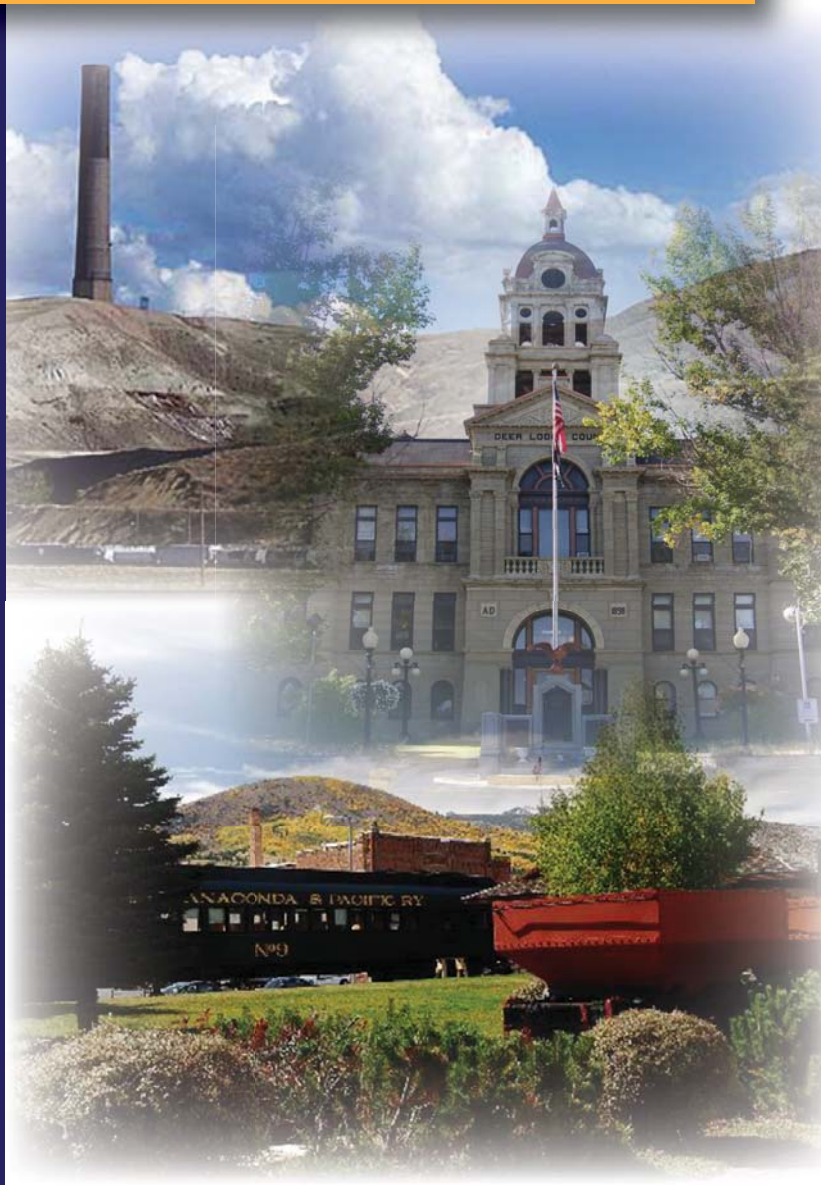
Anaconda-Deer Lodge County

Community Needs Assessment

Community Health Improvement Plan

2013



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ACKNOWLEDGEMENTS

The Anaconda-Deer Lodge County Public Health Department, the local agency charged with protecting and encouraging population-level health, embarked upon a county-wide planning process for public health in August of 2012. The process began with an assessment of public health needs, the purpose of which was to inform public health policy and priorities into the future and set a course for improving the health of Anaconda-Deer Lodge County citizens. Results of the assessment can be found in Chapters one and two of this document. Information gathered and analyzed served as the foundation for a Community Health Improvement Plan (CHIP), included in Chapter Three of this document, which will ultimately help direct important public resources to areas of greatest need.

The planning process relied upon the expertise, wisdom and knowledge of numerous community members and organizations. Broad participation that occurred throughout the process was necessary to make the assessment and planning process representative of important issues facing Anaconda-Deer Lodge County. The work was made possible by funding from the Anaconda-Deer Lodge County Public Health Department, ACI, Inc. and the District XII Human Resources Council. The process involved broad participation from citizens, local government and organizations. A debt of gratitude is owed to community members and organizations who gave valuable and scarce time to make this assessment and resulting plan a reality. *(See Appendix C for a list of participants.)*

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CHAPTER ONE: INDICATORS OF PUBLIC HEALTH

I. INTRODUCTION

This section of the Anaconda-Deer Lodge County Health Needs Assessment examines a series of factors affecting public health. The examination is intended to inform stakeholders involved in the community planning process about the status of public health as they set out to create a vision and related goals for healthy communities in the county. It provides information at the population-level related to geographic, demographic, socioeconomic, environmental, behavioral and general health factors. While these factors can stand alone in an analysis, they are also linked to population health outcomes. Thus, in reviewing the information, attention should be given to ways in which such things as the social environment and geography affect public health. Additionally, attention should be given to the link between land use and public health, recognizing the importance of community design to health of citizens and the necessary collaboration between public health officials and county planners.

II. METHODOLOGY/DATA SOURCES

The approach taken to this analysis was to examine factors that indicate patterns on a population level. The report relies entirely upon secondary data analysis with no primary data generated. Data contained in this section was the most recent available at the time of the analysis and draws from a number of sources that address population and demographics, economics, housing and health related outcomes. The U.S. Census Bureau was a primary source for population, demographic, economic and housing data. For general population and age information, the 2010 decennial census data was used. The American Community Survey was relied upon to illustrate characteristics of the population. Poverty and health insurance data came from the Census Bureau's Estimates program. Regional Economic Models, Inc. and Woods & Pool Economics, Inc. were relied upon for population projections.

The Montana Department of Labor and Industry was a source for labor statistics. Other state sources cited were the Montana Board of Crime Control and the Montana Office of Public Instruction. For health-related outcomes, sources included the *County Health Rankings* produced by a partnership between the Robert Wood Johnson Foundation and the University of Wisconsin Madison which compiles community health status reports based on a national Behavioral Risk Factor Surveillance System survey, and the Montana Department of Public Health and Human Services. Regional organizations providing data included the Western Montana Mental Health Center and the Butte Community Health Center. The Centers for Disease Control and Prevention was a source of national health-related data as was the U.S. Department of Health and Human Services, the National Cancer Institute, the American Association of Suicidology, the National Institute of

Mental Health and the United Health Foundation. A number of research publications were relied upon to provide deeper context to some of the discussions provided in the document. Sources are specifically cited throughout the document as end notes. To the greatest extent possible, local data was compared with state and national data. Due to data limitations, it was not always possible to compare exact time periods. However, the closest possible time periods were used in order to provide county planners with a sense of how their data compares with the general population.

III. KEY FINDINGS

DEMOGRAPHIC CHARACTERISTICS AND FACTORS

- Population decline in Anaconda-Deer Lodge County slowed significantly between 2000 and 2010. Slight growth is projected over the next 20 years with the county reaching a total estimated population of just over 10,000 by 2030.
- The county will experience significant growth in the number of people 65 years of age and older which will represent one of the most significant public health challenges for the county. By 2030, seniors will comprise 25% of the total population.

SOCIOECONOMIC CHARACTERISTICS AND FACTORS

- The county has higher rates of poverty and low-income households than Montana and the nation overall. Therefore, a greater proportion of the county population is at risk for poor health outcomes. One-fourth of children live in poverty, which puts their normal health development at risk.

HOUSING FACTORS

- The county has an aging housing stock, much of which is in average to poor condition. The age and condition of much of the housing stock could pose health risks to the population. This is particularly true for lower income people who are often forced by the market into the most unsafe housing.
- As the the baby boom segment of the population ages, there will be a greater need for housing options to meet their needs; that demographic group tends to prefer housing options that include aging in their homes and living close to amenities.

HEALTH RISK BEHAVIORS

- Suicide is a critical public health factor. Anaconda-Deer Lodge County has the highest suicide rate in Montana—a state which has consistently over 35 years had one of the highest suicide rates in the nation.
- Population level data indicates a pattern of behaviors in the county that can contribute to poor health outcomes. Relatively high rates of excessive alcohol use, tobacco use, overeating and physical inactivity that are risk factors for heart disease are present in county data.

YOUTH BEHAVIORS

- Youth behaviors in the county point to both positive and negative factors. The four-year graduation rate has improved significantly and, based on surveys done in schools among 8th, 10th and 12th graders, the proportion of youth with high protection, which helps offset risk for anti-social behavior, has also increased. However, the surveys also indicate a relatively high rate of youth using alcohol. They also show an increasing proportion of 8th grade students at high risk for problem behaviors; at the same time the proportion with high protection has been decreasing.

PREVENTION/WELLNESS BEHAVIORS

- In the areas of childhood immunization, women's health screenings and diabetic screening among Medicare patients, county rates are relatively high when compared with state and national rates. However, the rate of women 67-69 who are Medicare recipients receiving mammograms declined significantly between 2008 and 2010.
- An estimated 27% of adults in the county are obese and, therefore, at risk of heart disease. Nearly one quarter of adults report no leisure time physical activity, another risk factor for heart disease.

ENVIRONMENT HEALTH

- The Anaconda Smelter Superfund Site, located at the Southern end of the Deer Lodge Valley, is the result of nearly one hundred years of milling and smelting copper ore which produced wastes with high concentrations of arsenic, as well as copper, cadmium, lead and zinc. These contaminants pose potential risks to human health, to life in nearby streams, and to plants and animals in adjacent lands over some 300 square miles. In addition to the millions of cubic yards of tailings, furnace slag, flue dust, and square miles of soil contaminated by airborne wastes, millions of gallons of ground water have been polluted from wastes and soils. Arsenic is the primary contaminant of concern and drives remediation activity. EPA began investigations into the extent of contamination in 1983. Since then, removals and cleanup actions have reduced human health risks at the site.

HEALTH RANKING AND OUTCOMES

- In the 2013 *County Health Rankings,* which rank counties within states according to mortality, morbidity and a number of heath factors, Anaconda-Deer Lodge County ranked near the bottom for positive health behaviors and outcomes among Montana counties.
- The leading causes of death in the county are cancer and heart disease.
- One-fifth of the adult population in the county reported "poor to fair health" according the 2013 County Health Rankings; this is up from 19% in the 2012 Rankings is significantly higher than the state rate and national benchmark.

ACCESS TO HEALTHCARE

- Two primary factors inhibit access to healthcare in the county including lack of health insurance and a shortage of health professionals. Nearly 20% of county residents under 65 have no form of health

insurance. With implementation of the National Affordable Care Act in 2014, the percent of uninsured should diminish. The county is designated as medically underserved for the low-income population and has heath shortage designations for dental and mental health services.

IV. OVERARCHING RURAL HEALTH FACTORS

Anaconda-Deer Lodge County is a designated rural county in Southwest Montana with a population density of 12.6 people per square mile. The "rural" designation comes through the United States Department of Health and Human Services, Bureau of Primary Health Care.[i] In this rural county, and for rural communities across the United States, people are faced with many of the same health care challenges confronting the rest of the nation including rising health care costs, high numbers of uninsured and underinsured and an overextended health care infrastructure. But, the challenges are even greater in rural communities due to some unique trends.[ii]

First, access to healthcare is currently more inhibited in rural areas. Since the late 1990s, rural areas have witnessed a significant decline in jobs with higher rates of employer-sponsored health insurance while gaining jobs with much lower rates of employer-sponsored coverage. Lack of employer-sponsored health insurance is particularly acute for low-skilled jobs, which are more common in rural areas. The problem is also impacted by the fact that the rural economy is more likely to be based on self-employment and small businesses.[iii] Healthcare access may improve across the nation with changes mandated by the National Affordable Care Act, many of the components of which will take effect in 2014. If the intended results play out from the national policy changes, all individuals will have health insurance coverage, which should improve access to services for all.

Access in rural areas is also inhibited by a shortage of health care providers. More than a third of rural Americans live in Health Professional Shortage Areas. Nearly 82 percent of rural counties are classified as Medically Underserved Areas. All of Montana's rural healthcare organizations—whether a community health center, rural health clinic, sole community hospital, Critical Access Hospital, nursing home, assisted living facility or home health agency—face a shortage of healthcare professionals and workers.[iv] Recruitment of medical professionals is made difficult by the geographic isolation as urban areas offer more amenities and collegial support for professionals.[v]

Lack of access to mental health services is a critical issue for rural areas. Over half of the counties in the United States have no mental health professionals, a situation that has changed little in 45 years[vi;] the prevalence of major depression is significantly higher among rural than among urban populations"[vii] and research has shown that for rural patients in need of mental health care, specialty general medical care is significantly more likely to be provided than specialty mental health care. Since patients receiving care in the

specialty mental health sector are substantially more likely to receive adequate care than patients receiving care in the general medical sector, this indicates that rural individuals are receiving poorer quality mental health care.[viii]

Delivery of emergency medical services (EMS) also presents challenges to rural areas. EMS workers are often the first-line medical and health care providers in rural areas. Because of the demographic and health care system issues outlined here, EMS have had placed on them growing demands and health care responsibilities which can be difficult to meet, particularly because, at the same time, many rural EMS providers are underfunded and facing workforce and volunteer shortages.[ix]

Rural areas across the United States are also facing demographic shifts that impact healthcare and health outcomes. Chief among them is an aging population.[x] By 2030, Montana is projected to rank sixth among states for the percentage of people 65 and older.[xi] This is of particular concern because two-thirds of people with chronic disease in the United States are 65 years of age or older.[xii] This shift will be experienced more intensely in Southwest Montana where the proportion of people 65 and older is already higher than the state and national rates.

Finally, with regard to health outcomes, more rural people suffer from chronic conditions such as arthritis, asthma, heart disease, diabetes, hypertension and mental disorders than urban residents. The differences are not always large, but they are consistent.[xiii] As public health officials and communities in Southwest Montana plan for ways to improve health outcomes, these are some of the overarching issues that are impacting all rural areas and which should be factored into health improvement plans.

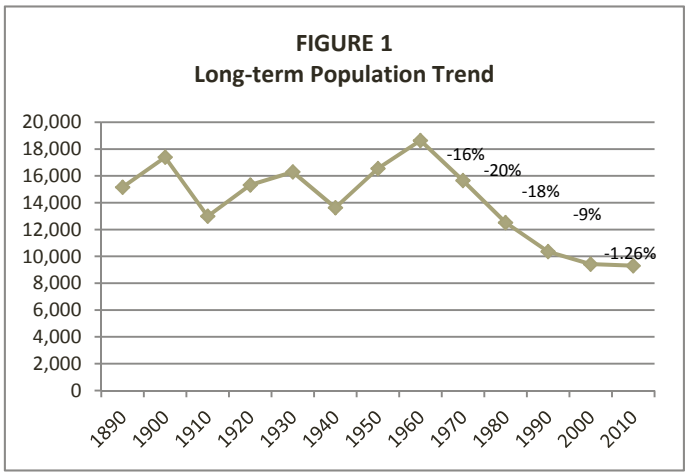
Anaconda-Deer Lodge County faces an added public health planning challenge as it works to determine the possible relationship between environmental pollutants resulting from copper smelting and milling between 1884 and 1980 and public health. As studies continue into that relationship, results can help inform action plans for public health officials.

