaborating entities sponsoring this study. Custer County is the primary service area for Holy Rosary Healthcare.

### **IRS Form 990, Schedule H**

*See Report*

Part V Section B Line 3a: A definition of the community served by the hospital facility: Page i

Part V Section B Line 3b: Demographics of the community: Pages 9-12

Part V Section B Line 3c: Existing healthcare facilities and resources within the community that are available to respond to the health needs of the community: Page 30

Part V Section B Line 3e: The significant health needs of the community: Pages ii-iii

Part V Section B Line 3f: Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups: Addressed throughout

Part V Section B Line 3g: The process for identifying and prioritizing community health needs and services to meet the community health needs: Pages ii-v

Part B Section B Line 3h: The process for consulting with persons representing the community's interests: Pages iv and 6

Part V Section B Line 3i: Information gaps that limit the hospital facility's ability to assess the community health needs: Pages vi and 7

Part V Section B Line 11: addressing the significant needs identified: Page 33

# ***SUMMARY OF FINDINGS***

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## **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 list below).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly state and national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue.

Areas of Opportunity Identified through This Assessment, in alphabetical order:

### **Access to Healthcare Services**

- Designated as a low income population Healthcare Provider Shortage Area
- Ranked by survey respondents as most important for a healthy community
- Top concerns availability of visiting specialists and increased primary care providers

### **Alcohol and Substance Abuse**

- Custer County excessive drinking rates higher than US average rates
- Ranked as a big problem by survey respondents
- Lack of knowledge among survey respondents of where to refer for substance abuse services

### **Alzheimer’s Disease**

- Alzheimer’s disease deaths in Custer County are in the least favorable quartile compared to peer counties in the United States

## Cancer and Cancer Screening

- Lower levels of clinical preventive practices than other Montana Counties for mammography, pap tests, and colorectal screenings
- Cancer deaths and cancer incidence rates in Custer County are in the least favorable quartiles compared to peer counties in the United States

## Chronic Lower Respiratory Disease

- CLRD deaths in Custer County are in the least favorable quartile compared to peer counties in the United States

## Injury Prevention

- Unintentional injury (including motor vehicle) deaths in Custer County are in the least favorable quartile compared to peer counties in the United States

## Nutrition, Physical Activity and Obesity

- Access to affordable, healthy food including concerns about food costs
- Lack of grocery stores close to low-income residents
- Higher levels of reported physical inactivity than other Montana Counties
- Higher obesity rates than other Montana Counties

## Mental Health and Suicide

- All 17 counties in Eastern Montana are designated as Mental Health Professional Shortage Areas by the Health Resources and Services Administration
- Compared to Montana, the rates of suicide in Eastern Montana for men and American Indians are elevated
- 20% of survey respondents classified their mental health as fair or poor

## **Prioritization of Health Needs**

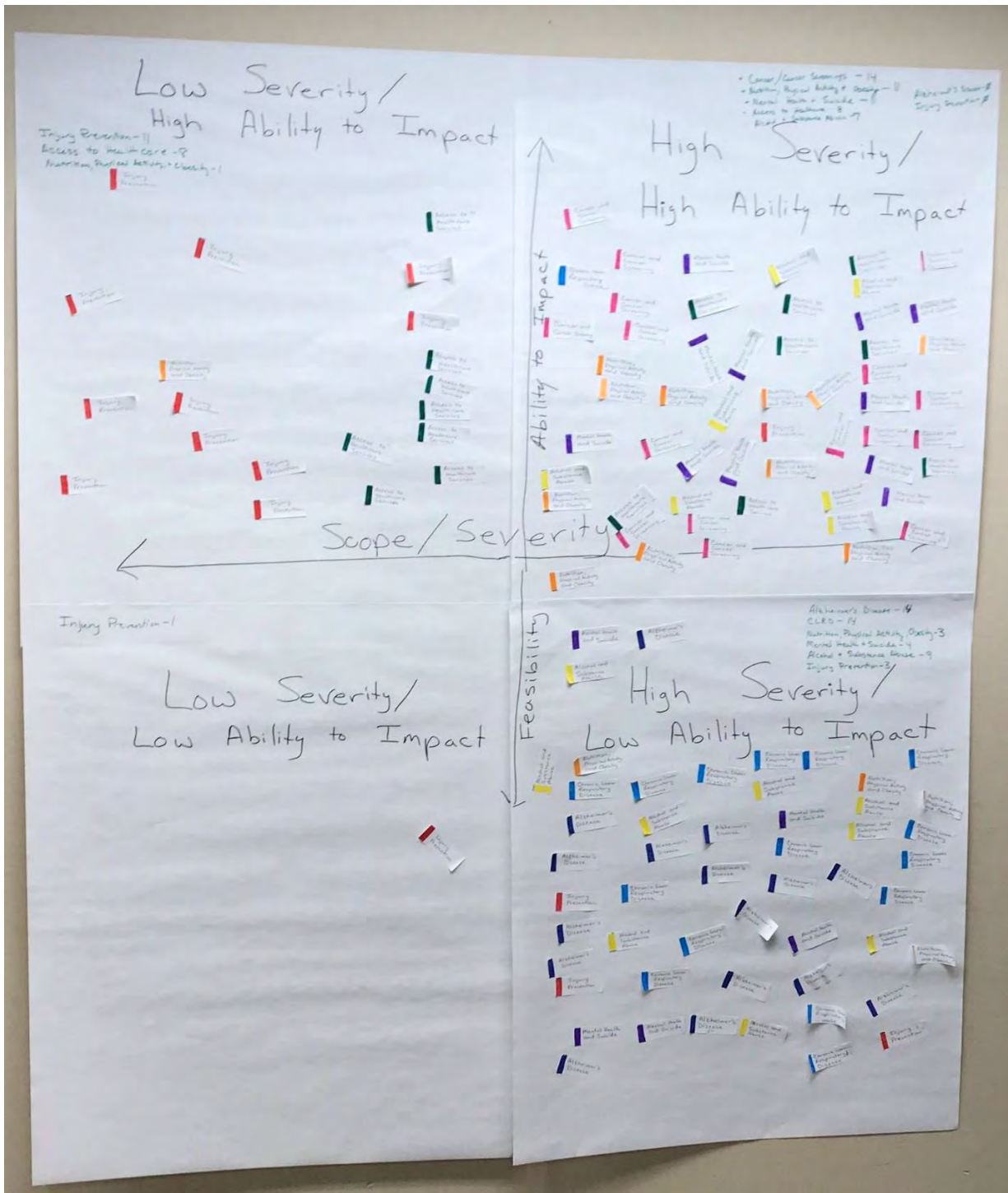
On Wednesday, May 2, 2018, Holy Rosary Healthcare convened a group of fourteen community stakeholders (representing a cross-section of community-based agencies and organizations including public health, healthcare, social services, government and faith community) to evaluate, discuss and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA).

The meeting began with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see "Areas of Opportunity" listed above). Following the data review, the facilitator answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. Next participants were provided an overview of the prioritization exercise that followed.

The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — A first rating was to gauge the magnitude of the problem in consideration of the following: How many people are affected? How does the local community data compare to state or national levels? To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?
- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the sponsors and community having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc.

Participants were given colored labels representing each of the identified areas of opportunity and placed those labels on a grid representing the two criteria. After the exercise was completed, there was discussion among the group.



From this exercise, the prioritized areas based on high severity and high ability to impact were:

1. Cancer and Cancer Screening (14)
2. Nutrition, Physical Activity and Obesity (11)
3. Mental Health and Suicide (11)
4. Access to Healthcare (8)
5. Alcohol and Substance Abuse (7)

### **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.

Also, additional secondary data sources exist beyond those included in this assessment that might further inform health issues in the community. 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.



## **ACKNOWLEDGEMENTS**

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Many community organizations collaborated with the Community Health Alliance to help contribute to data collection by allowing paper surveys and collection boxes to be located in their place of business, posting the announcement and link to the online survey on their social media sites and encouraging public participation. Special thanks to the community members of Custer County as they were an integral part of the data collection process by taking the time to complete the community health needs assessment survey.