V. COUNTY DEMOGRAPHIC FACTORS

1.0 Population Trends

With land area covering 736.3 square miles and a population of 9,298, Anaconda-Deer Lodge County is geographically one of Montana's smallest counties and ranks 22 among 56 counties for its population.[xiv] The number of people per square mile is 12.6[xv], giving the county "rural status" through the U.S. Department of Health and Human Services, Bureau of Primary Health Care.[xvi] The population has been in a downward trend since 1960, but the decline has shown signs of leveling off. The downward trajectory between 1960 and 1980

was a 16% to 20% rate of loss but has slowed over the last two decades, finally to a rate of 1.26% between 2000 and 2010. (*Refer to Figure 1.)* An estimated 80% of the total county population lives in or within a 10-mile radius of the city of Anaconda.[xvii]



According to Regional Economic Models, Inc., the Anaconda-Deer Lodge County population is expected to begin a gradual upward trend beginning in 2013 and continue into 2030, growing at a projected rate of 0.7% annually and reaching a population of 10,500. This would be an increase of approximately 1,200 people or a 12.9% increase over the 2010 population.[xviii] Another projection provided by Woods & Poole Economics, Inc. shows the county growing more slowly and reaching 10,012 by 2030, a 7.7% increase over the 2010 population.

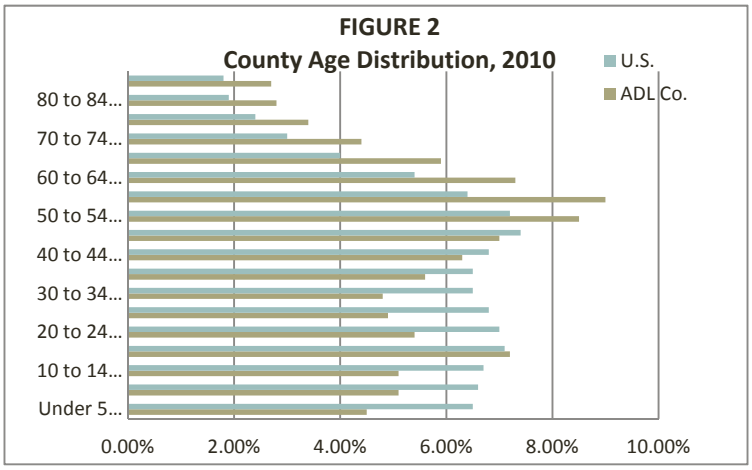
2.0 Characteristics of the Population

2.1 Race/Ethnicity

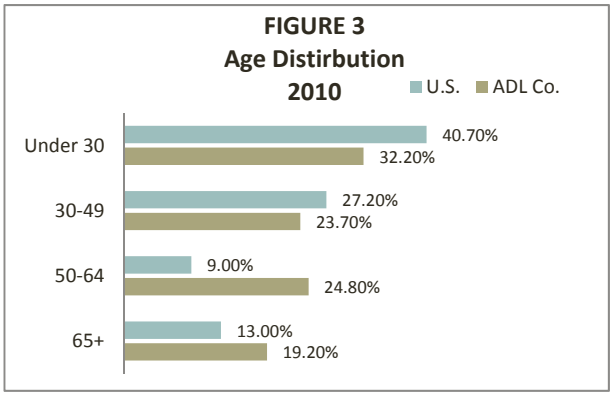
The Anaconda-Deer Lodge County population is primarily comprised of people claiming "white" as one race (93.1%). There are small proportions of American Indian/Alaska Native people (2.3%), Black or African American people (0.8%) and people of Asian descent (0.2%). Another 2.5% of the county population claim two or more races. According to the U.S. Census Bureau, 2.9% of the population claims a Hispanic or Latino ethnicity.[xix]

2.2 Age

The relationship between age and health is an important consideration in public health planning. People in different stages of life have varying health behaviors, health problems and medical needs. Due to common youth type behaviors, for example, people in their teenage years may need services to address such things as contraception and sexually transmitted diseases which are commonly offered through public health agencies. Children often receive important nutritional,

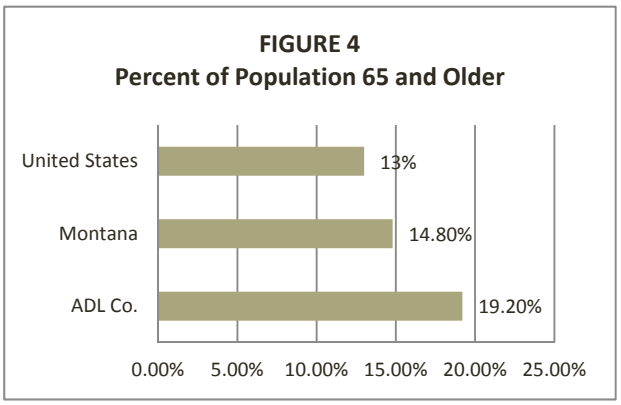


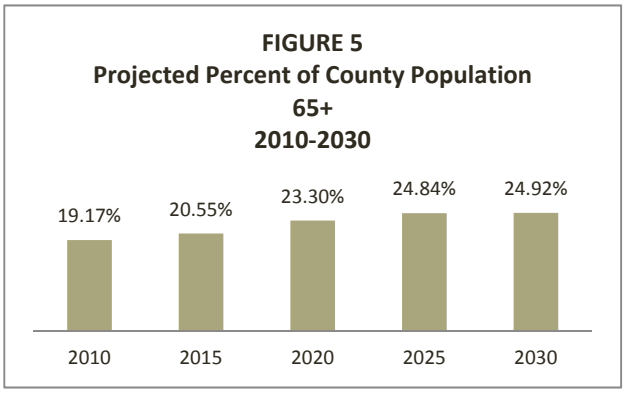
immunization and general well-child healthcare services through public health agencies, and senior citizens draw intensively from the healthcare system to address chronic illness. The potential child-bearing population is also a factor for public health planning as this group draws upon services often provided by public health agencies. An analysis of age distribution, therefore, helps communities target public health and other services to areas that support local population health.



Anaconda-Deer Lodge County has experienced population losses over the last five decades. Losses have tended to be in younger age cohorts, leaving a relatively older population. This is seen in the proportion of people under 30 years of age, a cohort which comprises only 32.2% of the county population compared with the national proportion of 40.7%. *(Refer to Figures 2 and 3.)* It is also seen in the percent of the female population within what is considered normal child-bearing years (20-39); 18% of females are within this group locally compared with 26% nationally.[xx] Finally, children and youth (under 20 years of age), comprise 22% of the county population compared to the national proportion of 27%.[xxi]

One of the most pressing age-related public health factors facing localities and the nation as a whole is the growing number of people 65 and older. Significant growth in this cohort is projected into 2030 due to a national trend associated with increased births during the two decades after World War II (the "baby-boom"). The phenomenon is expected to be even more intensely experienced in Anaconda-Deer Lodge County where the proportion of senior citizens is already significantly higher than the state and national rates. People 65 and older currently comprise 19.2% of the county population (1,782 people) compared with 13% for the nation and 14.8% for Montana. *(Refer to Figure 4.)* Median age in the county jumped from 39.8 in 2000 to 42 currently and is, logically, higher than the state (39.8) and national (36.5) median ages. People in the "baby boom" age cohorts (45 to 63) currently comprise an estimated 30% of the Anaconda-Deer Lodge County population.[xxii] With the aging of this group, by 2030, 25% of the





county population is projected to be 65 or older (2,495 people), a 40% increase in the number seniors over the 2010 Census count.[xxiii] *(Refer to Figure 5.)*

This phenomenon will not only increase the number of people needing health related services, but will increase the intensity of medical services provided by geriatric specialists or family/general practice providers who emphasize geriatric health issues in their practices. Aging "baby boomers" will contribute hugely to the prevalence of chronic illness into the future; today, approximately two-thirds of people living with a chronic illness are over the age of 65.[xxiv] Primary care physicians, including those in family practice and internal medicine who are at the forefront of managing chronic illness, are already in short supply. With a growing senior population, this shortage will become an even more pressing healthcare matter.

This wave of senior citizens will also have different lifestyle preferences that will change the way services are provided. For example, "baby boomers" tend to prefer living closer to amenities and aging in their homes. Home health services will likely play a larger role in service delivery for this group while assisted housing environments may be in less demand. In Anaconda-Deer Lodge County, 43.5% of people 65 and older have annual incomes at or below 200% of the federal poverty line.[xxv] This level of income is a threshold that qualifies people for certain types of public services. Provision of services to low-income seniors is more challenging as it adds an "affordability" layer to the equation and often requires special grants and pay sources to create access to services. Planning for for the needs of this growing segment of the population is critical.

FIGURE 6
Household Types

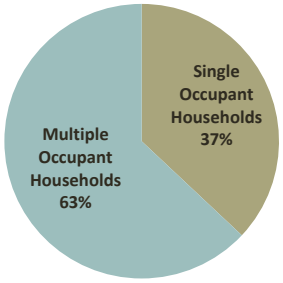
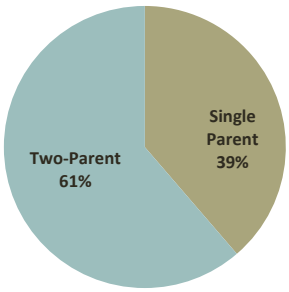


FIGURE 7
Single-parent v. Two-parent Households



2.3 Households and Families

There are 4,018 households in Anaconda-Deer Lodge County with an average size of 2.11 people per household.[xxvi] The average household size is smaller than the national average of 2.58. This correlates with a smaller average family size than the nation overall (2.73) people per family locally compared with 3.14 nationally) and a higher rate of single-occupant households; of the total county households, 37% have a single occupant compared with 27% nationally.[xxvii] *(Refer to Figure 6.)*

According to the 2010 Census, there are 2,350 family households in the county. Of these, 817 (20.3%) are households in which children (under 18) are present with at least one related parent in the household. Of these, 39% have only one parent present (316 households). *(Refer to Figure 8.)* The rate of single-parent households in the county is higher than the national rate of 32%.[xxviii] In single parent households, adults are at risk for mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.[xxix] Single-parent households are also more likely to have lower incomes, a status that adds to stress in the household which can contribute to conflict and depression and place normal child health and development at risk. According to the American Community Survey for the period 2007-2011, 85% of single-parent households have annual incomes at or below 185% of the federal poverty line in Anaconda-Deer Lodge County. For all families with children under 18, 51.5% have incomes at or below 185% of poverty.[xxx] There are another 80 households in the county with children under 18 present, but the children are not related to adults in the household.

2.4 Educational Attainment

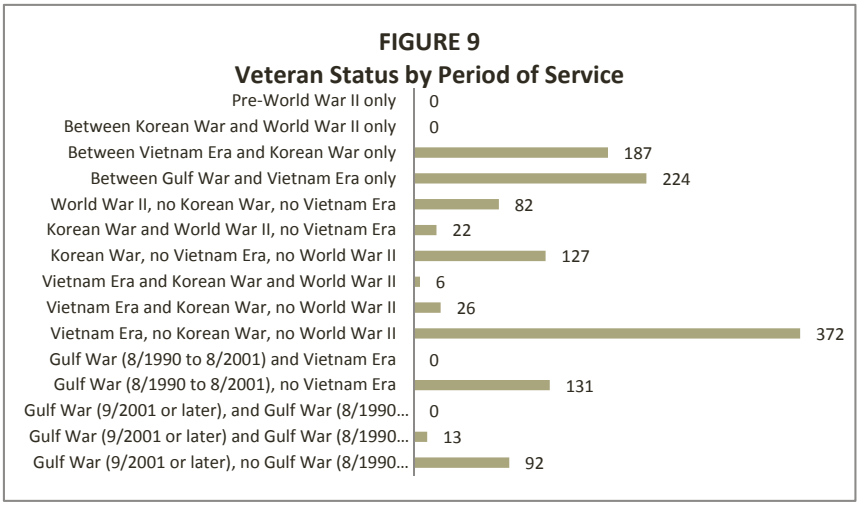
Because there is a relationship between education and health outcomes, assessing the educational attainment level of a local population is important to a community health analysis. A 2009 report by the Robert Wood Johnson Foundation entitled "*Reaching America's Health Potential Among Adults: A State-by-State Look at Adult Health*", found that, "nationally and in every state, the percent of adults in "less than very good health" varied by level of education. In Anaconda-Deer Lodge County, 85.8% of adults 25 and older have attained a high school diploma or higher. This rate is on par with the national rate of 85.8% but significantly lower than the Montana rate of 92.3%. The county has a significantly lower rate of adults 25 and older attaining a bachelor's degree or higher; the rate is 18.5% compared with 28.5% for the nation and 28.2% for Montana.[xxxi] In the 25 and older cohort, 14.2% have less than a high school education compared with 13.7% nationally.

According to the 2009 report, compared with the most-educated adults (college graduates), the least-educated adults (those who had not graduated from high school) were more than three times as likely, in some states, to be in "less than very good health". Differences were not seen only when comparing the most and least-educated groups. Even high-school graduates were more likely than college graduates to be in "less than very good health."

2.5 Veteran Status

Veterans often have special health issues that can result from their military experiences and may call upon the public health system either in the form of collaboration with veteran specific programs or in the form of

direct services. This may be of even greater concern in Anaconda-Deer Lodge County where the concentration of veterans is higher than in the general U.S. population. Of the adult civilian population (18 years of age and older) in the county; 17.1% have veteran status compared with 9.9% nationally. The county's rate also exceeds the Montana rate of 13.5%. There are an estimated 1,282 veterans in the county.

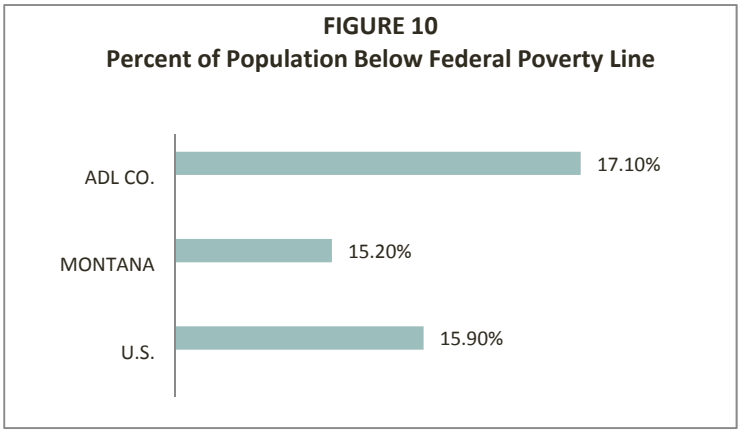


As is true nationally, the largest portion of the veteran population in the county is associated with the Vietnam War (31.5%). *(Refer to Figure 9.)* Over 40% of the veteran population in the county is 65 years of age or older. Median income among veterans in the county is higher than for non-veterans--$23,641 annually compared with $19,038.[xxxii]

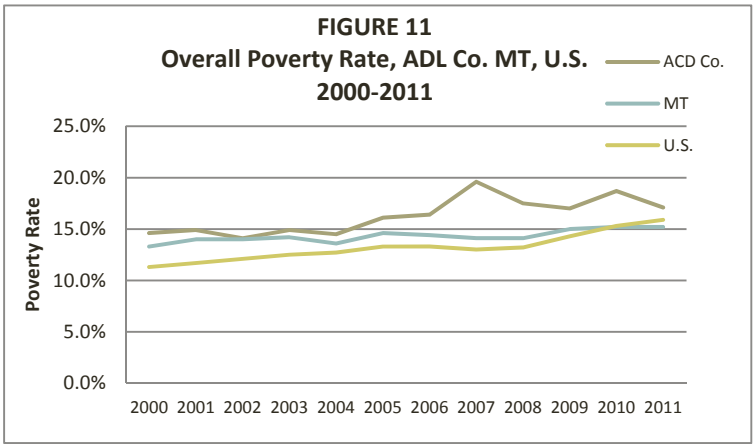
VI. SOCIOECONOMIC FACTORS

1.0 Poverty

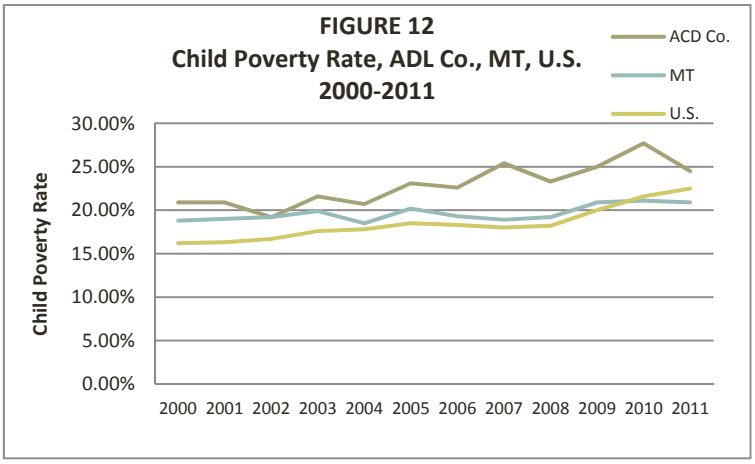
The impact of poverty and low-income on health is an important consideration for the public health system. Studies have firmly established that those with low incomes have lower health status than those with higher incomes.[xxxiii] "Health United States, 1998", the 22nd report on the health status of the Nation from the Secretary of Health and Human Services, draws a strong connection between income and health. According to the report, poor Americans are significantly more likely than those with high incomes to have health risk factors that include smoking, being overweight, and having a sedentary lifestyle. Socioeconomic status is also linked to depression; people with lower socioeconomic status are more likely to develop a depressive illness than those higher in the socioeconomic scale.[xxxiv] Poor and



near poor Americans are less likely than those with high incomes to have insurance and, together, account for nearly two-thirds of uninsured people in the nation,[xxxv] partially because low-wage workers are less likely to be offered health insurance as a job-related benefit.



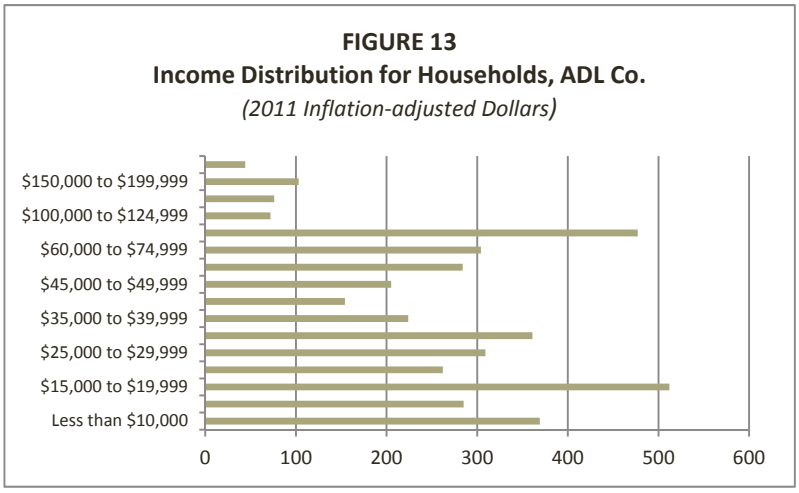
In Anaconda-Deer Lodge County, the poverty rate (percentage of people living below the federal poverty line[xxxvi]) is comparatively high. At 17.1%, the rate is higher than both the state (15.2%) and national (15.9%) rates and is an estimated 1,490 people.[xxxvii] (*Refer to Figure 10.*) The local rate has remained consistently higher than the national rate since 2000, which points to a sustained poverty status that can potentially impact health. [xxxviii]



The rate of children living in poverty in the county is an estimated 24.5% and is also higher than the national (22.5%) and state (20.9%) rates. The rate represents an estimated 407 children. The child poverty rate has also sustained at a rate higher than the national since 2000, which is of concern for normal health and development in children.[xxxix] *(Refer to Figures 11 and 12.)*

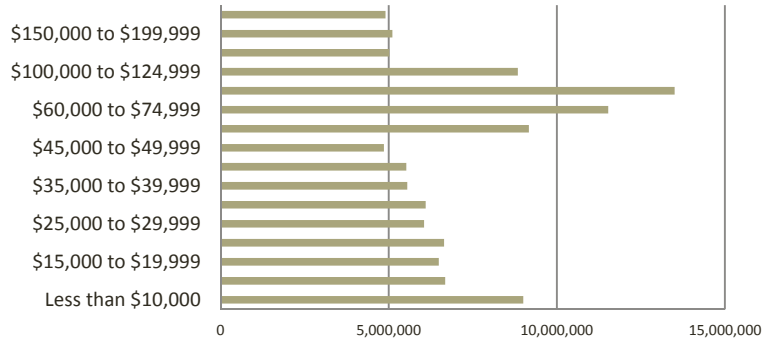
1.2 Low-Income Status

Another significant income factor to consider is the number and percentage of people who, although not considered poor, have low incomes. For many federal programs that provide assistance, a low income is considered to be one that is annually at or below 200% of the federal



poverty line. According to Census figures, an estimated 43% of the Anaconda-Deer Lodge County population subsists at that income level (3,924 people)[xl], making them eligible for various public assistance programs. The rate is higher in the county than it is for both the state (36.7%) and nation (35.17%).

FIGURE 14
Income Distribution for Households, U.S.
(2011 Inflation-adjusted Dollars)



The most recent and detailed Census data available illustrates that the county's household income distribution is more heavily weighted toward lower income brackets than the national distribution. In Anaconda-Deer Lodge County, 35.3% of households have annual incomes of less than $25,000 compared with 25% for the nation.[xli] *(Refer to Figures 13 and 14.)* Median household income, at $34,375, is 68% of the national figure of $50,502.[xlii] Low wages appear to be a contributing factor to a heavier low-income bracket; the annual average wage for workers in the county is $29,314 which is 62.7% of the national average.[xliii] Since 65% of households have income from wages[xliv] the impact of low wages on income distribution is significant. Additionally, the county has a relatively high proportion of adults who are not in the labor force. An estimated 42% of people 16 years of age and older are not in the labor force, which also contributes to an overall lower median income as many individuals in the group are retired and living on fixed incomes.[xlv]

The extent to which people rely upon public assistance programs to meet basic needs in a community is another indicator of low-income status. Such programs include those that provide food, housing and home heat assistance. Food assistance has been on the rise in the county over the last several years. Today, 14% of the population receives assistance through the Supplemental Nutrition Assistance Program (SNAP). Although the number had remained somewhat steady between 200 0 and 2008 with an average of 886 people receiving monthly assistance, the number began to climb in 2008. By 2012, 1,298 people on average monthly were receiving SNAP assistance, an increase of 48% over 2008.[xlvi] Another food program that has a high rate of eligible participants is the free and reduced school lunch program. According to the Montana Office of Public Instruction, over half of school-age children in the county (54.68%) are eligible for free or reduced lunch in the school system.[xlvii] Using Census figures, it appears 44% of households in Anaconda-Deer Lodge County (1,778 households) are eligible to receive heat assistance through the federal Low Income Energy

Assistance Program. However, only 17% of eligible households accessed the assistance during the 2011-2012 program year (307 households).[xlviii]

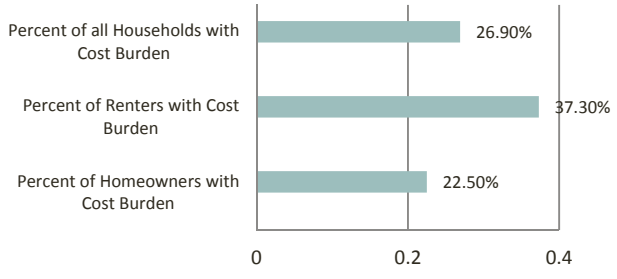
Finally, healthcare access is an important indicator of low-income status in a community. Access to healthcare has been inhibited in the United States for low-income people due to the high cost of health insurance and medical care. Although expected to change due to the National Affordable Care Act, the low-income population has been more likely to be without health insurance than those with higher incomes, which has created a barrier to healthcare access and put affected people at risk for poor health outcomes. According to the most recent Census estimate of the uninsured, 19.9% of the Anaconda-Deer Lodge County population under the age of 65 is without health insurance compared with 21.6% for Montana and 17.9% for the nation.[xlix] The rate is significantly higher for low-income people; 31.6% of people in the county who are living at or below 200% of the federal poverty line are without health insurance compared with 35.4% for Montana and 35% for the nation.[l] With implementation of the National Affordable Care Act coming in 2014, the rate of uninsured should improve and, if intended results play out, virtually disappear. However, for the very poorest of citizens in Montana where Medicaid expansion, a companion approach to health care reform, was not approved by the state Legislature. Currently, 29% of children in the county receive Medicaid assistance. However, without passage of the Medicaid expansion, there is potential for some of the most vulnerable citizens to be without insurance and, therefore, healthcare access. Impacts of the new law will not be seen in data until 2015.

VII. HOUSING FACTORS

1.0 Affordability and Condition

The built environment is a consideration in public health planning because the extent to which housing is safe and affordable can impact health outcomes. The concern is greater for lower income people who are more likely to be forced by the market into unsafe housing that can place them, and particularly children, at risk of health problems. Additionally, for lower-income people, a higher proportion of income is generally devoted to housing costs which can force people to forego healthcare, thereby contributing to poorer health outcomes.

FIGURE 15
Housing Cost Burden among County Households



Cost burden is a measure of how affordable housing is for the population and a factor in public health planning. In the United States, housing costs are considered a burden when they exceed 30 percent of income. In Anaconda-Deer Lodge County, an estimated 1,087 households have monthly housing costs that are a cost burden; this represents 27% of all households. Thirty-seven percent (37.3%) of renters and 22.5% of homeowners are paying more than 30% of their income for housing payments. *(Refer to figure 15.)* The rate for renters has increased significantly since 2000 when it was 25%. The rate of cost burden is considerably higher for lower-income households. Of households with annual incomes of less than $35,000, 48% in the county are paying more than 30% of income for rent.[li]

Condition of housing is another consideration for which overall condition of units, the year they were constructed and the type of housing units in the housing stock are factors. A 2005 "Condition of Housing in Montana" report was reviewed to determine the overall condition of the housing stock in Anaconda-Deer Lodge County. According to the report, 11% of housing units in the county ranged from 'poor' to 'unsound' condition at the time of the report. Another 34.3% were in fair condition and 33.2% were in average condition. Thus, 78.5% of all county housing units in the county were in average condition or lower. The remaining 21.5% ranged from 'good' to 'excellent' condition.[lii]

Another indicator of housing condition is the year structures were built. Age of housing units can indicate whether lead paint might be present in the units. Lead paint in the home can be a health risk, particularly for children. In Anaconda-Deer Lodge County, 83% of housing units were built prior to 1978 when lead paint standards went into effect.[liii] Lead paint in pre-1978 homes can be addressed through testing of homes and occupants, which is provided through the Anaconda-Deer Lodge County Community Protective Measures Program.

Older mobile homes, which are often an affordable option for lower income people, but not always the safest option, are also a housing-related health consideration. There are currently an estimated 266 occupied mobile homes in Anaconda-Deer Lodge County. Of these, 47 were constructed prior to the enactment of national safety standards for mobile homes in 1976. Mobile homes comprise only 5% of the county's overall occupied housing stock. Thus, they are likely not contributing to a wide-spread health concern. However, the safety of the estimated 47 households living in pre-1976 mobile homes is a safety concern for those occupants.

2.0 Housing Considerations for the Aging Population

Given the impact of the "baby boom" on the population, a discussion of housing for senior citizens is important to a public health needs assessment. People in the baby-boom age cohorts represent 30% of the Anaconda-Deer Lodge County population and occupy 48% of housing units.[liv] As this age group grows in association with the 'baby boom' phenomenon into 2030 and occupies an ever-increasing percentage of the population, providing for their housing needs will become paramount to community planning efforts.

Trends among aging baby boomers nationally should be considered in current planning efforts. Foremost among those trends is the provision of services that allow seniors to age in place. Along with aging in place, comes a demand for home health services. According to Harvard University's Housing America's Seniors, only 10% of seniors lived in age-restricted communities in 2000. However, the Harvard study noted that the existing housing stock is not designed to meet the changing needs of seniors as they age. As a result, the market for home modifications and healthcare and other supportive services to help older Americans live safely and comfortably in their homes is large and growing. Yet, much of the current demand for modifications is unmet. Only about half of those who are over 65 with disabilities have the modifications they believe they need. (*Schafer*) The Harvard study also pointed to the need for housing to accommodate senior couples as men begin to live longer.

VIII. HEALTH RISK BEHAVIORS

Risk behaviors, as they related to health, are defined as lifestyle activities that place a person at risk of suffering particular health conditions. A variety of health problems can be caused by behaviors such as excessive alcohol and drug use, tobacco use, reckless driving, poor nutrition, sedentary lifestyle and unprotected sex. For this reason, indicators that speak to population risk behaviors among Anaconda-Deer Lodge County residents were reviewed for this assessment.

1.0 Ranking Among Montana Counties for Targeted Health Behaviors

One existing analysis of risk behaviors considered for this assessment created a 'composite severity score' for Montana counties based on six measures that included the suicide rate, prescription drug death, drug arrests, DUI's, liquor law violations and percent of car crashes involving alcohol or drugs. In this 2012 analysis, in which a low composite score indicated higher severity, Anaconda-Deer Lodge County had a composite score of 118 which gave it a ranking of '9' among Montana's 56 counties when the six factors were considered. The

composite score placed the county into the "very high risk" category for the specified targeted health behaviors. (*See Appendix B for the methodology.)* Notably, the county ranked number 1 in the category of "suicide rate per 100,000 population for the period 2001-2009, number 7 for "prescription drug death per 1,000 residents" and number 11 for the "percent of car crashes involving alcohol over the period 2005-2009". The county with the lowest severity of risk was Treasure County with a composite score of 326. Table 1 illustrates the rankings Anaconda-Deer Lodge County received in each of the six categories considered in the analysis.

TABLE 1
DEER LODGE CO. TARGETED HEALTH BEHAVIORS COMPOSITE SCORE

RISK CATEGORY	RANK
1. Suicide Rate per 100,000 population; average 2001-2009	1
2. Prescription Drug Death per 1,000 Residents; average 2005-2009	7
3. Drug Arrests per 1,000 residents; average 2005-2011	26
4. DUI's per 1,000 residents; average 2005-2011	41
5. Liquor law violations per 1,000; average 2005-2011	32
6. Percent of car crashes involving alcohol; average 2005-2009	11
TOTAL COMPOSITE SCORE	**118**

Source: Ranking of Counties by Severity of Targeted Health Behaviors; Presentation prepared by William Connell, Economist, Montana Department of Labor, 2012

2.0 Suicide

Suicide is a critical issue in Southwest Montana where rates are among the highest in Montana. The involvement of public health in addressing suicide is typically in the area of universal prevention which has a focus on decreasing suicide through public education and the enhancement of protective or mitigating factors. However, public health agencies might also be involved in selective prevention collaboratives that aim to identify people at risk and collaboratives that aim to increase the availability of mental health services, particularly in rural areas that are often plagued with shortages of mental health professionals. In light of the data reviewed for purposes of current public health planning in Anaconda-Deer Lodge County, increased attention to methodologies that decrease suicide are called for and should be part of the county's comprehensive public health strategies toward building a healthier county.