## **PARTNERS**

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- Key Project Partners (Core planning team)
  - Carla Boucher – Billing Clinic Miles City
  - Christine Williams – Montana Health Network
  - Chelsea Jerke – oneHealth-Custer County Public Health
  - Cindia Ellis – oneHealth-Custer County Public Health
  - Heidi Zentz – Holy Rosary Healthcare
  - Karla Lund – Miles Community College
  - Marybeth Squires – Holy Rosary Healthcare
  - Meredith Hirsch – Billings Clinic Miles City
  - Wendy Richards – oneHealth-Custer County Public Health
  
- Community Partners, stakeholders, and organizations
  - Billings Clinic Miles City
  - Holy Rosary Healthcare
  - Miles Community College
  - CareHere Clinic
  - Dr. Rauh Clinic
  - Eastern Montana Mental Health Center
  - Miles City Public Library
  - Senior Citizens Center
  - Miles City Soup Kitchen
  - OneHealth-Custer County Public Health

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## ***EXECUTIVE SUMMARY***

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The Public Health Accreditation Board’s (PHAB) definition of a community health assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of the Custer County Community Health Assessment is to develop strategies to address the community's health needs and identified issues. After gathering and analyzing the data obtained, community stakeholders and other partners can begin to develop a community health improvement plan.

The mission of the Custer County Health Alliance is to create a culture of health and to promote health and wellness in Custer County with a unified voice.

Key findings of the survey:

What is important for a healthy community, top three:

#1 – Access to health care and other services – 54.82% of responses

#2 – Good jobs and a healthy economy – 42.13% of responses

#3 – Clean air/water – 31.47% of responses

Good schools – 31.47% of responses

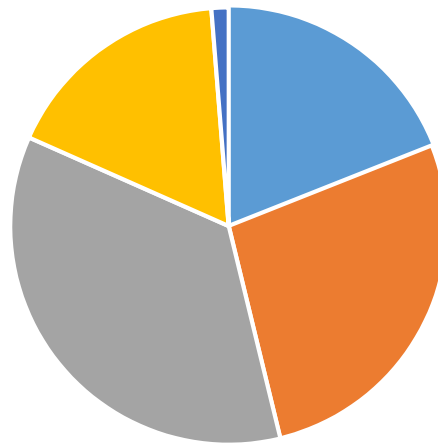
What issues do you consider a “big problem”, top three:

#1 – Illegal drug use – 68.54% of responses

#2 – Prescription drug abuse – 50% of responses

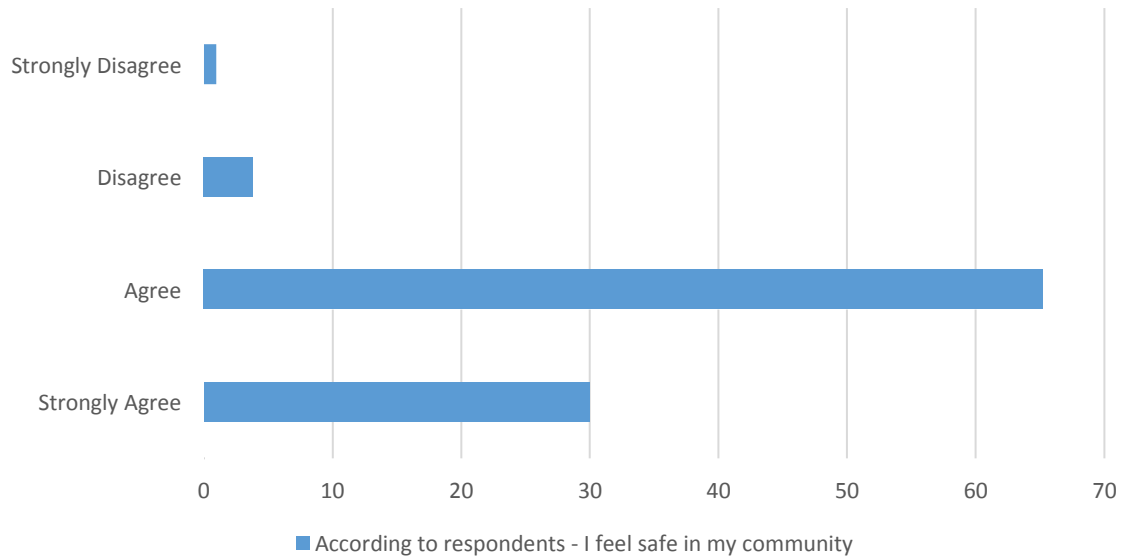
#3 – Alcohol Abuse – 44.38% of responses

According to respondents- The environment of Custer County has:



■ Improved ■ Declined ■ No Change ■ Don't know ■ Prefer not to say

I feel safe in my community - when asked of respondents



■ According to respondents - I feel safe in my community

## ***METHODOLOGY***

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The Community Health Alliance was convened to lead the assessment. This group includes individuals representing various healthcare businesses and service organizations throughout the community. This diverse group of individuals from the community allowed for the development of a survey to act as the primary data collection tool. Data was collected through an online survey collection tool called Survey Monkey. A web link to the survey was shared throughout the community using social media, newspaper, websites, and radio. There were also survey collection boxes and hardcopy's of the survey placed around the community at eight different sites for individuals who chose not to fill out the survey online. Next to the survey box, the web-link was provided on piece of paper for others to take home and fill out if they chose.

The survey consisted of questions that assessed factors for a healthy community, individual health and barriers to health, emergency preparedness and demographics.



## LIMITATIONS

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Limitations to the

- ☒ Used online survey as primary data collection tool (included paper copies around town)
  - Access to internet
  - Ability to use internet
- ☒ Length of survey (many comments regarding survey was too long)
- Gender Bias – 77.78% of respondents were Female



## **BACKGROUND**

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Custer County is located in southeastern Montana. The county seat of Miles City was founded in 1876 and is rich in history. Both livestock and crop production is the foundation of eastern Montana’s economy, and Miles City is its hub. The region is known for its high-quality, carefully bred cattle. Eastern Montana also leads in sheep production. Wheat, both winter and summer varieties, is the major small grain grown in the region.

Miles City is probably best known for bucking horses and its proud Western heritage. Annually in May the population nearly doubles to host the World Famous Miles City Bucking Horse Sale, earning Miles City’s nickname - “The Cowboy Capital of the World”.

Miles City hosts medical facilities, a community college and a steadily expanding business district serving several outlying communities as well as farm and ranch families.



## Demographic Information



<input type="text"/>	<b>Montana</b>	<b>Custer County, Montana</b>
<b>Population estimates, July 1, 2016, (V2016)</b>	<b>1,042,520</b>	<b>11,924</b>

### PEOPLE

<b>Population</b>		
<b>Population estimates, July 1, 2016, (V2016)</b>	<b>1,042,520</b>	<b>11,924</b>
Population estimates base, April 1, 2010, (V2016)	989,414	11,699
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	5.4%	1.9%
Population, Census, April 1, 2010	989,415	11,699
<b>Age and Sex</b>		
Persons under 5 years, percent, July 1, 2016, (V2016)	6.0%	6.2%
Persons under 5 years, percent, April 1, 2010	6.3%	6.2%
Persons under 18 years, percent, July 1, 2016, (V2016)	21.8%	21.5%
Persons under 18 years, percent, April 1, 2010	22.6%	22.7%
Persons 65 years and over, percent, July 1, 2016, (V2016)	17.7%	19.2%
Persons 65 years and over, percent, April 1, 2010	14.8%	17.5%
Female persons, percent, July 1, 2016, (V2016)	49.7%	49.7%
Female persons, percent, April 1, 2010	49.8%	50.3%



<b>Race and Hispanic Origin</b>		
White alone, percent, July 1, 2016, (V2016)(a)	89.2%	94.7%
White alone, percent, April 1, 2010(a)	89.4%	95.5%
Black or African American alone, percent, July 1, 2016, (V2016)(a)	0.6%	0.4%
Black or African American alone, percent, April 1, 2010(a)	0.4%	0.3%
American Indian and Alaska Native alone, percent, July 1, 2016, (V2016)(a)	6.6%	2.2%
American Indian and Alaska Native alone, percent, April 1, 2010(a)	6.3%	1.7%
Asian alone, percent, July 1, 2016, (V2016)(a)	0.8%	0.5%
Asian alone, percent, April 1, 2010(a)	0.6%	0.3%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016, (V2016)(a)	0.1%	0.1%
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010(a)	0.1%	0.1%
Two or More Races, percent, July 1, 2016, (V2016)	2.7%	2.0%
Two or More Races, percent, April 1, 2010	2.5%	1.6%
Hispanic or Latino, percent, July 1, 2016, (V2016)(b)	3.6%	3.1%
Hispanic or Latino, percent, April 1, 2010(b)	2.9%	2.2%
White alone, not Hispanic or Latino, percent, July 1, 2016, (V2016)	86.5%	92.2%
White alone, not Hispanic or Latino, percent, April 1, 2010	87.8%	94.1%
<b>Population Characteristics</b>		
Veterans, 2011-2015	90,000	1,081
Foreign born persons, percent, 2011-2015	2.1%	1.7%
<b>Housing</b>		
Housing units, July 1, 2016, (V2016)	497,756	5,596
Housing units, April 1, 2010	482,825	5,560
Owner-occupied housing unit rate, 2011-2015	67.2%	69.1%
Median value of owner-occupied housing units, 2011-2015	\$193,500	\$137,300
Median selected monthly owner costs -with a mortgage, 2011-2015	\$1,294	\$1,033
Median selected monthly owner costs -without a mortgage, 2011-2015	\$387	\$348
Median gross rent, 2011-2015	\$711	\$612
Building permits, 2016	4,781	0
<b>Families &amp; Living Arrangements</b>		
Households, 2011-2015	409,394	4,827