TABLE 2
DEER LODGE COUNTY
SUICIDE RATE, 1997-2011
(per 100,000)

ADL County	29.1
Montana	22.9
United States	12.3

Anaconda-Deer Lodge County has the highest suicide rate in Montana—a state that has consistently ranked in the top five among U.S. states for its high suicide rate over the last 35 years and ranked number one in 2009 with a rate of 22.5 per 100,000 population.[lv] The 2010 rankings placed Montana third among states,

but with an increased rate of 22.9 per 100,000.[lvi] The suicide rate over the period 1997-2011 in Anaconda-Deer Lodge County was 29.1 per 100,000 population (40 suicides as tracked by county of residence) compared with the 2011 national rate of 12.3 per 100,000.[lvii] (Note: this rate covers a different period than the rate considered in the "*Ranking of Counties by Severity of Targeted Health Behaviors*" noted above.) Thus, Anaconda-Deer Lodge County ranks number one in a state that ranks high nationally. A major contributing factor to suicide is depression, another indicator reviewed for this report. The rate of major depression in Anaconda-Deer Lodge County is an estimated 9%[lviii] compared with 6.7% for the nation.[lix]

These rates are indicative of population level mental health problems that are present not just in Anaconda-Deer Lodge County, but across rural Southwest Montana. Four counties in in the region (including Beaverhead, Deer Lodge, Madison and Silver Bow Counties) have suicide rates that are in the top ten among Montana counties. A deeper study to determine the risk factors at work in Southwest Montana is needed. However, three factors surfaced during this review. First, by virtue of being a rural area, southwest Montana has the potential for a higher prevalence of depression. According to a 2005 Rural Health Research Center report entitled "*Depression in Rural Populations: Prevalence, Effects of Life Quality and Treatment-seeking Behavior*", "the prevalence of major depression is significantly higher among rural than among urban populations." Second, in rural Southwestern Montana, the likelihood of depression is compounded by financial hardship for a significant portion of the population. "Research has shown that people with lower socioeconomic status (SES) are more likely to develop a depressive illness and that their depression is more severe than that of people higher on the SES scale."[lx] Finally, lack of access to mental health services creates risk for people suffering from depression or who are in crisis. Anaconda-Deer Lodge County is, in fact, a designated professional shortage area for mental health, a designation assigned by the U.S. Department of Health and Human Services.[lxi]

3.0 Drug, Alcohol Use/Abuse

Alcohol and drug abuse are given separate consideration in this report because this type of abuse is a contributing factor to poor health outcomes for adults and children. Substance abuse is a factor in physical health outcomes, often co-occurs with mental illness, has negative impacts on the developmental environment for and well-being of children, contributes to crime and has potential negative impacts on public safety. These types of indicators were reviewed to determine the extent of substance in Anaconda-Deer Lodge County.

Montana, as a state, faces the challenge of high substance abuse rates. According to the 2010-2011 National Survey on Drug Use and Health, Montana had rates in several categories that were high enough to be among the top ten in the nation. Categories included: binge alcohol use in the past month for all age groupings considered in the survey; illicit drug use in the past month for all age groupings; alcohol dependence or abuse in the past year for all age groupings; and, dependence on or abuse of illicit drugs in the past year for all age groupings. The state ranked in the top ten for the percentage of people needing but not receiving treatment for alcohol use in the past year in all age groupings.

In Anaconda-Deer Lodge County, the percent of the adult population engaging in excessive drinking is estimated to be 19%, which is on par with the state rate but far exceeds the national benchmark of 7% that comes from the County Health Rankings.[lxii] The benchmark represents a rate for counties that are in the 90th percentile among all counties for having the most positive rates (meaning only 10% are better). The percent of motor vehicle crashes involving alcohol is higher than the state rate—11.4% compared with the state rate of 10%.[lxiii]

Another public health concern related to substance abuse is its contribution to child abuse and neglect. "Research has demonstrated that children of substance abusing parents are more likely to experience physical, sexual and/or emotional abuse."[lxiv] Although statistics vary, substance abuse contributes to at least one-third[lxv] and up to two-thirds of child welfare cases in the United States.[lxvi] At the time of this report, there were 22 children from 15 families in Anaconda-Deer Lodge County in out-of-home placement due to child abuse or neglect. In all affected families, substance abuse was a factor.[lxvii] This is a rate of 12.5 per 1,000, higher than the national rate of 9.2 per 1,000. Substance abuse is also related to the fact that over the period 2000 through 2012, 137 children from Anaconda-Deer Lodge County had been evaluated for sexual abuse through the Child Evaluation Center in Butte, 57 of who were seen between 2009 and 2012.[lxviii]

The relationship between mental health and substance abuse is another public health consideration. Research has shown that there is a strong association between mental health disorders and substance abuse disorders. Adults and adolescents with a major depressive episode (MDE) within a year are more likely than those without MDE to have used alcohol heavily or to have used an illicit drug in the past year."[lxix] The combination of relatively high rates of depression and suicide with a relatively high rate of excessive alcohol use in Anaconda-Deer Lodge County may point to a problem of co-occurring mental illness and substance abuse that is worth further consideration and investigation.

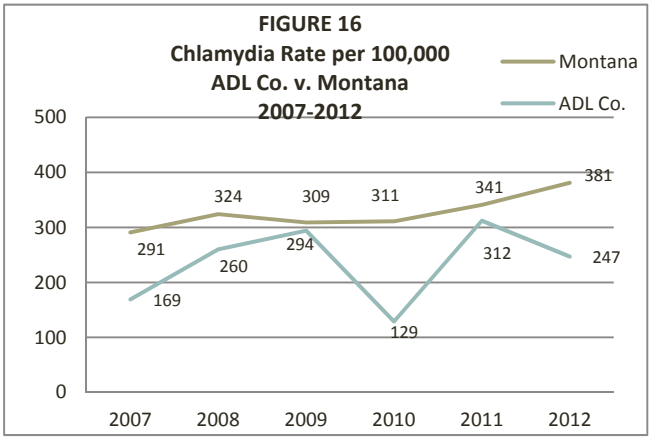
4.0 Tobacco Use

Smoking has been a significant public health concern for decades, and though on the decline, continues to be a significant concern. Smoking prevalence was at a high of 29.5% in 1990, but, according to "*America's Health Rankings: A Call to Action for Individuals and their Communities*" the prevalence of smoking in the past year decreased from 17.9% to 17.3% of the adult population, the lowest in 22 years. The Centers for Disease Control and Prevention's 2012 annual Behavioral Risk Factor Surveillance Survey puts the U.S. rate of adult smoking at a higher rate of 19.6%.[lxx] In Anaconda-Deer Lodge County, the rate of adults who are current smokers and who have smoked at least 100 cigarettes in their lifetimes is an estimated 28% which is significantly higher than both the state (18%)[lxxi] and national rates. According to the Montana Department of Health and Human Services, data for the period 2004-2008, 21.4% of pregnant women in the county smoked during pregnancy, a rate that is also higher than the state rate of 16.6%.[lxxii]

The detrimental effects on health for these portions of the population are an important factor in prevention planning efforts at the local level. Tobacco use is the leading preventable cause of death in the United States.[lxxiii] It is, overall, responsible for an estimated one out of five deaths in the U.S. annually (approximately 443,000 deaths per year). It increases the risk of coronary heart disease and stroke by 2 to 4 times, the risk of men developing lung cancer by 23 times, the risk of women developing lung cancer by 13 times, and the risk of dying from chronic obstructive lung diseases (such as chronic bronchitis and emphysema) by 12 to 13 times.[lxxiv] Smoking during pregnancy is linked to a higher likelihood of miscarriage, certain birth defects, premature birth and low birth weight. Smoking during and after pregnancy is also a risk factor of Sudden Infant Death Syndrome (SIDS).

5.0 Unsafe Sex

In the County Health Rankings program, which was used as a source of public health indicators for this report, the sexually transmitted infection (STI) rate is measured as chlamydia incidence or the number of new cases reported per 100,000 population. Although one of many STIs, chlamydia is associated with unsafe sexual activity, is one of the most common bacterial STIs in North America and remains the most commonly reported infectious disease in the United States.[lxxv] Chlamydia incidence rates are readily available and reliable for nearly all counties, which make them an important indicator of unsafe sexual activity. The groups most impacted by the disease are adolescent girls (15-19 years of age) and young women (20-24 years of age).



According to Montana Public Health and Human Services, the 2012 chlamydia incidence rate in Anaconda-Deer Lodge County was 247 per 100,000, which amounted to 23 cases.[lxxvi] The rate was lower than the state rate of 381 per 100,000 and has been lower over the last 5 years. [lxxvii] Although lower than the state rate, the county's chlamydia rate is significantly higher than the national benchmark of 92 per 100,000 from the 2013 County Health Rankings (meaning that only 10% of counties have a lower rate).[lxxviii] *(Refer to Figure 16.)*

In women, infection can result in pelvic inflammatory disease (PID), a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. As with other inflammatory STDs, chlamydia infection can facilitate the transmission of HIV. In addition, pregnant women infected with chlamydia can pass the infection to their infants during delivery, potentially resulting in neonatal ophthalmia or pneumonia.[lxxix] There is evidence that screening is an effective tool in reducing the incidence of chlamydia; data from a randomized controlled trial of chlamydia screening in a managed care setting suggested that screening programs can lead to a reduction in the incidence of PID by as much as 60%.[lxxx] Local health departments that are responsible for the direct delivery of free STD and HIV prevention and control services play a critical role in addressing STI's. The Centers for Disease Control and Prevention (CDC) recommends annual chlamydia screening for young women under the age of 25.

6.0 Youth Behaviors

The choices young people make and the behaviors in which they engage can have both short and long-term effects on public health and the healthcare system. Incompletion of high school and involvement with the criminal justice system can predict a future of low socioeconomic status which is linked to poor health outcomes; teen pregnancy can also lead to cyclical poverty or low-income status; and, use of tobacco, alcohol and drugs can have long-term, detrimental physical and developmental effects. A number of factors that relate to youth behaviors were reviewed for purposes of Anaconda-Deer Lodge County's public health planning effort. While the county shows strengths in some areas of youth behavior, some behaviors point to the need for attention and further investigation.

A strength that emerged was the high school graduation rate, which is one predictor of future health status. The percentage of students in 2012 graduating from high school in four years (four-year adjusted cohort graduation rate) at the county's only high school—Anaconda High School—was 90.6%. The rate is higher than both the state and national rates and is up from 2010-2011 when the rate was 79.6%.[lxxxi] The way in which this data is compiled and tracked has changed and there are only two years of consistent data to track. It will be important to continue tracking the trend, which hopefully will continue to be in a positive direction.

The teen birth rate is another indicator of youth behaviors that factors into public health planning. It is defined as the rate of births per 1,000 to females aged 15-19. According to the 2012 Montana Teen Birth and

Pregnancy Report, the rate in Anaconda-Deer Lodge County is is 49.1 per 1,000 (over the period 2007-2011) compared to the Montana rate of 38 per 1,000.[lxxxii] The county had the fourteenth highest rate among 36 Montana counties for which a rate was calculated in the report. (Only counties for which there were 20 or more births in the time interval were included in the ranking).

Another source of insight into youth behaviors is the biennial Prevention Needs Assessment Survey conducted by the Montana Department of Health and Human Services in grades 8, 10 and 12 of Montana public schools. The survey gathers information about substance use, antisocial behavior as well as risk and protective factors for students in the family, peer, school and community environments. Information for this report was taken from the survey done in Anaconda-Deer Lodge County schools in 2012.

The survey, which had an overall participation rate of 78.3% among the three participating grades, may point to a progressive pattern of youth alcohol use from 8th grade through high school. In each of three categories of use including "binge drinking", "use within the last 30 days" and "lifetime use" of alcohol, the percentage of responders indicating use increased significantly between 8th and 12th grades. *(Refer to Figure 17.)*

FIGURE 17
Progression of Alcohol Use, Grades 8, 10, 12

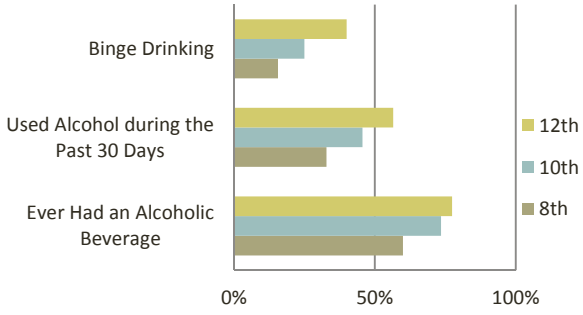


FIGURE 18
Youth who Engaged in Binge Drinking in Last 2 Weeks

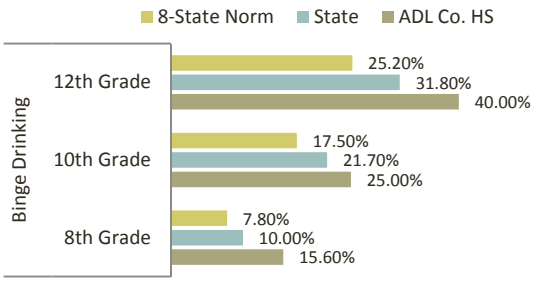
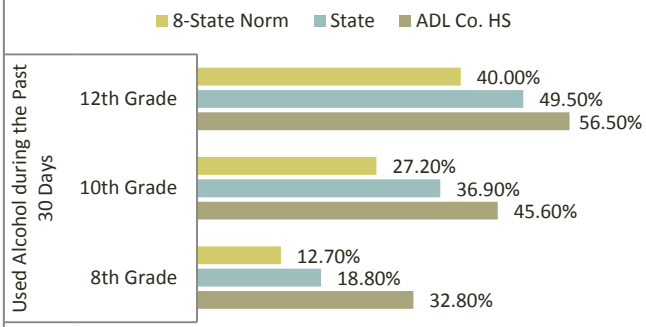
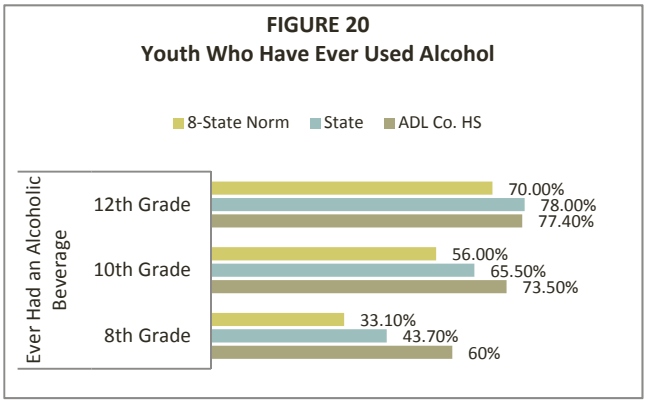


FIGURE 19
Youth who Have Used Alcohol in Past 30 Days



In all three grades, the rate of responders engaging in all three types of alcohol use was higher in Anaconda-Deer Lodge County than it was for students included in an 8-state norm used for comparison purposes. *(Refer to Figures 18-20.)* Notably, the percent of youth who said they had engaged in binge drinking (consuming 5 or more consecutive drinks) during the last two weeks was higher among all three participating grades in the county than it was for the state and multi-state group. Forty percent (40%) of 12th graders, 25%

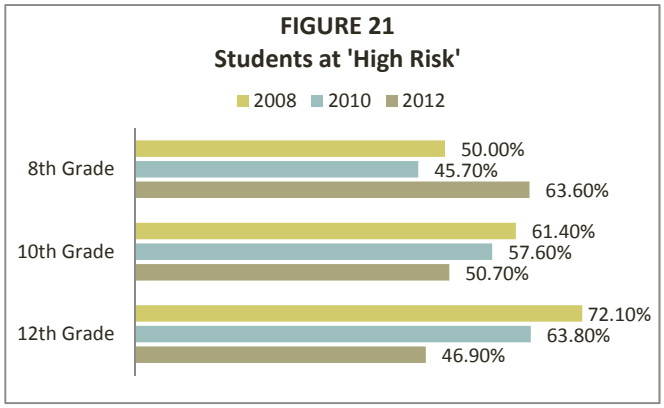
of 10th graders and 15.6% of 8th graders indicated through the survey they had engaged in binge drinking within 2 weeks of taking the survey. (*Refer to Figure 18*.)