Persons per household, 2011-2015	2.41	2.38
Living in same house 1 year ago, percent of persons age 1 year+, 2011-2015	83.6%	82.3%
Language other than English spoken at home, percent of persons age 5 years+, 2011-2015	4.1%	3.1%
<b>Education</b>		
High school graduate or higher, percent of persons age 25 years+, 2011-2015	92.8%	91.4%
Bachelor's degree or higher, percent of persons age 25 years+, 2011-2015	29.5%	20.0%
<b>Health</b>		
With a disability, under age 65 years, percent, 2011-2015	9.1%	9.4%
Persons without health insurance, under age 65 years, percent	14.0%	12.2%
<b>Economy</b>		
In civilian labor force, total, percent of population age 16 years+, 2011-2015	63.6%	66.4%
In civilian labor force, female, percent of population age 16 years+, 2011-2015	59.5%	62.8%
Total accommodation and food services sales, 2012 (\$1,000)(c)	2,420,455	28,523
Total health care and social assistance receipts/revenue, 2012 (\$1,000)(c)	6,469,475	67,153
Total manufacturers shipments, 2012 (\$1,000)(c)	11,535,236	D
Total merchant wholesaler sales, 2012 (\$1,000)(c)	12,645,824	64,342
Total retail sales, 2012 (\$1,000)(c)	15,623,573	256,660
Total retail sales per capita, 2012(c)	\$15,544	\$21,590
<b>Transportation</b>		
Mean travel time to work (minutes), workers age 16 years+, 2011-2015	18.1	13.2
<b>Income &amp; Poverty</b>		
Median household income (in 2015 dollars), 2011-2015	\$47,169	\$48,750
Per capita income in past 12 months (in 2015 dollars), 2011-2015	\$26,381	\$25,506
Persons in poverty, percent	14.6%	12.2%
<b>BUSINESSES</b>		
<b>Businesses</b>		
Total employer establishments, 2015	37,270	425
Total employment, 2015	375,041	4,500
Total annual payroll, 2015 (\$1,000)	14,227,065	154,680

Total employment, percent change, 2014-2015	3.1% <sup>1</sup>	-0.4%
Total nonemployer establishments, 2015	86,969	867
All firms, 2012	112,419	1,058
Men-owned firms, 2012	55,913	478
Women-owned firms, 2012	35,449	344
Minority-owned firms, 2012	5,578	26
Nonminority-owned firms, 2012	102,746	961
Veteran-owned firms, 2012	11,486	125
Nonveteran-owned firms, 2012	93,393	778

## GEOGRAPHY

Geography		
Population per square mile, 2010	6.8	3.1
Land area in square miles, 2010	145,545.80	3,783.36
FIPS Code	30	30017

Source: [https://www.census.gov/quickfacts/fact/table/MT\\_custercountymontana/PST045216](https://www.census.gov/quickfacts/fact/table/MT_custercountymontana/PST045216) (i)



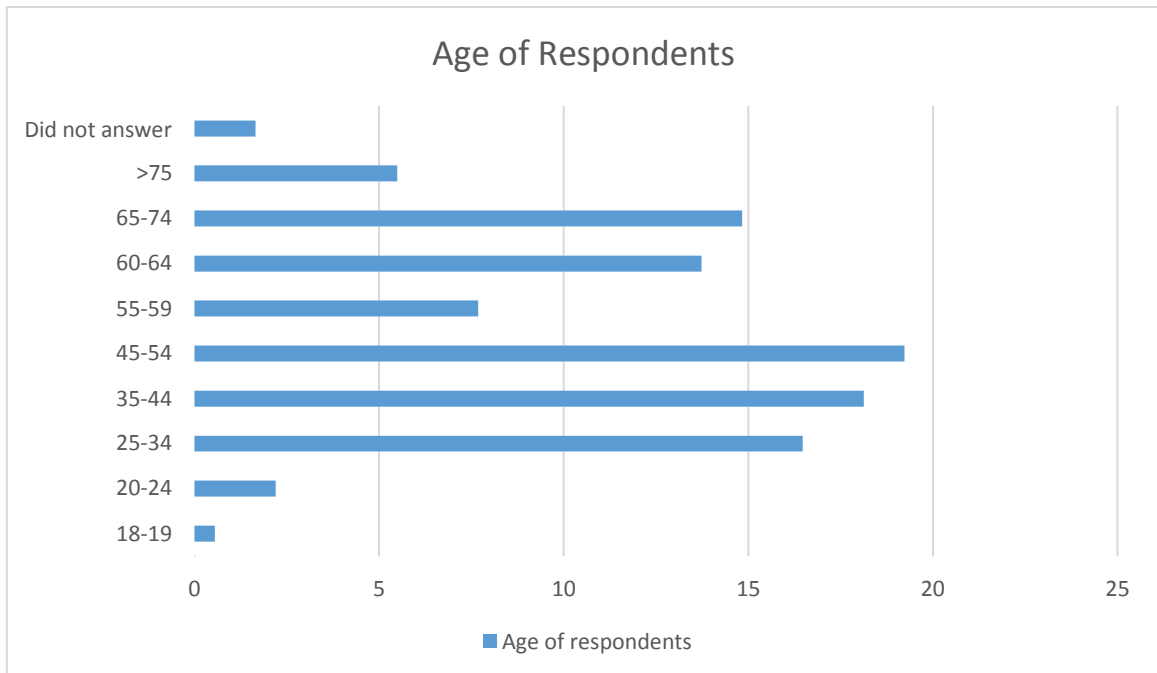
## PRIMARY DATA SUMMARY

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The Primary Data Summary is based off of the 212 surveys that were obtained from community members.

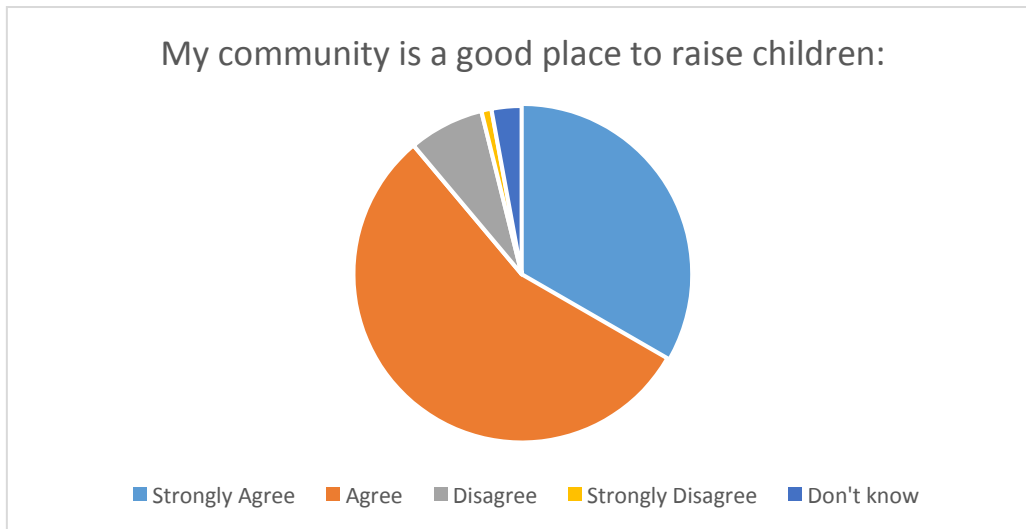
Who completed the surveys:

- 78% Female, 19% Male, 3% Other
- 80% own their home and 90% live in a single family home
- 60% have lived in Custer County 20+ years and 15% less than 5 years
- 95% White/Caucasian race, 2% American Indian or Alaska Native
- 96% non-Hispanic and 2% Hispanic



**Raising Children:**

Approximately 88% of those surveyed Agree/Strongly Agree.



What needs to be available or improved to make it a better place to raise children, top 3 responses:

#1 – More activities for teens – 49% of responses

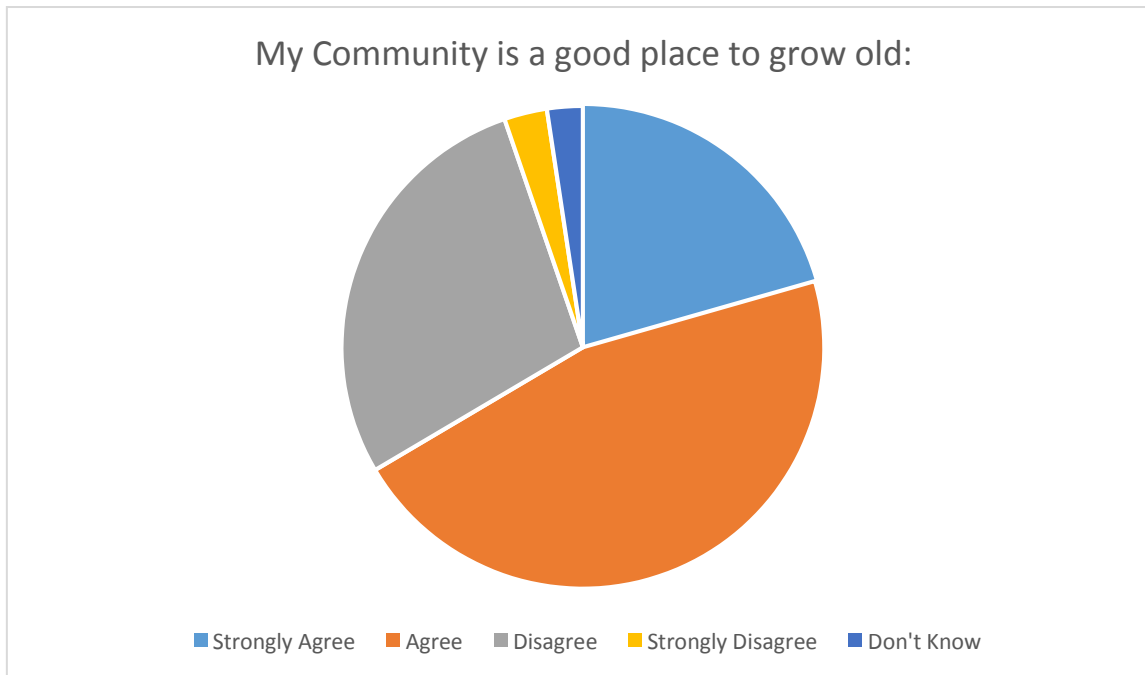
#2 – Improved summer activities – 43% of responses

#3 – More things for children to do with free time – 42% of responses



## Growing Old

Approximately 30% Disagree/Strongly Disagree



What do you think would make our community a better place to grow old, top 3 responses:

- #1 – Transportation assistance – 68% of responses
- #2 – Expanded medical services – 52% of responses
- #3 – Expanded senior center – 42% of responses



## Health Care, Dental Health, Mental Health and Healthy Living

- I can get the health care I need near my home:
  - 77% Agree or Strongly agree and 22% Disagree or Strongly disagree
- How long has it been since you last visited a dentist for a routine checkup:
  - 58% less than 1 year and 2% have never been for a routine checkup
- In the past year delayed or did not get health services:
  - 30% answered yes and 69% answered no
    - Of those that answered yes: cost, could not get appointment and could not get off work were the top 3 reasons why.
- What would improve access to health care, top 3:
  - Availability of visiting specialists, more primary care providers and improved quality of care.
- Do you know where someone in your community who may need mental health services like counseling or treatment could go to get them?
  - 74% answered yes and 19% answered no.
- Top 3 reasons listed for not eating a healthy diet were:
  - Healthy food costs too much, it's hard to find healthy food and it takes too much time to prepare.
- 20% of respondents felt they could not afford healthy food near their home and 14% have skipped meals or cut the size of a meal because there was not enough money for food.
- 84% of respondents feel prepared for an emergency, however 60% do not have a basic emergency supply kit and plan.

## SECONDARY DATA

### Montana Behavioral Risk Factor Surveillance System (BRFSS)<sup>(iii)</sup>

The following table includes an overview of selected findings from the 2014 Montana BRFSS survey. The survey is conducted through a collaborative effort with the Division of Behavioral Surveillance of the Centers for Disease Control and Prevention (CDC) and the Montana Department of Public Health and Human Services (DPHHS). This survey provides valuable information on health trends, chronic disease risks, and data for monitoring the effectiveness of policies, programs, and interventions. Due to the small numbers in Montana, these indicators are reported by Health Planning Regions.

Health Indicator	Eastern Montana Region	Montana
<b>Health Status Indicators</b>	<b>Wt% (95% CI)</b>	<b>Wt% (95% CI)</b>
Self-Reported Fair or Poor Health	15.7% (13.0%-18.9%)	15.4% (14.3%-16.7%)
Frequent Poor Physical Health	9.4% (7.4%-11.7%)	12.5% (11.5%-13.6%)
Frequent Poor Mental Health	10.2% (7.5%-13.8%)	9.9% (8.9%-11.0%)
Frequent Activity Limitation	11.3% (8.3%-15.2%)	16.0% (14.4%-17.8%)
Activity Limited Due to Health Problems	19.3% (16.5%-22.5%)	23.1% (21.8%-24.5%)
Self-Reported Disability	20.8% (17.8%-24.0%)	24.8% (23.4%-26.2%)
<b>Health Care Indicators</b>	<b>Wt% (95% CI)</b>	<b>Wt% (95% CI)</b>
No Health Care Coverage (ages 18-64)	12.1% (8.8%-16.3%)	16.1% (14.6%-17.8%)
Couldn't Afford to See Doctor (past 12 months)	8.6% (6.4%-11.5%)	11.9% (10.8%-13.2%)
No Personal Health Care Provider	33.2% (29.1%-37.6%)	29.1% (27.6%-30.8%)
No Routine Checkup in the Past Year	37.9% (33.7%-42.3%)	36.4% (34.7%-38.0%)
No Dental Visit in the Past Year	42.6% (38.4%-46.9%)	37.4% (35.8%-39.1%)



<b>Clinical Preventive Practices</b>	Wt% (95% CI)	Wt% (95% CI)
No Mammogram in Past 2 years (women ages 50+)	30.2% (24.5%-36.5%)	28.0% (25.7%-30.5%)
No Mammogram Ever (women ages 50+)	7.6% (4.7%-12.1%)	4.8% (3.8%-6.0%)
No Pap Test in Past 3 years (women ages 18+)	29.1% (22.1%-37.3%)	25.4% (23.0%-28.0%)
No Colonoscopy in Past 10 years (ages 50-75)	52.3% (47.0%-57.6%)	41.2% (39.0-43.4%)
No Up-To-Date Colorectal Cancer Screening (ages 50-75)	46.9% (41.6%-52.3%)	37.6% (35.5%-39.8%)
Received Influenza Vaccine in Past Year (ages 18-64)	32.8% (28.4%-37.5%)	32.4% (30.6%-34.3%)
Received Influenza Vaccine in Past Year (ages 65+)	61.0% (54.3%-67.3%)	60.7% (58.1%-63.3%)
Received Pneumococcal Vaccine (ages 65+)	68.9% (62.1%-75.0%)	70.3% (67.7%-72.7%)



## County Health Rankings and Roadmaps (iii)

The *County Health Rankings & Roadmaps* program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The *County Health Rankings* measure the health of nearly all counties in the nation and rank them within states. The *Rankings* are compiled using county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights. The annual *Rankings* provide a revealing snapshot of how health is influenced by where we live, learn, work and play.