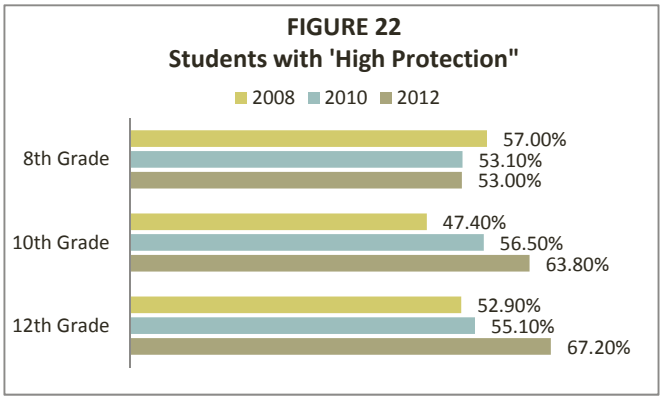
Over one-third of 8th graders, 45.6% of 10th graders and 56.5% of 12th grade students responding to the survey reported having used alcohol during the last 30 days. For all grades, the county rate exceeded the state and multi-state rates in that category. *(Refer to Figure 19.)* The percentage of responders who indicated they had ever used alcohol was higher in the county f or 8th and 10th graders than it was for the state and multi-state students. The rate for high school seniors in the county was on par with the state, but higher than the multi-state norm. (*Refer to Figure 20*.)

From a public health perspective, consideration should be given to whether there are environmental factors encouraging substance abuse among youth. The PNA survey attempts to ascertain community risk factors that may contribute to antisocial behavior in youth. (Antisocial behaviors are actions that violate protective rules, conventions, and codes of a society and in the PNA are defined as such things as drug and alcohol use, crime, school suspension and carrying handguns, among others.) The 2012 PNA results indicate that a significant number of youth in the school system believe community laws and norms as well as parental attitudes are favorable toward drug use and overall antisocial behavior. Just over half of students completing the 2012 survey indicated they believe laws and norms are favorable toward drug use. Forty percent (40%) of respondents indicated they believe their parents have favorable attitudes toward drug use and 53% indicated they believe their parents have favorable attitudes toward antisocial behavior.

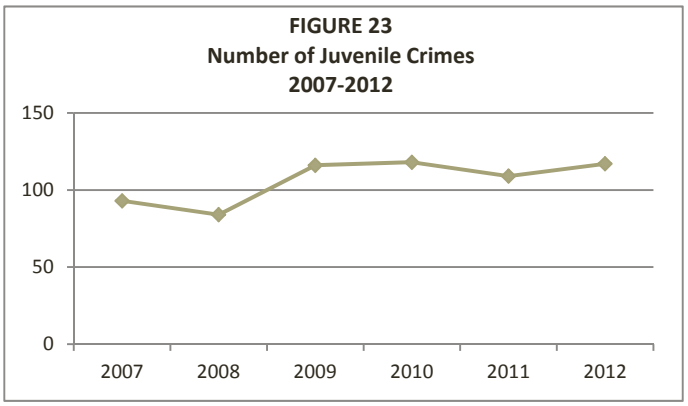
Overall, the 2012 survey indicated that 63.6% of 8th graders responding, 50.7% of 10th grade respondents and 46.9% of 12th grade respondents were at high risk for anti-social behavior. For purposes of the survey, high risk is defined as having 9 or more risk factors present in an 8th grader's life and 10 or more risk factors present in a 10th or 12th grader's life. A positive finding is that it



appears from three years of PNA surveys that the percentage of 10th and 12th graders at high risk is decreasing. For 8th graders, the 2012 PNA survey shows a significant increase in the percentage at high risk for anti-social behaviors. Particular risk factors that showed a high response rate from 8th graders included perceived community disorganization, perceived favorability of laws and norms toward drug use, perceived favorability of parents' attitudes toward anti-social behavior, perceived availability of hand guns, low commitment to school, interaction with antisocial peers, and peer use of drugs. (*Refer to Figure 21.)*



While the PNA survey attempts to identify risk for antisocial behavior among youth, it also helps to assess protection—factors that exert positive influence and buffer against the negative influence of risk.[lxxxiii] Although there appears to be a significant proportion of youth at high risk in Anaconda-Deer Lodge County, it also appears a significant proportion have high protection that can help offset the risk. According to the survey, 53% of 8th grade respondents, 63.8% of 10th grade respondents and 67.2% of 12th grade respondents had high protection in their lives, which means they had five or more protective factors at work to help buffer risk. The proportion of 8th grade respondents with high protection was significantly lower than the older grades among responders to the 2012 survey. Further, the proportion of 8th graders with high protection appears to have decreased over the course of three biennial surveys. The decrease in the percent of 8th graders with high protection coincides with an increase in the percentage at high risk over the last two survey periods. (*Refer to Figures 21-22.*) The 2012 PNA for Anaconda-Deer Lodge County provides results for numerous factors that are important to community planning. For more information, the report can be found on the website for the Montana Department of Public Health and Human Services.



An accompanying measure of youth behavior is the juvenile crime rate—a measure of crime among juveniles 10-18 years of age. The number of juvenile crimes in Anaconda-Deer Lodge County increased 38% between 2008 and 2009 going from 84 to 116, which is a rate of 91 per 1,000.[lxxxiv] The rate has remained above the 2008 rate since then with a 2012 rate of 114 per

1,000. (*Refer to Figure 23.)*

For comparison purposes, juvenile crime rates in two Montana counties of similar size were reviewed for this report, including Beaverhead and Stillwater Counties. The Anaconda-Deer Lodge County rate was higher than rates in both comparison counties in 2012. Although higher than the Stillwater County rate in 2011, Anaconda-Deer Lodge County had a lower rate than Beaverhead County in 2011. *(Refer to Table 3 for rates.)*

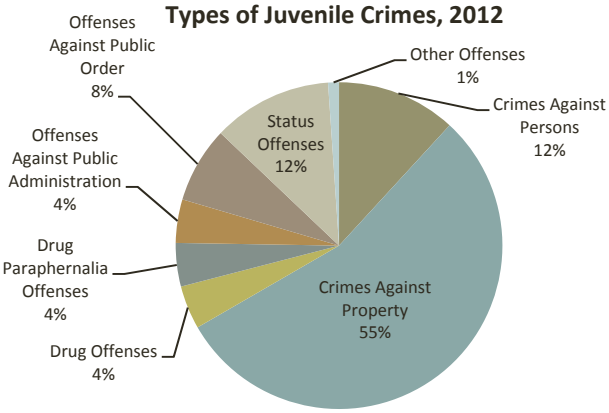
TABLE 3
JUVENILE CRIME RATE

	JUVENILE POPULATION	2011 JUVENILE CRIME RATE PER 1,000	2012 JUVENILE CRIME RATE PER 1,000
ADL Co.	1,023	82	91
Beaverhead Co.	1,060	109	76
Stillwater Co.	1,065	17	24

Sources: Juvenile Population: Missouri Census Data Center; Summary File 1; P14, Sex by Age for the Population Under 20; 2010 Census
Crimes: Montana Board of Crime Control; Juvenile Crime Statistics

The most commonly occurring crimes reflected in the 2012 rate included "crimes against property" that comprised 55% of total crimes, "crimes against persons", which comprised 12%, " and "status offenses", which comprised 12% of total juvenile crimes. Juvenile status offenses include such things as truancy, running away, being ungovernable or incorrigible, violating curfew laws, or possessing alcohol or tobacco).[lxxxv] (*Refer to Figure 24.*)

FIGURE 24
Types of Juvenile Crimes, 2012



7.0 Prevention and Wellness Behaviors

One of public health's primary functions is to protect and promote the population's health through prevention activities. The public health system, through its prevention work, has the potential to reduce the need for expensive medical care. In order to gauge current population participation in prevention activities for this report and indicate the possible need for improved or stepped-up prevention work, a number of indicators were reviewed for Anaconda-Deer Lodge County. Although there are many more prevention related behaviors, data limitations prevent the review of all related indicators.

7.1 Women's Prevention Behaviors

Data suggests a relatively high rate of engagement in prevention behaviors among women in the county. Just over 81% of women 18 years of age and older received mammography services in Anaconda-Deer

Lodge County according to a 2009 Community Health Status Report.[lxxxvi] To provide a comparison, the figure nationally was 80.9% in 2010 and 78.3% for the state of Montana[lxxxvii]. The same report indicated that 75.5% of women 18 years and older received pap smears. However, another figure provided by the *County Health Rankings* indicates a significant drop in engagement among women 67-69 years who are Medicare recipients. According to the *2013 County Health Rankings*, 59% of women in this group received mammograms, down from 71% in 2008.[lxxxviii]

7.2 Diabetic Screening

According to the 2012 County Health Rankings, 86% of the county's diabetic Medicare patients received blood sugar screenings, which was higher than the state rate of 79% and slightly lower than the national benchmark from the *County Health Rankings* of 89%.[lxxxix] The 2013 *County Health Rankings* showed a decrease in the percent of patients receiving screenings, dropping to 79%. The rate fell below the state rate of 80%.

7.3 Childhood Immunization

Immunization is an important disease prevention strategy and a critical function of public health departments and healthcare providers. A way to measure the extent to which the public is immunized is through childhood immunization rates. Anaconda-Deer Lodge County shows a high rate of children who are up to date on vaccinations. According to data gathered through clinic assessments by the Montana Department of Public Health and Human Services, the rate of children 24 to 35 months who were up to date on immunizations in 2012 is 87.3% in the county.[xc] This rate is higher than both the Montana state rate of 71% and the national rate of 77% which are assessed through the National Immunization Survey.[xci]

7.4 Overeating

In 2011, the United Health Foundation set forth a set of findings related to public health in a report entitled, "*America's Health Rankings: A Call to Action for Individuals and their Communities*". Among the findings in the report were health concerns related to overeating and lack of exercise which lead to obesity and diabetes. According to the report, obesity is one of the fastest growing health issues and America is spending billions in direct health care costs associated with poor diet and physical inactivity. Obesity has increased 137% since 1990, going from 11.6% of the adult population to 27.5% in 2011.

The rate of adult obesity in Anaconda-Deer Lodge County, at 27%, matches the national rate and is higher than the Montana rate of 24%.[xcii] A significant portion of the population is, therefore, at risk for heart disease, diabetes and other poor health outcomes. The estimated rate of diabetes in Anaconda-Deer Lodge County is

slightly higher than the national rate according to the 2013 *County Health Rankings*; 8% of county residents 20 years of age and older have been diagnosed with diabetes compared with 7% for Montana and 7.7% for the nation.[xciii] Health issues associated with obesity are compounded by the lack of physical activity. The 2013 *County Health Rankings* report indicates that 24% of adults 20 years and older in Anaconda-Deer Lodge County report no leisure time physical activity. This rate is only slightly lower than the national rate of 25%[xciv] and is slightly higher than the state rate of 23%.

IX. ENVIRONMENTAL FACTORS

1.0 Superfund Related Factors

Anaconda-Deer Lodge County is faced with potential environmental hazards that resulted from mining related activities for nearly 100 years. The Anaconda Smelter Superfund Site is located at the southern end of the Deer Lodge Valley, at and near the location of the former Anaconda Minerals Company (AMC) ore processing facilities. The processing facilities at the site were developed to remove copper from ore mined in Butte from about 1884 through 1980. Milling and smelting produced wastes with high concentrations of arsenic, as well as copper, cadmium, lead and zinc. These contaminants pose potential risks to human health, to life in nearby streams, and to plants and animals in adjacent lands over some 300 square miles. In addition to the millions of cubic yards of tailings, furnace slag, flue dust, and square miles of soil contaminated by airborne wastes, millions of gallons of ground water have been polluted from wastes and soils. Arsenic is the primary contaminant of concern and drives remediation activity.

In September 1983, the EPA placed the area surrounding the smelter on the Superfund National Priorities List (NPL). Consulting with the State of Montana and coordinating with Atlantic Richfield, the current owner of the property, EPA began investigations into the extent of contamination. Since then, removals and cleanup actions have reduced human health risks at the site.

The Unilateral Administrative order associated with the Record of Decision or ROD for the Anaconda Smelter site cleanup prescribed a series of institutional controls which included the Community Protective Measures Program (CDMP). The CDMP includes five measures as follows:

1. The provision of information to homeowners regarding cleanup activities that are or will occur on their properties
2. Sampling of properties in response to inquiries by owners

3. The requirement for a development permit for land disturbances with minimum thresholds based on the side of the proposed disturbance
4. Medical monitoring of residents, measuring blood lead and urinary arsenic, and associated referrals to medical professionals
5. The provision of information to EPA regarding findings

In addition to these measures, Atlantic Richfield is working with the community to undertake a program of lead paint abatement. Other issues including potential contaminants associated with attic dust and mold infestations, not necessarily related to the Smelter Site have also been raised by local residents.

2.0 Availability of Healthy Food

There is strong evidence that residing in a food desert is correlated with a high prevalence of overweight, obesity, and premature death. Additionally, lack of access to fresh fruits and vegetables is a substantial barrier to healthy food consumption and is related to premature mortality. Supermarkets, which traditionally provide healthier options than convenience stores or smaller grocery stores, are not always accessible to people residing in rural areas. For these reasons, the *County Health Rankings* project measures the percent of people who are low-income and do not live close to a grocery store, which in a rural area is defined as living within 10 miles of a healthy food source. According to the 2013 *County Health Rankings*, only 3% of the county population has limited access to health foods. Because an estimated 80% of the county population resides within 10 miles of Anaconda, most local people have access to stores that make healthy food available.

X. HEALTH FACTORS AND OUTCOMES

1.0 Overall Health Ranking (*County Health Rankings*)

Through a collaborative project of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, county health rankings are conducted every year for counties across the nation. 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 as well as the Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is a national random digit dial telephone survey. Data obtained from the BRFSS are representative of the total non-institutionalized population over 18 years of age living in households with a land line telephone. For the purposes of the *County Health Rankings*, data from the BRFSS are used to measure various health behaviors and health-

related quality of life (HRQOL) indicators. All data from the BRFSS are weighted by population and the HRQOL measures are age-adjusted. Measures contained in the *County Health Rankings* are standardized and combined using scientifically-informed weights. The rankings are based on an analysis of data for one mortality, four morbidity factors and ten health categories.