Health Indicator	Custer County	Montana
<b>Quality of Life</b>	Custer County (Error Margin)	Montana
Poor or fair health	12% (11%-12%)	14%
Poor physical health days	3.2 (3.0-3.4)	3.9
Poor mental health days	3.1 (3.0-3.3)	3.4
Low birthweight	8% (6%-9%)	7%
Frequent physical distress (not included in overall ranking)	10% (9%-10%)	12%
Frequent mental distress (not included in overall ranking)	9% (9%-10%)	10%
<b>Health Behaviors</b>		
Adult Smoking	17% (16%-18%)	20%
Adult Obesity	30% (26%-34%)	25%
Physical Inactivity	28% (24%-32%)	22%
Excessive drinking	21% (20%-21%)	21%
Alcohol-impaired driving deaths	57% (39%-71%)	47%
Teen births	41 (33-49)	33

<b>Clinical Care</b>		
Uninsured	18% (16%-20%)	20%
Preventable Hospital Stays	64 (52-75)	44
Primary Care Physicians	1,200:1	1,310:1
Dentists	1,730:1	1,480:1
Diabetic Monitoring	89% (74%-100%)	81%
Uninsured Adults (not included in overall ranking)	22% (19%-24%)	23%
Uninsured Children (not included in overall ranking)	9% (7%-12%)	11%
Health Care Costs (not included in overall ranking)	\$6,979	\$7,477



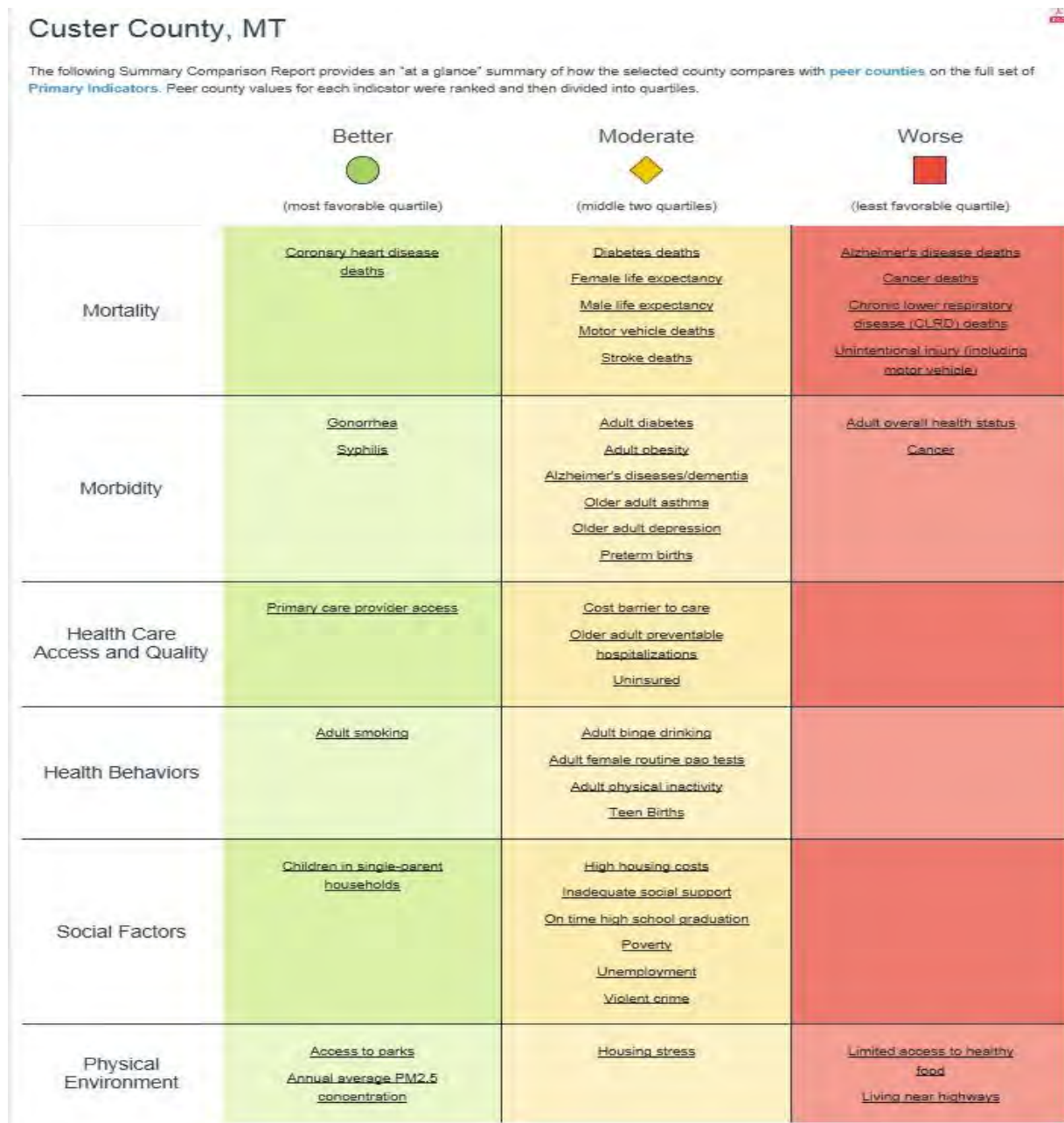
**The Institute for Health Metrics and Evaluation, University of Washington (2014)** <sup>(iv)</sup>

The *Institute for Health Metrics and Evaluation* analyzed performance of all US counties or county-equivalents in terms of mortality rates for select causes, life expectancy at birth, alcohol use, smoking prevalence, obesity prevalence, and recommended physical activity using novel small area estimation techniques and the most up-to-date county-level information. This data is based on estimates.

<b>Finding</b>	<b>Custer County Rate per 100,000 population, age-standardization, 2014</b>	<b>Montana Rate per 100,000 population, age-standardization, 2014</b>
All-Cause Mortality	Female 725.5 Male 1025.1	Female 682.9 Male 912.5
Diabetes, Urogenital, Blood, and Endocrine Diseases Mortality	Female 62.7 Male 61.5	Female 43.9 Male 53.8
Self-Harm and Interpersonal Violence Mortality	Female 14.0 Male 48.7	Female 13.7 Male 43.0
Transport Injuries Mortality	Female 10.9 Male 44.3	Female 13.8 Male 30.9
Mental and Substance Use Disorders Mortality	Female 10.3 Male 15.3	Female 9.3 Male 17.3
Cirrhosis and Other Chronic Liver Diseases Mortality	Female 15.5 Male 23.0	Female 16.1 Male 23.3
<b>Finding</b>	<b>Custer County Life expectancy at birth (years), 2013</b>	<b>Montana Life expectancy at birth (years), 2013</b>
Life Expectancy	Female 80.2 Male 74.9	Female 81.2 Male 76.4
<b>Finding</b>	<b>Custer County Prevalence (%), age-standardization, 2012</b>	<b>Montana Prevalence (%), age-standardization, 2012</b>
Heavy Drinking	Female 6.4 Male 11.1	Female 10.0 Male 13.4
Binge Drinking	Female 15.3 Male 26.8	Female 17.9 Male 30.3
Smoking	Female 22.0 Male 24.6	Female 19.8 Male 22.1
<b>Finding</b>	<b>Custer County Prevalence (%), age-standardization, 2011</b>	<b>Montana Prevalence (%), age-standardization, 2011</b>
Obesity	Female 33.9 Male 36.6	Female 32.0 Male 31.3
Recommended Physical Activity	Female 53.5 Male 57.3	Female 58.5 Male 60.4

## Community Health Status Indicators 2015 (v)

The *Community Health Status Indicators (CHSI 2015)* is an interactive web application created by the Centers for Disease Control and Prevention. The application has health profiles for all counties in the United States. Each county profile displays key indicators of health outcomes.



Health Indicator	Custer County
Alzheimer’s disease death rate	33.2 (per 100,000)
Cancer death rate	200.7 (per 100,000)
Chronic lower respiratory disease death rate	71.1 (per 100,000)
Unintentional injury death rate (including motor vehicle)	84.2 (per 100,000)
Percent of adults reporting fair or poor health	18.7%
Cancer incidence rate	489.4 (per 100,000)
Limited access to healthy food (percent of individuals who are low-income and do not live close to a grocery store)	17.6%
Percent of population living near a highway	4.2%



## County Health Profile 2015 <sup>(vi)</sup>

### Communicable Disease

**Table 1. Number and rate of selected communicable diseases — Montana, 2011–2013.**

Custer County			Medium County Data		Montana
Health Indicator	Number	Rate per 100,000a (95% CI)	Number per County	Rate per 100,000a (95% CI)	Rate per 100,000a (95% CI)
Chlamydia	112	314.76 (259.1, 378.3)	3,344	484.99 (468.9, 501.7)	366.2 (359.5, 373.1)
Hepatitis C	25	70.26 (45.3, 103.4)	1,185	171.86 (162.4, 181.9)	123.0 (119.1, 127.0)
Pertussis	4	11.24 (3.2, 28.4)	253	36.69 (32.4, 41.5)	44.6 (42.3, 47.0)
Campylobacteriosis	11	30.91 (15.0, 54.9)	169	24.51 (21.1, 28.5)	22.2 (20.6, 24.0)

aDepartment of Corrections population included in county rate where applicable.  
Data provided by the Communicable Disease Epidemiology Section.