In the 2013 *County Health Rankings*, Anaconda-Deer Lodge County ranked 42 out of 46 counties in Montana (not all counties were ranked). The county's rank in 2012 was 43 among 47 counties. In the annual rankings process, it is important to note that rank is relative to what is occurring within all other counties under consideration. For example, a fall in rank can be related to improved outcomes in other counties and not necessarily poorer outcomes in your county. Further, factors used in the health rankings sometimes change, making time comparisons difficult.

The "*Rankings*" reveal some notable changes within county health outcomes that are relevant to public health planning. First, the number of years of life lost due to premature death has been on the decline since 2011. This figure represents the aggregate of every death occurring before the age of 75. Thus, a person dying at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years. The measure is presented as a rate per 100,000 population and is age-adjusted to the 2000 U.S. population. In Anaconda-Deer Lodge County, the rate of premature death in 2011 was 10,163 per 100,000, and dropped to 9,092 per 100,000 in 2013. Although the rate in the county far exceeds the national benchmark of 5,317, the

2013 figure indicates a positive trend.

Another less positive change worth noting is the increase in the percent of BRFSS survey respondents reporting poor or fair overall health. Self-reported health status is a widely-used general measure of health-related quality of life in a population. The measure helps characterize the burden of disabilities and chronic diseases and is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the *County Health Rankings* is the percent of adult respondents who rate their health "fair" or "poor." The measure is age-adjusted to the 2000 U.S. population. The percent of respondents in Anaconda-Deer Lodge County reporting poor or fair health was 20% in the 2013 "*Rankings*" which is up from 18% in 2010 and 19% in 2011 and 2012. A related factor is the average number of poor mental health days that is also based on the BRFSS survey. The survey asks the question, "thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported in the *County Health Rankings* is the average number of days the county's adult respondents report their mental

health was not good. The measure is age-adjusted to the 2000 US population. The average number of poor or fair mental health days from the 2013 *County Health Rankings* was 5.1, which is up from 4.6 in 2010.

2.0 Leading Causes of Death

In 2011, the two leading causes of death in Anaconda-Deer Lodge County were cancer and heart disease. They were followed by unintentional injury (external cause of death such as motor vehicle incident, drowning, fall, poisoning, etc.) and chronic lower respiratory disease. There were 34 deaths in the county attributable to cancer in 2011 with an associated death rate of 365.6 per 1,000 population. Heart disease caused 28 deaths in 2011 with an associated death rate of 301.1 per 1,000. Seven deaths were due to unintentional injury and 6 deaths were attributable to chronic lower respiratory disease.[xcv] While the leading cause of death in Anaconda-Deer Lodge County is the same as Montana, it differs from the nation for which the leading cause of death is heart disease.

2.1 Cancer (Leading Cause of Death)

The National Cancer Institute compiles cancer incidence and death rates by county over 5 year periods. The data provides smaller populations with insight into cancer occurrence and death trends. The Institute's age-adjusted cancer incidence rate calculated over the period 2006-2010 for Anaconda-Deer Lodge County was 403.3 per 100,000 with an average of 54 occurrences per year for all cancer types over the period. The age-adjusted county incidence rate was lower than the Montana rate of 455.9 per 100,000 population and the national rate of 453.7 per 100,000 population.[xcvi] (*Refer to Table 4*.) According to the Institute's State Cancer Profiles for the same period, the most commonly occurring cancer type was cancer of the prostate with an incidence rate of 110.4 per 100,000 or an average of 8 cases annually over the period. Female breast cancer was the second most commonly occurring cancer in Anaconda-Deer Lodge County for the period with an average of 5 cases annually and a rate of 82 per 100,000. Both rates are lower than the state and national incidence rates.[xcvii]

TABLE 4
CANCER INCIDENCE AND MORTALITY
Rate Period (2006-2010)
Age-Adjusted Rate per 100,000

	Incidence Rate	Annual Death Rate
ADL County	403.3[1]	173.4[2]
Montana	455.9[3]	166.3[4]
United States	453.7[5]	176.4[6]

[1] 95% confidence interval from 355.2 to 456.8; average annual count is 54.
[2] 95% confidence interval from 143.6 to 208.5 and 24 average annual deaths.
[3] 95% confidence interval from 450.3 to 461.6; average annual count is 5,227.
[4] 95% confidence interval from 163.0 to 169.8 and 1,913 average annual deaths.
[5] 95% confidence interval from 453.4 to 454.0; average annual count is 1,463,786
[6] 95% confidence interval from 176.2 to 176.6 and 566,112 average annual deaths.

Source: National Cancer Institute; State Cancer Profiles

According to the State Cancer Profiles, the age-adjusted cancer mortality rate for the five-year period 2006-2010 in Anaconda-Deer Lodge County is 173.4 per 100,000, which is higher than the state death rate, but lower than the national rate of 176.4 per 100,000. (*Refer to Table 4*.) The average number of deaths annually over the period was 24. This death rate is age-adjusted for the purpose of controlling for differences in age distribution among populations before making comparisons. When the crude cancer death rate (actual number of deaths divided by the population) is used, the county's rate is higher than the state and national rates. This is not surprising since Anaconda-Deer Lodge County has a higher proportion of older people than the general population. The one year 2011 crude death rate from cancer for Anaconda-Deer Lodge County was 365.6 per 1,000 compared with the state rate of 199.5 per 1,000[xcviii] and the national rate of 184.6 per 100,000.[xcix]

Research shows that certain risk factors increase the chance of developing cancer. The most common risk factors include:

- Growing older
- Tobacco
- Sunlight
- Ionizing radiation
- Certain chemicals and other substances
- Some viruses and bacteria
- Certain hormones
- Family history of cancer
- Alcohol
- Poor diet, lack of physical activity, or being overweight

While many of these risk factors can be avoided, others, such as family history, cannot. As discussed in the Health Behaviors section of this report, behaviors that include overeating, lack of physical activity, over use of alcohol and use of tobacco are present at levels in the local population that can present risk to a significant portion of the population. It is important for the public health agency, in the interest of prevention and overall public health, to develop approaches that discourage behaviors that create risk and encourage those that protect the public from cancer risk.

2.2 Heart Disease

Heart disease is the second leading cause of death in Anaconda-Deer Lodge County and nationally. The associated crude death rate in the county is higher than it is for both Montana and the nation. The rates are not age adjusted and, therefore, are not controlled for age distribution. (*Refer to Table 5.)* There is currently

no available data related to prevalence of coronary heart disease at the county level. However, the age adjusted prevalence of coronary heart disease in Montana is 5.5% which is lower than the national rate of 6%.[c]

TABLE 5 2011 MORTALITY RATE FROM HEART DISEASE *Crude One-Year Rate per 100,000*	
ADL County[1]	365.6
Montana[1]	199.5
United States[2]	191.4

[1] Selected Vital Statistics, Frequencies and Rates or Ratios by County, Montana, 2011
[2]Centers for Disease Control and Prevention; National Center for Health Statistics Hoyert DL, Xu JQ. Deaths: Preliminary data for 2011. National Vital statistics reports; vol 61 no 6.. 2012.

As the second leading cause of death, it is important for planning purposes, to assess health factors and behaviors in the population that increase the risk of heart disease. Tobacco use, excessive drinking, diets high in salt, saturated fat and cholesterol, and physical inactivity all raise the risk of developing heart disease. In Anaconda-Deer Lodge County, an estimated 19% of adults engage in excessive drinking, an estimated 28% are current smokers, an estimated 24% are physically inactive and an estimated 27% are obese. Local rates for all these factors exceed state and national rates; the increase in rates for obesity and physical inactivity should be regarded as a public health problem contributing to heart disease.

Diabetes and high blood pressure are additional health factors that increase the risk of heart disease and were considered for this report. In Anaconda-Deer Lodge County, an estimated 8% of adults 20 years of age and older have had a diabetes diagnosis, which is slightly higher than the national and state rates. It is estimated that 33.6% of the adult population in the county has high blood pressure, a rate that exceeds both the state and national rates. *(Refer to Table 6.)* Because high blood pressure is a risk factor for heart disease, a significant portion of the county population is at risk.

TABLE 6 DIABETES AND HIGH BLOOD PRESSURE INCIDENCE		
	% of Adults with Diabetes	**% of Adults with High Blood Pressure**
ADL County	8%[1]	33.6%[3]
Montana	7%[1]	27%[4]
United States	8.3%[2]	31%[5]

[1] 2013 County Health Rankings (2009 data)
[2] Centers for Disease Control and Prevention; Health United States, 2011
[3] Community Health Status Report, 2009; U.S. Department of Health and Human Services
[4] Montana Department of Public Health & Human Services; News Bulletin; Hypertension: What You Don't Know Can Hurt You; January 20, 2011
[5] Centers for Disease Control and Prevention; High Blood Pressure Facts; http://www.cdc.gov/bloodpressure/facts.htm

2.3 Chronic Lower Respiratory Disease

Chronic lower respiratory disease, which refers to chronic diseases that affects the lower respiratory tract (including the lungs), was the third leading cause of death in the United States in 2011 and the fourth leading cause in Anaconda-Deer Lodge County. The most common form is Chronic Obstructive Pulmonary

Disease, or COPD, which refers to a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema, chronic bronchitis, and in some cases asthma.

In the United States, tobacco smoke is a key factor in the development and progression of COPD, although exposure to air pollutants in the home and workplace, genetic factors, and respiratory infections also play a role. The following groups were more likely to report COPD: people aged 65–74 years; non-Hispanic whites; women; individuals who were unemployed, retired, or unable to work; individuals with less than a high school education; people with lower incomes; individuals who were divorced, widowed, or separated; current or former smokers; and, those with a history of asthma.[ci]

According to data compiled over the period 2004-2008, the crude mortality rate associated with Chronic Lower Respiratory Disease in Anaconda-Deer Lodge County was 134.8 per 100,000 population, which is significantly higher than the state rate for the same period (63.9 per 100,000).[cii] In 2011, there were 6 deaths attributed to chronic lower respiratory disease in the county which amounts to a mortality rate of 65.5 per 100,000.[ciii] This compares with a national mortality rate of 46 per 100,000 for 2011.[civ] These figures are not age adjusted, and therefore, do not control for age distribution in the population.

3.0 Morbidity

Morbidity is a term that refers to how healthy people feel while alive. The *County Health Rankings* provide data on measures related to quality of life including overall health as well as physical and mental health. Data gathered for these measures is based on the national Behavioral Risk Factor Surveillance System (BRFSS) survey. In the annual survey, questions aimed at ascertaining Health-Related Quality of Life (HRQoL) are posed. Measuring HRQoL helps characterize the burden of disabilities and chronic diseases in the population. The measures are age-adjusted to the 2000 population and, therefore, are controlled for disparate age distributions among communities.

According to the 2013 *County Health Rankings,* the percent of adult respondents in Anaconda-Deer Lodge County who rate their overall health as "fair" or "poor" was 20%, which is up from 18% in 2010 and 19% in 2011 and 2012. The measure is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The rate is higher than the 13% of Montanans who perceive their health to be fair or poor and significantly higher than the national benchmark of 10%.

The *County Health Rankings* also provide a measure for physical health. The measure is based on survey responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" The value reported in the *County Health Rankings* is the average number of days a county's adult respondents report that their physical health was not good. The measure is also age-adjusted to the 2000 US population. The average number of unhealthy days for the Anaconda-Deer Lodge adult population resulting from the 2013 survey is 4.8, which is also higher than the average number of days for Montana and the Nation. (*Refer to Table 7.*)

TABLE 7
MORBIDITY
From 2013 County Health Rankings

	Perceived Poor or Fair Health	Average # of Physically Unhealthy Days	Average # of Poor Mental Health Days
ADL County	20%	4.8	5.1
Montana	13%	3.4	3.2
National Benchmark	10%	2.6	2.3

Source: County Health Rankings, 2013

A related factor is the average number of poor mental health days; this measure is also derived from the BRFSS survey and reported in the *County Health Rankings*. The survey asks the question, "thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported in the *Rankings* is the average number of days the county's adult respondents report their mental health was not good, and like the other morbidity measures, is age-adjusted to the 2000 US population. The average number of poor or fair mental health days from the 2013 *County Health Rankings* was 5.1, which is up from 4.6 in 2010 and is higher than both the state and national averages. *(Refer to Table 6.)*

4.0 Maternal and Infant Health

Pregnancy and childbirth have a significant impact on the physical, mental, emotional, and socioeconomic health of women and their families. Related health outcomes are influenced by a woman's health and other factors like race, ethnicity, age, and income. A number of factors were reviewed to determine population level outcomes related to maternal, infant health in Anaconda-Deer Lodge County, including entrance into prenatal care, pre-term births, low birth weight, gestational diabetes and infant mortality.

4.1 Prenatal Care

Appropriate prenatal care is important to preventing problems and helping women achieve the ideal result of full-term pregnancy without unnecessary interventions, the delivery of a healthy baby, and a healthy postpartum recovery. An important indicator of appropriate prenatal care is the percentage of pregnant women who begin prenatal care during the first trimester of pregnancy. Over the period 2008-2010, 72% of pregnant women in the county entered prenatal care in the first trimester, which was higher than the state and national rates for the period. (*Refer to Table 8.)*

4.2 Preterm Births/Low Birth Weight

The rate of preterm births was considered in this analysis because preterm infants are at increased risk of life-long disability and early death. At 11.3%, the percent of infants born preterm (less than 37 weeks) in the county was slightly lower than the national rate of 11.9%, but higher than the state rate of 10%. The rate of births that are considered 'low birth weight' (less than 2,500 grams) was significantly higher in the county (12%) than the state (7%) and national (8.1%) rates for the period reviewed. Data from the period 2008-2011 complied by the Montana Department of Public Health and Human Services indicated that 21.5%[cv] of women smoked during pregnancy compared with 10.7%[cvi] nationally. Because there is a known connection between smoking during pregnancy and low birth weight, public health approaches that aim to reduce smoking during pregnancy may be called for. No infant deaths were reported in the county in 2011. (*Refer to Table 8.)*

TABLE 8
MATERNAL AND INFANT HEALTH MEASURES

	United States	ADL County	Montana
Entrance into prenatal care in first trimester (County and State rates are for 2008-2010; national rate is for 2008)	70.7% [3]	**72% [1]**	69% [1]
Low birth weight (less than 2500 grams) as a percent of live births (County and state rates are 2008-2011; national rate is 2011)	8.1% [4]	**12.8% [2]**	7.3% [2]
Infant Mortality (deaths per 1,000 live births, 2011	6.05 [6]	**0 [7]**	6.1 [7]
Pre-term births (< 37 weeks) as a percent of live births (MT and County Rate is for 200-2011; National rate is 2011)	11.7% [5]	**11.3% [2]**	10% [2]
Percent of live births involving gestational diabetes 2004-2010	NA	**5% [8]**	2.5% [8]

[1]Montana Kids Count; Deer Lodge County; website: http://www.montanakidscount.org
[2]Montana Department of Public Health and Human Services; Maternal., Infant, and Early Childhood Home Visiting Program; Deer Lodge County Profile;
[3]Centers for Disease Control and Prevention; Health United States, 2011; Table 5; Prenatal Care for Live Births; 2008
[4]National Vital Statistics Reports; Volume 60, Number 2 November 17, 2011; Births: Preliminary Data for 2010 by Brady E. Hamilton, Ph.D.; Joyce A. Martin, M.P.H.; and Stephanie J. Ventura, M.A., Division of Vital S
[5]Centers for Disease Control and Prevention; FASTSTATS; website: http://www.cdc.gov/nchs/fastats/birthwt.htm
[6]National Center for Health Statistics. 2013. MacDorman MF, Hoyert DL, Mathews TJ; Recent declines in infant mortality in the; United States, 2005–2011. NCHS data brief, no 120.
[7]Montana Department of Public Health and Human Services; Selected Vital Statistics, Frequencies and Rates or Ratios by County, Montana, 2011
[8]Montana Department of Health and Human Services; Data compiled for Community Health Assessments; Deer Lodge County

5.0 Compiled Health Behaviors and Outcomes Table

The following table presents a compilation of health behaviors and outcomes for Anaconda-Deer Lodge County. For comparison purposes, national and state data are also provided. Data is presented in categories and with three separate columns. The first column provides figures at the national level. Some national figures are benchmarks set forth in the 2013 *County Health Rankings*; national benchmarks were used only for factors that came from the *Rankings*. Benchmarks represent the figures for counties across the nation that are in the 90th percentile for positive outcomes (only 10% of counties have more positive results). Other national figures are simply national rates and are indicated as such where that occurs. The center column presents figures for the county level and in the far right column are figures at the state level. The most recent available data was used and to the greatest extent possible, comparable time periods were used for national, state and local data. Where this was not possible, time periods that were as close as possible to the period used for local data was used. This was done in order to provide at least some sense of how health-related behaviors and outcome in Anaconda-Deer Lodge County compare to the general population. Sources are provided at the end of the table.

TABLE 9
HEALTH BEHAVIORS AND OUTCOMES

	NATIONAL BENCHMARK	ADL COUNTY	MONTANA
Alcohol Consumption (2013 County Health Rankings)			
Excessive Drinking: % Heavy Drinkers (males-more than 2 drinks/day; females-more than one drink per day) and binge drinking (males-more than 5 drinks/day; females-more than 4 drink per day)[3]	7%	19%	18%
Adult Obesity (2013 County Health Rankings)			
% Obese (BMI of 30 or greater)[3]	25%	27%	24%
% of adults aged 20 and over reporting no leisure time physical activity[3]	21%	24%	23%
Adult Smoking Prevalence (2013 County Health Rankings)			
% Adults who smoke every day or most days[3]	13%	28%	18%
% Mothers who smoked during pregnancy (2008-2011)[11]	NA	21.4%	16.6%
Morbidity (age adjusted) (2013 County Health Rankings)			
Self-reported health status; % of adults reporting fair or poor health[3]	10%	20%	13%
Average number of physically unhealthy days reported in last 30 days[3]	2.6	4.8	3.4
Average number of mentally unhealthy days reported in last 30 days[3]	2.3	5.1	3.2
Disability (2000)			
% of Population 5 years of age and older with a disability[9]	NA	23.8%	17.5%

Mortality			
Median age at death (all races) (2004-2008)[1]	NA	78	78
Heart disease mortality rate per 100,000 population (Crude Rate 2011)	191.4[2] *National Rate*	365.6[5]	199.5[5]
Pneumonia/Influenza mortality rate per 100,000 population (2004-2008)[1]	NA	60.7	19.0
Chronic lower respiratory disease mortality rate per 100,000 population (2004-2008)[1]	NA	134.8	63.9
Suicide rate per 100,000 population (1997-2011)	12.3 [12]	29.1 [6]	22.9 [6]
Drug-related mortality rate per 100,000 population (2004-2008)[1]	NA	33.7	13.8
Motor Vehicle Crash Death Rate per 100,000 population (2004-2008)[1]	NA	27	25.5
Percent of motor vehicle crashes involving alcohol (2003-2007)[1]	NA	11.4%	10%
Unintentional injury death rate per 100,000 population (2004-2008)[1]	NA	112.4	55.8
Work-related injury death rate per 100,000 population (2004-2008)[1]	NA	6.7	3.7
Immunizations (2011)			
Childhood Immunization Up-to-Date (24-35 months) [16]	77% *National Rate*	87.3%	71%
Health Insurance (2011)			
Percent of population (under 65) without health insurance[7]	15.7%	19.9%	20.7%
Maternal and Child Health			
Entrance into prenatal care in first trimester 2008-2010	70.7% [14] *National Rate*	72%[13]	69%[13]
Low birth weight (less than 2500 grams) as a percent of live births (MT and County rates are 2008-2011; National rate is 2011)	8.1% [10] *National Rate*	12.8% [11]	7.3% [11]
Infant Mortality (deaths per 1,000 live births 2011	6.05[15] *National Rate*	0[5]	6.1[5]

Cancer mortality rate per 100,000 population (Age-adjusted Rate 2011)[8]	176.4 *National Rate*	173.4	166.3
Diabetes mellitus mortality rate per 100,000 population; (county and State rates are 2004-2008; national rate is 2008)	23.2[2]	38.2[1]	27.1[1]
Chronic liver disease and cirrhosis mortality rate per 100,000 population (2004-2008)[1]	NA	15.7	12.7
Cerebrovascular disease (including stroke) mortality rate per 100,000 population (2004-2008)[1]	NA	51.7	49.7

Percent of live births involving gestational diabetes 2004-2008[1]	NA	4.5%	2.5%
Pre-term births (< 37 weeks) as a percent of live births (MT and County Rate is for 2008-2011; National rate is 2011)	11.7%[12] *National Rate*	11.3%[11]	9.5%[11]
Cancer Incidence (2006-2010) – Age Adjusted			
Cancer incidence rate (diagnosis per 100,000)[8]	453.7 *National Rate*	403.3	455.9
Communicable Disease (2012)			
Chlamydia; reported cases per 100,000 population[5]	NA	247	381
Hepatitis C (chronic) cases per 100,000 population[5]	NA	0	137.3
Tuberculosis; reported cases per 100,000 population[5]	NA	0	0.5
Pertussis: reported cases per 100,000 population[5]	NA	139.8[17]	55.68[17]
Diabetes			
Diabetes (percent of population diagnosed)	8.3%[10] *National Rate*	8%[3]	7%[3]

[1]Montana Department of Public Health and Human Services; Data compiled for Community Health Assessments; Deer Lodge County
[2]National Vital Statistics Reports; Volume 61, Number 6 October 10, 2012; Deaths: Preliminary Data for 2011; by Donna L. Hoyert, Ph.D., and Jiaquan Xu, M.D., Division of Vital Statistics; Also, Volume 59, No. 10, December 10, 2011
[3]County Health Rankings; 2013; Collaboration between Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute
[5]Montana Department of Public Health and Human Services; Selected Vital Statistics, Frequencies and Rates or Ratios by County, Montana, 2011
[6]Montana Strategic Suicide Prevention Plan; Montana Department of Public Health and Human Services; Mental Health Services Bureau
[7]U.S. Census Bureau; SAHIE; State and County; Rate is for 2011
[8]National Cancer Institute; State Cancer Profiles; 2006-2010
[9]2000 Decennial Census; no current data available
[10]National Vital Statistics Reports; Volume 60, Number 2 November 17, 2011; Births: Preliminary Data for 2010
[11]Montana Department of Public Health and Human Services; Maternal., Infant, and Early Childhood Home Visiting Program; Deer Lodge County Profile; 2008-2011
[12] Centers for Disease Control and Prevention; FASTSTATS; website; http://www.cdc.gov/nchs/fastats/birthwt.htm
[13]Montana Kids Count; Deer Lodge County, website: http://www.montanakidscount.org/filelib/120.pdf
[H] Centers for Disease Control and Prevention; Health United States, 2011; Table 5; Prenatal Care for Live Births; 2008
[15]National Center for Health Statistics. 2013. MacDorman MF, Hoyert DL, Mathews TJ; Recent declines in infant mortality in the United States, 2005–2011. NCHS data brief, no 120[16] Montana Department of Public Health and Human Services; 2011-2012 Clinic Assessment Results
[17]Montana Department of Public Health and Human Services; Pertussis Update: Quarter 3 2013; 2013 Year to Date (YTD) confirmed and probable cases reported to Montana DPHHS through 9/30/13

XI. HEALTHCARE ACCESS

There are two major barriers to healthcare access in America today. The first is the inability of many to purchase health insurance, which has been an enormous barrier for the last decade as the cost of healthcare and insurance has skyrocketed. As this report is written, the way in which Americans access health insurance is changing due to the National Affordable Care Act. By January of 2014, it is the intent of the new law to ensure every American is covered by health insurance. As it is, just over 15% of Americans have no health insurance, which is a deterrent to healthcare access.[cvii] According to the most recent health insurance estimate from the U.S. Census Bureau, 19.9% of people (1,377) in Anaconda-Deer Lodge County under the age of 65 have no form of health insurance compared with 21.6% for Montana.[cviii] For people with incomes at or below 200% of the federal poverty line (low-income), the percentage without health insurance increases dramatically. Overall, 31.6% of low-income people in Anaconda-Deer Lodge County under 65 have no health insurance compared with 34.3% for Montana. (*Refer to Table 10.)*

TABLE 10
HEALTH INSURANCE COVERAGE

	Population <65 Years	Population <200% of Poverty	Population <19 Years
ADL County	19.9%	31.6%	10%
Montana	21.6%	34.3%	12.2%
United Sates	15.1%		9.7%

Sources: U.S. Census Bureau; Small Area Health Insurance Estimates

For children in the county, health insurance coverage is higher, due in part to the availability of the Healthy Montana Kids program—a health insurance program for poor and lower income children administered by the State of Montana—and Medicaid, which also provides access to healthcare for the very poorest of children. Nearly one-third of children in Anaconda-Deer Lodge County are enrolled in and receive Medicaid assistance (513 children).[cix] According to the most recent Census estimate (2011), 10% (178) of people under the age of 19 in the county have no health insurance. *(Refer to Table 10.)* Again, the National Affordable Healthcare Act, much of which will take effect in 2014, has the potential to greatly increase the rate of insured people, and therefore, increase healthcare access. Outcomes will likely not be seen in data until 2015.

A second major barrier to healthcare access is the unavailability of health care providers who are critical to maintaining population level health. Anaconda-Deer Lodge County has some healthcare professional

shortage designations as assessed by the U.S. Department of Health and Human Services that are important to note for planning purposes. The county is designated as a dental health professional shortage area and also has a dental shortage designation specific to the low-income population.[cx] The county as a whole is designated as a mental health professional shortage area[cxi], which is a critical issue in a county with high rates of depression and suicide. Finally, Anaconda-Deer Lodge County has a "medically underserved population" designation specific to the low-income population, which means the county has too few primary care providers for that population, high infant mortality, high poverty and/or high elderly population.[cxii]

CHAPTER TWO: SERVICES AND GAPS

I. INTRODUCTION

The gap analysis portion of the health assessment for Anaconda-Deer Lodge County is the second part of the community health needs assessment process. While the first part examines various indicators of public health, this portion provides a means to identify gaps and deficiencies in health related services and programs. The following section of the report summarizes existing initiatives and also notes those that are missing or are in some way inadequate to address identified needs.

II. METHODOLOGY

In the months of October and November of 2012, representatives of service agencies and organizations were contacted by telephone to learn the nature and extent of existing services and programs in Anaconda-Deer Lodge County. Each interviewee was presented with the following questions:

- What services (and areas of service) does your program/agency provide?
- Do these services meet the need?
- Are there needs which are currently unmet?

Interviews were conducted with the following people:

- Marcie Stoppler, Pintlar Family Medicine; October 19, 2012
- Cookie Johnson, School Nurse, School District #10, October 22, 2012
- Mary Pat Brown, Office of Public Assistance, October 22, 2012
- James Rosien, Anaconda Leader, October 23, 2012
- Deb Cuny, Anaconda Family Resource Center, October 26, 2012
- Heidi Nielsen, Acting Director, ADLC Public Health Department; November 1, 2012
- Joeanne Heaney, Vicitms, Witness Advocacy, County Attorney's Office, November 1, 2012
- Janel Pliley, Adult Protective Services, Pintler Suicide Prevention, Senior Companion Program, Deer Lodge County Caregivers, November 1, 2012
- Jo Lynn David, Smelter City Senior Citizen Center, November 2, 2012
- Terrie Casey, Anaconda Veterans Montana Health Care System, November 15, 2012
- Ann Dobney, Adult Basic Literacy Education Program, November 27, 2012
- Janine Stewart, Western Montana Mental Health Center and Western Montana Tri-County Addiction Services, November 29, 2012

III. SUMMARY OF IDENTIFIED GAPS

A review of the information gathered in interviews and in stakeholder meetings indicates that there are a number of critical gaps in health related services provided in Anaconda-Deer Lodge County. Most respondents identified the lack of mental health service providers, access to affordable health insurance and lack of affordable housing options for all groups as the most critical unmet needs. A summary list of all gaps/unmet needs identified includes the following:

- Mental health service providers, including prescribers
- Affordable and accessible insurance coverage
- Affordable housing options – for all demographics
- Greater community participation in prevention programs, particularly related to suicide prevention and addiction
- Youth activities that reinforce healthy behaviors
- A public school based dental program
- Chronic pain management specialists/clinics
- Programs that address community decay (e.g. abandoned cars and properties)
- Licensed day care providers (children)
- Homeless and Transitional Housing
- Domestic Violence Shelters
- Emergency Services for victims of domestic abuse
- Secondary Crisis Response Teams
- Respite and Adult Day Care
- Geriatric Healthcare providers
- Services in support of seniors aging in place (healthcare, home maintenance, etc.)
- Housing for severely mentally ill adults
- Inpatient chemical dependency treatment center
- Hospital detoxification unit

IV. CURRENT SERVICES

1.0. PUBLIC HEALTH AND PREVENTION SERVICES

The Anaconda/Deer Lodge County (ADLC) Public Health Department is funded through seven separate grants in addition to general funds distributed by the county. The Department serves people of all ages; however the majority of people served are from birth through age 45. Most participants are insured through Medicaid, Medicare, or possess privately owned insurance, while very few participants are uninsured. The following services are provided through the health department:

- Local Disaster Preparedness
- Women, Infants, & Children (WIC); approximately 450 eligible participants utilize WIC services per month an income restrictions apply.
- Federal Nutrition Program
- Public Health Home Visiting Services
- Maternal & Child Health Services
- Family Planning; approximately 225 family planning clients utilize the program per year.
- Immunizations; approximately 650 immunizations are administered per year.
- Hemoglobin and Lead Screenings
- Participation Opportunities on Several Boards such as DUI Task Force, Board of Health, and Anaconda Community Intervention.

2.0 HOSPITAL SERVICES

Community Hospital of Anaconda (CHA) serves Anaconda/Deer Lodge County, primarily Anaconda, and is a five-time recipient of the Highest Quality Award from the Mountain Pacific Quality Health Foundation. CHA has 350 employees working at the hospital or at one of the off-campus affiliated clinics including Anaconda Internal Medicine, Pintler Family Medicine, and Pinter Surgical Specialists. The staff consists of administrative personnel, nurse practitioners, physician assistants, two orthopedic surgeons, neurosurgeon, neurologist, two gynecologists, family practitioners, and internists. Additionally, CHA has five visiting physicians who specialize in gastroenterology, ophthalmology, podiatry, and cardiology. While CHA does not have an oncologist, two registered nurses are certified to administer chemotherapy.