**Table 2. Up-to-date (UTD) on childhood vaccinations for 24–35 month old children as of March 1st of the year of assessment based on imMTrax data reviewed during Vaccines for Children Program Clinic Reviews conducted every other year — Montana, 2011 and 2014.a**

Health Indicator	Custer County	Medium County Data	Montana
Number assessed 2011b	73	731	2,249
Number UTD 2011	47	471	1,305
Percent UTD 2011c	64.4	64.4	58.7
Number assessed 2014d	-	1,536	4,042
Number UTD 2014	-	987	2,651

Percent UTD 2014	-	64.3	65.6
(95% CI)	-	(61.8, 66.7)	(64.1, 67.1)

aUTD = 4 DTaP, 3 Polio, 1 MMR, 3/4 HIB, 3 Hep B, 1 Var, 4 PCV by 24 months.

bIn 2011, chart reviews occurred. Clinics with fewer 50 chart, the review included all available charts. Clinics with more than 50 charts, a sample of charts were reviewed and validated.

cConfidence interval cannot be calculated because the total number of records reviewed is unknown.

dIn 2014, all immunization records were reviewed electronically in the Montana Immunization Information System (imMTrax). The precision of each estimate was quantified using 95% confidence intervals.

Data provided by the Immunization Section of the Communicable Disease Bureau.

## **Chronic Disease**

**Table 3. Inpatient admissions for selected chronic conditions — Montana, 2011–2013.**

<b>Custer County</b>			<b>Medium County Data</b>		<b>Montana</b>
Health Indicator	Number	Rate per 100,000a (95% CI)	Average Number per County	Rate per 100,000a (95% CI)	Rate per 100,000a (95% CI)
Asthma	27	64.4 (41.7, 98.3)	26.6	52.0 (46.7, 57.9)	47.7 (45.2, 50.3)
Chronic Obstructive Pulmonary Disease (COPD)b	476	905.1 (823.7, 995.3)	536.2	819.0 (800.0, 838.3)	716.8 (708.1, 725.6)
Cardiovascular Disease	408	825.7 (744.2, 916.3)	518.6	807.9 (788.8, 827.4)	746.7 (737.7, 755.8)
Diabetes (types 1 and 2)	555	1,157.0 (1058.3, 1264.9)	608.0	1,000.7 (978.5, 1023.4)	822.5 (812.8, 832.3)

aRates are age standardized to the 2000 Projected US Population using Distribution #1 as described in Klein and Schoenborn 2001 and given per 100,000 person years.

bChronic obstructive pulmonary disease (COPD), includes chronic bronchitis, emphysema, bronchiectasis, and chronic airway obstruction.

‡ Does not meet standards of reliability or precision.

Inpatient admission and ED visit data provided courtesy of participating MHA members, collected through the Montana Hospital Discharge Data System (MHDDS).



**Table 4. Inpatient admissions for injury by type and mechanism of injury — Montana, 2011–2013.**

Custer County			Medium County Data		Montana
Health Indicator	Number	Rate per 100,000a (95% CI)	Average Number per County	Rate per 100,000a (95% CI)	Rate per 100,000a (95% CI)
All Unintentional Injury	271	600.3 (527.2, 683.2)	369.7	671.1 (652.1, 690.7)	538.6 (530.6, 546.8)
Falls	140	269.3 (224.9, 323.1)	189.5	312.1 (299.9, 324.7)	268.7 (263.2, 274.3)
Struck by/against	5	‡ ‡	12.4	24.6 (20.9, 28.9)	18.0 (16.5, 19.6)
Motor Vehicle	19	‡ ‡	42.2	93.6 (86.0, 101.8)	60.6 (57.8, 63.6)
Poisoning	16	‡ ‡	19.6	36.8 (32.3, 41.8)	36.3 (34.2, 38.5)
Intentional Self-Harm	36	113.8 (78.7, 160.9)	42.4	100.1 (92.0, 108.8)	106.5 (102.6, 110.5)
Traumatic Brain Injury	23	51.9 (31.8, 83.1)	59.1	117.5 (109.2, 126.2)	91.3 (87.9, 94.8)

aRates are age standardized to the 2000 Projected US Population using Distribution #1 as described in Klein and Schoenborn 2001 and given per 100,000 person years.

‡ Does not meet standards of reliability or precision.

Inpatient admission and ED visit data provided courtesy of participating MHA members, collected through the Montana Hospital Discharge Data System (MHDDS).

**Table 7. Cancer incidence — Montana, 2011–2013.**

Custer County			Medium County Data		Montana
Health Indicator	Number	Rate per 100,000 (95% CI)	Average Number per County	Rate per 100,000 (95% CI)	Rate per 100,000 (95% CI)
All Cancer	241	497.7 (434.6, 570.1)	290.1	442.1 (428.1, 456.6)	439.8 (432.9, 446.8)
Prostate (males)	40	163.9 (115.8, 233.3)	36.4	103.0 (94.0, 113.0)	112.8 (108.1, 117.8)
Breast (female)	22	88.5 (53.8, 144.3)	38.0	113.9 (104.0, 124.8)	115.7 (110.8, 120.9)
Lung and Bronchus	38	77 (54.1, 110.0)	38.2	56.7 (51.9, 62.0)	56.4 (54.0, 58.9)
Colon and Rectum	22	48.5 (29.7, 78.5)	25.2	37.9 (33.9, 42.4)	36.9 (35.0, 39.0)
Corpus Uteri (female)	9	‡ ‡	10.4	29.8 (25.0, 35.7)	25.4 (23.2, 27.9)
Melanoma	11	‡ ‡	14.6	23.4 (20.1, 27.1)	24.9 (23.2, 26.7)

‡ Does not meet standards of reliability or precision.

Cancer incidence data are from the Montana Central Tumor Registry.

### **Maternal and Child Health**

**Table 9. Births to Custer County Residents, 2011–2013.**

Health Indicator	Custer County	Montana
Number of births	457	35,881

Data about births were tabulated from birth certificates of infants to Montana-resident mothers who delivered in Montana, 2011–2013, covering more than 95% of all births.

† Fewer than five events.

**Table 10. Teen birth rate per 1,000 females age 15–19 years, 2009–2013.a,b**

Health Indicator	Custer County	Montana
Teen birth rate per 1,000	40.3	31.6

aDue to the small number of events in some counties, five year rates have been used to include more counties with at least 20 events over the five years. Not all counties had enough events to be included.

bFull report can be found at:

<http://dphhs.mt.gov/Portals/85/publichealth/documents/WMH/2014%20Teen%20Birth%20and%20Pregnancy%20Report%20Final.pdf>

‡Rates are not calculated for fewer than 20 events; data do not meet standards of precision or reliability.

**Table 12. Births to Custer County Residents 2011–2013.<sup>a</sup>**

Health Indicator	Custer County		Medium County Data		Montana	
	Number	Percent (95% CI) <sup>b</sup>	Number	Percent (95% CI) <sup>b</sup>	Number	Percent (95% CI) <sup>b</sup>
Born less than 37 weeks	35	7.6 (5.3, 10.4)	673	9.5 (8.9,10.2)	3,226	8.9 (8.6, 9.2)
Born weighing less than 2,500 grams	32	7 (4.8, 9.7)	508	7.2 (6.6, 7.8)	2,607	7.2 (6.9, 7.5)
Women entering prenatal care after first trimester	82	17.9 (14.5, 21.7)	2,596	36.9 (35.8, 38.1)	9,733	27.1 (26.6, 27.5)
Women whose Kotelchuck Index is $\geq$ 80% <sup>c</sup>	423	92.5 (89.7, 94.7)	5,492	78.2 (77.2, 79.1)	30,429	84.8 (84.4, 85.1)
Smoking during pregnancy	107	23.4 (19.6, 27.5)	1,546	22 (21, 23)	5,847	16.2 (15.9, 16.6)

Education less than high school graduate	35	7.6 (5.3, 10.4)	1,365	19.4 (18.5, 20.3)	4,281	11.9 (11.5, 12.2)
Any insurance	425	92.9 (90.2, 95.1)	6,371	90.7 (90, 91.4)	32,615	90.8 (90.5, 91.1)
Receiving WIC	146	31.9 (27.6, 36.4)	2,769	39.4 (38.2, 40.5)	11,778	32.8 (32.3, 33.3)
Breastfeeding at discharge	374	81.8 (77.9, 85.2)	5,396	76.8 (75.8, 77.8)	30,728	85.6 (85.6, 86)

aData about births were tabulated from birth certificates of infants to Montana-resident mothers who delivered in Montana, 2011–2013, covering more than 95% of all births. Demographic information on the birth certificates is self-reported by parents; medical information is abstracted from medical records.

bConfidence intervals (95%) for the percentage are computed using the Exact Method.

cKotelchuck Index: computed index of adequacy of prenatal care, function of early initiation and enough visits, 80% or greater is defined as adequate.

† Fewer than five events.‡ Rates are not calculated for fewer than 20 events; data do not meet standards of precision or reliability.

Data provided by Office of Epidemiology and Scientific Support, MT DPHHS

## **Mortality**

**Table 13. Median age at death in years by race and sex — Montana, 2011–2013.**

<b>Custer County</b>			<b>Medium County Data</b>		<b>Montana</b>	
<b>Health Indicator</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>
White	77.0	83.0	75.0	82.0	76.0	83.0
American Indian	†	†	59.0	65.0	62.5	63.5

† Too few events to report or complimentary suppression of corresponding cell.

## ***COMMUNITY RESOURCES***

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The following community resources have been identified as organizations that have the ability to improve the health and overall well-being of Custer County residents as a whole.

oneHealth

Holy Rosary Healthcare

Billings Clinic Miles City

Montana Health Network

Custer City-County Board of Health

Miles City Police/Fire

Custer County Sheriff/Fire

Child & Family Services

Adult Protective Services

Council on Aging

CNADA

DEAP

AWARE

OPA

Grounds for Change

EMCMHC

EMI

Miles City & Rural Schools

## ***DATA SOURCES:***

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- ② <http://www.census.gov/quickfacts/table/INC910215/30017,30079,30> (i)
- ② <http://dphhs.mt.gov/publichealth/BRFSS/Annual-Reports/2014AnnualReport> (ii)
- ② <http://www.countyhealthrankings.org/app/montana/2016/rankings/custer/county/outcomes/overall/snapshot> (iii)
- ② [http://www.healthdata.org/sites/default/files/files/county\\_profiles/US/2015/County\\_Report\\_Custer\\_County\\_Montana.pdf](http://www.healthdata.org/sites/default/files/files/county_profiles/US/2015/County_Report_Custer_County_Montana.pdf) (iv)
- ② <https://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/MT/Custer/> (v)
- ② <http://dphhs.mt.gov/Portals/85/publichealth/Publications/County%20Health%20Profiles/Custer%20Community%20Health%20Profile.pdf> (vi)



# PROGRESS ON ADDRESSING PREVIOUSLY IDENTIFIED PRIORITY HEALTH NEEDS



## Current Health Improvement Priorities (2015-2018)

- Access to Healthcare Services
  - IN PROGRESS • Centralized resource tool
  - ✓ • Cancer Patient Navigators and support groups
  - ✓ • Transportation assistance
  - ✓ • Financial support of Holy Rosary Clinic
  - ✓ • Certified Application Counselors for marketplace
  - ✓ • Added 2 additional primary care physicians and 1 midlevel
- Mental Health
  - ✓ • Integrated behavioral health access
  - ✓ • Mental Health First Aid training
- Tobacco Use
  - ✓ • Patient tobacco education to all patients
  - IN PROGRESS • Reporting and documentation process
  - IN PROGRESS • Decrease Holy Rosary Associate smoking rates



Additional data related to mental health need was included in Holy Rosary Healthcare's Community Health Needs Assessment from the *2017 Eastern Montana Behavioral Health Crisis Response and Jail Diversion Strategic Plan* prepared by Jane Smilie, MPH, Population Health Partners; Katie Loveland MPH, MSW, Loveland Consulting LLC; and Deann Carr, LCSW, CCEP, TCN Consultation. Pages 20-24 of this report are included on the following pages.



# Quantifying the impact of behavioral health crises in Eastern Montana

Though behavioral health crises are difficult to define and capture in clinical and billing data, we analyzed a number of sources to assess the impact of behavioral health crises in the region including:

- Medicaid data showing the utilization of mental health and SUD related treatment

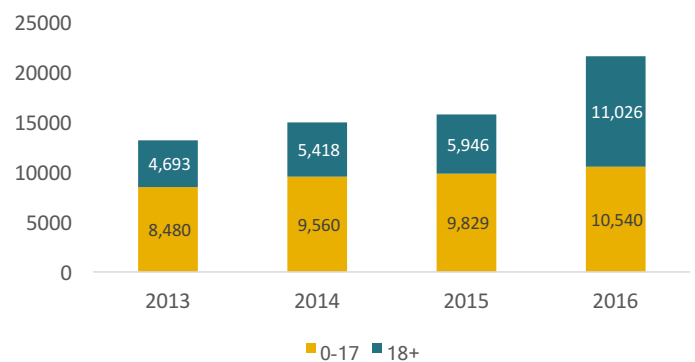
and prescriptions in the region for low income adults and children

- Hospitalization data (both inpatient and ER) for behavioral health concerns in the 16 critical access hospitals that serve the region
- Vital records data on intentional self harm (suicide)

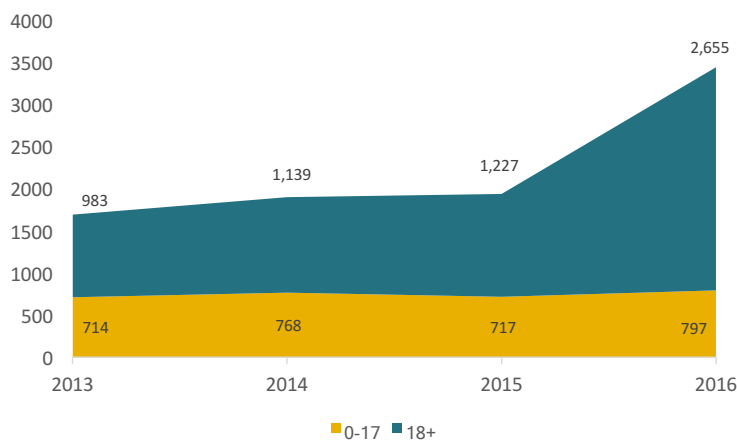
## Behavioral health services and Medicaid

The Montana HELP Act expanded Medicaid coverage to adults up to 138% of the Federal Poverty Level effective January 2016. This law caused a surge in enrollment in Medicaid. Eastern Montana saw a 64% increase in Medicaid enrollment from 2013 to 2016 driven by an 135% increase in the number of Medicaid enrolled adults. In all, 21,566 individuals are now enrolled in Medicaid in Eastern Montana. This constitutes 26% of the entire population, up from 16% in 2013.

Medicaid and CHIP enrolled individuals, Eastern Montana, 2013-2016



Individuals in Eastern Montana with any mental health prescription on Medicaid or CHIP, 2013-2016

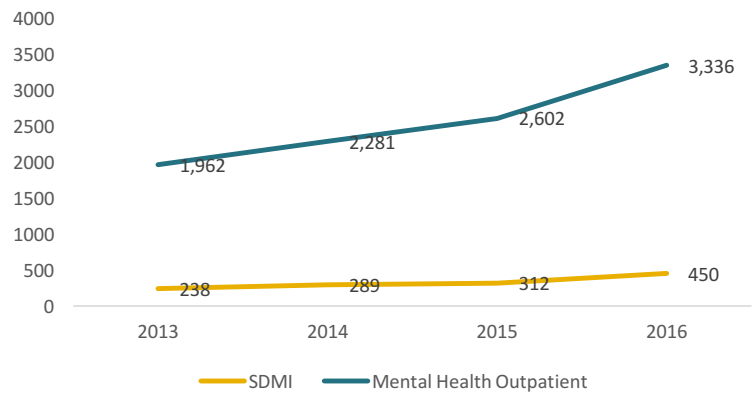


Increased enrollment brought an increase in the number of individuals receiving care for behavioral health concerns through Medicaid. The number of adults with a prescription related to mental health grew at an even faster rate than the increase in enrollment, up 170% from 2013 to 2016. In 2016, 3,452 individuals on Medicaid in Eastern Montana received at least one mental health prescription. In all, 8% of the children on Medicaid or CHIP (the Children's Health Insurance Plan) in Eastern Montana and 24% of the adults on Medicaid received a mental health prescription in 2016.

# Behavioral health services and Medicaid

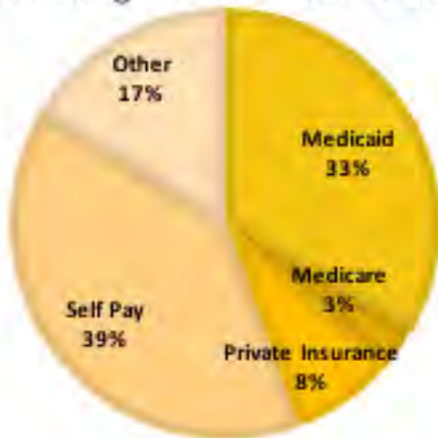
Other behavioral health-related services also increased as a result of Medicaid expansion. There were over 3,300 individuals on Medicaid in Eastern Montana with an outpatient visit for mental health in 2016, compared to only 1,900 in 2013 (a 70% increase) and the number of adults in Eastern Montana on Medicaid with Severe and Disabling Mental Illness (SDMI) increased 89% from 2013 to 2016. Individuals being treated for substance use disorders (SUD) also increased under Medicaid expansion. In 2013, only 210 individuals in Eastern Montana on Medicaid had an outpatient visit for SUD. In 2016, the number more than tripled to 674.

Number of individuals on Medicaid in Eastern Montana with a mental health outpatient visit or with Severe and Disabling Mental Illness, 2013-2016



# Crisis events among EMCMHC clients

Insurance type for EMCMHC Clients experiencing a crisis in the last year



From February 2015 to January 2016, clients of the EMCMHC experienced a total of 535 crisis events, amounting to more than one per day. In all, 274 total clients had crisis events with 103 (38%) experiencing more than one event during the twelve month period. Almost three out of four EMCMHC clients experiencing a crisis in the last year (72%) were insured through Medicaid or were self-paying clients. Only 8% have private health insurance. In contrast, 66% of all Montanans have private health insurance. (Source: American Community Survey, 5 year estimates, 2011-2015).

# Hospitalizations related to SUD

To quantify the impact of substance use and mental health on hospitalization in Eastern Montana, the Montana DPHHS Office of Epidemiology and Scientific Support ran an analysis using the Healthcare Cost and Utilization Project's definition of "Hospitalizations Involving Mental Health and Substance Use Disorders Among Adults, 2012." These definitions focus on the mental health aspect of substance use, and are different than other definitions that focus on other aspects of substance use."<sup>13</sup>

Of the 29,000 inpatient admissions to Montana residents in the chosen counties during 2010 through 2014, excluding those for pregnancy and childbirth, 8.9% had at least one diagnosis for a substance use disorder with total annualized charges of \$11 million. The percentage slightly increased from 2010 to 2014 (range: 7.3% to 10.4%).

**TABLE 1. INPATIENT ADMISSIONS WITH ALL-CAUSE SUBSTANCE USE DISORDERS, EASTERN MONTANA RESIDENTS, MONTANA HOSPITAL DISCHARGE DATA SYSTEM, 2010-2014**

AGE RANGE	0-17	18-44	45-64	65+
NUMBER OF ADMISSIONS	96	991	1,063	408

**TABLE 2. INPATIENT ADMISSIONS WITH ALL-CAUSE SUBSTANCE USE DISORDERS, EASTERN MONTANA RESIDENTS, MONTANA HOSPITAL DISCHARGE DATA SYSTEM, 2010-2014**

PRIMARY PAYER	Commercial	Medicare	Medicaid	Self Pay	All Other
NUMBER	442	554	543	395	624
PERCENT	17.3%	21.7%	21.2%	15.4%	24.4%

The most common SUD type was alcohol, followed by opioids (Table 3). The number of admissions with opioid SUD increased from 44 to 76 (72%) from 2010 to 2014. Among those admitted for a substance use disorder, 59% were male.

**TABLE 3. INPATIENT ADMISSIONS WITH ALL-CAUSE SUBSTANCE USE DISORDERS (SUD), EASTERN MONTANA RESIDENTS, MONTANA HOSPITAL DISCHARGE DATA SYSTEM, 2010-2014**

	Number	Annual Total Charges	Mean Age	Percent Male
<b>TOTAL</b>	2,558	\$10,686,062	47.5	59.2
<b>ALCOHOL</b>	1,853	\$7,408,497	47.8	65.5
<b>AMPHETAMINES</b>	174	\$609,475	36.2	51.7
<b>CANNABIS</b>	227	\$705,925	31.1	57.3
<b>COCAINE</b>	10	\$52,154	43.8	90.0
<b>DRUG-INDUCED MENTAL DISORDERS</b>	188	\$881,119	57.6	42.0
<b>HALLUCINOGENS</b>	9	\$19,967	24.9	88.9
<b>OPIOIDS</b>	258	\$1,244,956	48.6	39.9
<b>SEDATIVES</b>	29	\$92,529	44.5	24.1
<b>OTHER</b>	287	\$1,056,958	40.2	45.6

\*Admissions with more than one sud are counted in separate categories.

# Hospitalizations related to mental health

Twenty-eight percent of all hospital admissions in Eastern Montana from 2010-2014 had at least one diagnosis for a mental disorder (MD). The most common MD was the broad category of screening and history of mental health and substance abuse codes, present on roughly 46% of admissions with codes for at least one MD followed by mood disorders, present on rough-

ly 38% of admissions with codes for at least one MD (Table 3). The MD with the lowest mean age was attention-deficit disorders; the MD with the highest mean age was anxiety disorders. The MD with the highest percentage of diagnoses to females was anxiety disorders (65%), the MD with the highest percentage of diagnoses to males was attention-deficit disorders (59%; Table 4).

**TABLE 4. INPATIENT ADMISSIONS WITH ALL-CAUSE MENTAL DISORDERS (MDS), MONTANA RESIDENTS, MONTANA HOSPITAL DISCHARGE DATA SYSTEM, 2010-2014**

	Number	Annual Total Charges	Mean Age	Percent Male
<b>TOTAL</b>	8,350	\$37,375,179	55.4	46.6
<b>SCREENING AND HISTORY OF MENTAL HEALTH AND SUBSTANCE ABUSE CODES</b>	3,877	\$20,716,966	57.4	57.6
<b>MOOD DISORDERS</b>	2,756	\$10,741,620	52.8	34.9
<b>ANXIETY DISORDERS</b>	966	\$3,471,818	60.1	34.6
<b>SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS</b>	364	\$1,049,877	54.0	50.5
<b>SUICIDE AND INTENTIONAL SELF-INFLICTED INJURY</b>	129	\$342,335	38.7	51.9
<b>MISCELLANEOUS MENTAL DISORDERS</b>	87	\$303,399	51.5	33.3
<b>ADJUSTMENT DISORDERS</b>	66	\$184,514	50.8	40.9
<b>ATTENTION-DEFICIT, CONDUCT, AND DISRUPTIVE BEHAVIOR DISORDERS</b>	58	\$278,241	32.6	58.6
<b>PERSONALITY DISORDERS</b>	25	\$100,692	56.0	44.0

\*Admissions are assigned to the single class with the most primary diagnosis. Excludes categories with 20 or fewer admissions.

# Acute drug overdose

The analysis on the previous pages does not include hospital admissions for acute drug overdose. In 2014, there were 86 ED admissions and 69 inpatient hospital admissions for acute drug overdose in Eastern Montana. Of those admissions where intent was determined, about two thirds of the inpatient admissions and one third of ED admissions were for intentional self harm. Thus, one third of the inpatient admissions and two-thirds of ED admissions for drug overdose were for unintentional.<sup>14</sup>

There are more than 150 emergency department or hospital admissions annually for acute drug overdose in Eastern Montana.

# Suicide in Eastern Montana

From 2010 to 2015 there were 134 deaths due to intentional self-harm injuries in the 17 county region out of 1,433 total in Montana. This averages to around 22 suicides in the region per year. The age-adjusted death rate for intentional self harm in these communities is 28.8 per 100,000 (2010-2015). For American Indians in these

counties, the rate for intentional self harm is 59.3 per 100,000 (2010-2015) compared to 21.8 for whites. The rate of death for intentional self harm for men in these counties is 42.9 per 100,000 and for women, 14.0 per 100,000. Compared to Montana, the rates of suicide in Eastern Montana for men and American Indians are elevated.

Death rate per 100,000 population, Intentional Self Harm, 2010-2015