Approximately eight percent of patients who seek medical services at CHA or the affiliated clinics are uninsured; however, the hospital offers financial services to those who cannot afford care.

The number of people served in 2010 in the following categories:

- Hospital Admits: 850
- Observation Admits: 500
- ER Visits: 230
- Outpatient Services (lab tests, radiology, pharmacy etc.): 5,600 per month
- Outpatient Surgeries: 60
- Inpatient Surgeries: 30
- Overall Total: over 10,000 per year

CHA Clinics:

- Anaconda Pediatrics
- Pintler Family Medicine
- Pintler Surgical Specialists: Neurosurgery and Spine Clinic, General and Thoracic Surgery Clinic, Orthopedic Surgery Group, Gastroenterology and Endoscopy Group

CHA Departments:

- Internal Medicine
- Convenient Care/Emergency Room
- Patient Access and Financial Advisor
- Accounting
- Business Office
- Food and Nutrition
- Maintenance and Engineering
- Health Information Management
- Laboratory
- Materials Management
- Nursing Services
- Occupational Therapy
- Pharmacy
- Physical Therapy
- Pintler Home Options
- Pintler Hospice
- Radiology
- Cardiopulmonary Services
- Social Services
- Surgery
- Medical Staff Coordinator
- Administration Services

3.0 CLINICS

Community Hospital of Anaconda has three associated clinics including:

- **Anaconda Pediatrics**. Anaconda Pediatrics, serves patients from infancy through college. It's staff includes one pediatrician and a nurse practitioner. The practice accepts Medicaid payments, as well as those from private insurers and is open Monday through Friday.
- **Pintler Family Medicine**. The clinic provides preventative care for individuals and families of all ages. The following services are provided: maternity care and delivery (full time OBGYN physician), trauma, annual examinations, and walk-ins, depending upon physician availability. All emergency care is provided through the hospital. There are eight full time providers including physicians and nurse practitioners. Additionally, the clinic has five visiting doctors who specialize in cardiology, neurology, ophthalmology, podiatry, and ENT. Pintler Family Medicine does not have any income restrictions and is accepts all patients. Those people who are unable to afford care are offered financial assistance through the hospital. The majority of patients who utilize the clinic are insured through Medicaid, Medicare, or have privately owned insurance.
- **Pintler Surgical Specialists.** Pintler Surgical Specialists includes specialists in the areas of
    - general surgery
    - neurosurgery
    - vascular surgery
    - urology
    - non-invasive spine care
    - gastroenterology
    - orthopedics

  The practice provides services at the clinic and at the hospital and employs five full-time physicians and five additional doctors who travel to the clinic part time. Patients with Medicare and Medicaid insurance, as well as private insurers are accepted and the clinic is open Monday through Friday.

4.0 ORAL HEALTH SERVICES

There are eight currently providing services in Anaconda-Deer Lodge County, including the following:

- Katherine Slocum, DDS, 307 E Park Ave, Anaconda MT, 59711 #308, Anaconda, MT 59711 (406) 563-3473
- Curtis Andrews, DDS, 116 W 3rd St, Anaconda, MT 59711 (406) 494-8866
- Andrew Cromwell, DDS, 315 Oak St, Anaconda, MT 59711 (406) 563-3025
- Edward Bartoletti, DDS, 215 Hickory St, Anaconda, MT 59711 (406) 563-5450
- Charles Stokke, DMD PC and Wini Stokke, 116 W 3rd St, Anaconda, MT 59711 (406) 563-7426
- Amy K. Lowe, DDS, 116 W 3rd St, Anaconda, MT 59711 (406) 563-7666

- Edward J. Miller, DDS, 1115 Commercial Avenue, Anaconda, MT 59711
- Katherine A. Sims, DDS, 307 E Park Ave Suite 308, Anaconda, MT 59711

5.0 NURSING HOMES AND ASSISTED LIVING FACILITIES

- **Community Nursing Home of Anaconda** is a 62-bed facility licensed by Medicare, Medicaid and the Veteran's Administration, providing nursing and long-term care services. Eleven beds are located in the Special Care Unit designed especially for those residents with more advanced dementia such as Alzheimer's disease. Respite care is also available. The nursing staff and the Home's social workers facilitate regular meetings for dementia care givers within the Anaconda community. The Nursing Home of Anaconda is associated with the Community Hospital of Anaconda.
- **New Horizons Assisted Living** is licensed for 15 persons and accepts Medicaid waivers. Its services include:
  - Three meals a day
  - An activity program that includes exercise, social events and crafts
  - Limited transportation services
  - A visiting nurse (one-three times per week), who administers medicines, draws blood and dispenses shots
  - An adult daycare program that is licensed for up to five participants
  - Basic first aid

  Residents also take advantage of the Caravan transportation service, which is provided by Community Hospital of Anaconda.

6.0. HOSPICE ORGANIZATIONS

- **Community Hospital of Anaconda.** CHA offers hospice services through the Pintler Hospice Program. The program serves people of all ages who are experiencing a serious illness. The program offers comfort, pain management, help with daily activities, support for caregivers and overall guidance through care planning and decisions.
- **Rocky Mountain Hospice.** Rocky Mountain Hospice provides advanced home health care for people with life-limiting illnesses in Southwest Montana through its Butte office. Life limiting illnesses include lung disease, heart disease, neuromuscular disease, cancer, Parkinson's, Alzheimer's or dementia, and others. The organization has skilled nurses, certified home health aides, licenses social workers, pastoral/bereavement counselors, physical, occupational, speech and massage therapists, nutritional

counselors and volunteers to care for the physical, psychological and spiritual needs of the sick person and their families.

7.0. SENIOR SERVICES

- **The Smelter City Senior Citizen Center**. The Center is 501(c)(3) organization that serves people who are 60 years of age or older in Anaconda/Deer Lodge County. The center provides a wide variety of services and programs to best serve the senior citizen population.

  Programs and Services:

  - *Congregate Dining*. The center provides a free lunch, Monday-Friday. All costs are based on the individual's ability to pay. Approximately 250 people utilize congregate dining per month.
  - Meals on Wheels. Approximately 85-90 people utilize Meals on Wheels per month.
  - *Commodity Supplemental Food Program*. The center provides low-income seniors, 60 years of age or older, nutritious USDA commodity food. Each qualified participant receives one supplemental food package per month.
  - *Transportation Services*. The center offers free transportation services to and from the center for congregant dining and other activities. Additionally, the center offers transportation services to and from shopping areas, including a monthly trip to Butte. All shopping trips require a three-dollar fee per person. Note: While the public caravan transit typically conveys seniors to doctor's appointments, the center's transportation system offers occasional help.
  - *Senior Activities*. The center offers exercise classes, "Fit and be fit," every Tuesday. All meals served by the center meet FDA state regulations. Additionally, seniors are given nutritional education.
  - *Health Screenings*. The center provides screenings for: blood pressure levels, auditory impairment, foot care (observed by a podiatrist), and flu shots.
  - *Aging Services*. A representative from the Aging Services in Butte visits the center once per month to help manage and counsel seniors regarding Medicare.
  - *Dementia Support Group*
  - *Transportation Options for Non-drivers-AARP*. The center's private transportation system occasionally collaborates with AARP to help seniors consider alternative means of transportation without relying on family members.
  - *Veterans Service Officer*. Veterans who utilize the center are given a Veterans Service Officer who provides information and referrals as to where to seek help, such as with Post Traumatic Stress Disorder (PTSD). Additionally, the officer assists the veterans fill out paperwork for appointments and other related issues.

- *General Information and Assistance***.** The center provides direction and guidance for seniors dealing with various issues or difficulties.
- *Computer Education*
- *Durable Loaner Closet***.** The center provides free medical equipment for seniors including walkers, canes, and are no longer being used. The Durable Loaner Closet serves as a "recycling center" for people so they can avoid paying high costs for new medical equipment.

The center offers a meeting place for The Association of the Blind. The center is quite large and has separate rooms, which allows for privacy and co-occurring activities. Major sources of funding include: state and federal grants, endorsed county mill levies, donations, and memorials; however, the grants and mill levies only account for half of the funding. It is difficult to estimate the number of seniors who utilize the center since many participate in more than two programs.

- **Anaconda Seniors Companion Program (SCP).** SCP is a public organization, which recruits community volunteers, aged 55 and older, to provide services for homebound older adults, adults with disabilities, or those with terminal illnesses. SCP assigns one volunteer (companion) who spends two to four hours, one day per week, with each client. Volunteers provide nutritional guidance, exercise regimens, medication monitoring, transportation (in-town), companionship, advocacy, financial assistance, and mail correspondence. Currently, six companions are assisting 28 Anaconda qualified residents to live a more fulfilled and independent life**.**

8.0 YOUTH ACTIVITIES AND SERVICES

- **School Based Programs**

A school nurse cares for approximately 1100-1200 students throughout four schools located in School District #10 in Anaconda. The following services are provided: general screenings, BMI (Body Mass Index) determination, visual and auditory assessment, scoliosis detection, fluoride distribution, and health education. (Sexual) abstinence is enforced and exclusively advised for middle and high school aged students. Students who suffer from chronic illnesses, such as asthma or Type I diabetes, are consistently monitored. Additionally, immunization records are kept for all students and any physician referrals are made by Cookie. Most students have a general care practitioner and are insured under Medicaid, Medicare, or hold privately owned insurance.

- **Youth Employment and Training Program**

This program is provided through the District XII Human Resources Council headquartered in Butte. Youth between the ages of 14 and 21 have the opportunity to become more prepared for the workforce by participating in the Youth Employment and Training Program. The program provides both educational and employment experience for participants. Case managers travel to Deer Lodge County from Butte.

- **Discovery House**

In July 1974, Discovery House began its operation as a result of the state deinstitutionalization program and the need for a facility in Southwestern Montana where at-risk-youth in crisis could be placed, other than in county jails. Discovery House serves youth from Deer Lodge, Granite, Powell, Silver Bow, Beaverhead and Madison counties on a regular basis, and, when space allows, from other areas of the state. Since its inception, it has served over 6,000 youth. Most of the youth are referred by probation or welfare agencies. Runaway youth receive services at the house on an emergency basis. Discovery House is a member of the National Network for Runaway and Homeless Youth and is licensed by the State of Montana Department of Public Health and Human Services. It is licensed to accommodate up to nine youth, between the ages of 10 and 18 years old. Most youth are emotionally disturbed and suffer from drug and/or alcohol abuse or from neglect. Some have been physically, sexually or emotionally abused, and come with loss and abandonment issues.

- **Boys and Girls Club**

The Boys and Girls Club of Anaconda/Deer Lodge County provides a positive place for young people after school and during the summer. The staff and volunteers create a caring atmosphere, fun and educational activities, and necessary support for a successful future (http://www.anacondafrc.org/gal.html). Approximately 150 children and adolescents are actively involved with the Boys and Girls Club. All members are required to pay a standard fee.

9.0. NUTRITION SERVICES

- **Supplemental Nutrition Assistance Program (SNAP)**. SNAP, previously called the Food Stamp Program, provides supplemental food assistance for low-income families. SNAP distributes food assistance electronically by utilizing Electronic Benefit Transfer (EBT) cards. Recipients use their EBT cards, which function as debit cards, to purchase food at accredited retail stores. In order to be eligible for SNAP, applicants must be United States citizens or qualified non-native citizens, whom intend to reside in Montana and possess a Social Security number.
- **Women, Infants, and Children (WIC).** WIC is a supplemental nutrition program targeted towards low income, pregnant, lactating and postpartum women, infants and children up to age five, at nutritional risk. The Montana WIC provides the following services: nutrition information and tips for eating well to improve health, breastfeeding promotion and support, health and social service referrals, and benefits to buy healthy foods. Roughly 21,000 participants in Montana are currently receiving services through 27 local WIC Programs, including seven Indian Reservations.

- **Project Care Food Bank.** Discovery House operates the Project Care *Food Bank,* located in the basement 4th & Alder in Anaconda.

10.0 AFFORDABLE HOUSING

- **Public Housing**. The Housing Authority of the City of Anaconda provides safe, decent and sanitary housing conditions for very low and low income families. Its mission is to promote personal, economic and social upward mobility to families, to enable them to make the transition from subsidized to non-subsidized housing. The Authority owns and operates four complexes located throughout Anaconda. Mount Haggin Homes, located at 10 Main Street, consists of 80 family units; Cedar Park Homes, located at 211 N. Cedar Street, has 50 family units; and P.J. Hagan Manor, located at 201 W. Commercial Street, consists of 40 elderly, disabled or handicapped units. The fourth complex, Pintlar Apartments, located at 400 East 4th Street, consists of 20 fair market units that can accommodate families and elderly tenants. All facilities have the ability to accommodate persons with disabilities. Generally, tenants in subsidize public housing pay 30% of their income for rent.

- **Neighborhood Stabilization Program (NSP)**. Anaconda-Deer Lodge County has received NSP funding, targeted at addressing both foreclosed and blighted/abandoned homes. Homeward of Missoula is the developer on the project and provides program management services. To date, Homeward has undertaken the development of seven properties that were acquired by both purchase and through tax deed. Four of the properties required removal of the existing homes and the construction of a new single-family houses. Three other single family homes were renovated. All but three of the homes have been purchased. One of the renovated homes is still under construction and two of the remaining six are for sale. Home purchasers must earn less than 120% of median income.

- **Section 8 Rental Assistance**. Through the Human Resources Council, District XII (HRC), 300 rental assistance vouchers are made available through the Montana Department of Commerce in the six-county region of Southwest Montana that includes Beaverhead, Deer Lodge, Granite, Madison, Powell and Silver Bow Counties. Eligible low-income families, seniors and disabled people can receive assistance with monthly rent through this program. There are consistently about 200 households on the waiting list for vouchers in the region. Funding ultimately comes from the United States Department of Housing and Urban Development. Applications are received and processed by HRC in its Butte office at 304 N. Main Street.

- **Hearthstone Apartments.** Hearthstone provides 74 affordable senior living units, including both studios and one-bedroom apartments. Some units are subsidized through the Section 8 Program. Hearthstone provides meal services to its residents.

11.0. SOCIAL SERVICES

- **Victim Advocacy**. A crime victim advocate is available through the County Attorney's Office serving Anaconda/Deer Lodge County. Any person who is a victim of a crime is provided with advocacy services and oversight for restitution provisions, at no cost. During the last quarter (July, August, and September), Joanne received 61 new victim cases. On average, she receives a new case every other day, while other cases are ongoing. Many of the victims that she represents are uninsured.
- **Adult Protective Services (APS).** Through the Montana Department of Public Health and Human Services, this agency provides services for Anaconda/Deer Lodge County and Powell County. The target population is inclusive of persons 60 years of age or older and disabled persons who are 18 years of age or older. APS performs investigations pertaining to abuse, neglect, and exploitation. Additionally, home assessments are performed to evaluate home environments and safety. If APS feels that the living situation is dangerous or ill equipped the person is removed from their home and placed in a nursing home, assisted living, or a relative or guardian home. The placement of victims depends upon the severity or manner of the situation. APS supplies provisional solutions for those who arrive in a state of dementia or derangement until a more thorough evaluation is completed, such as hospitalization or, in some cases, a motel room if necessary. Any person who is qualified under APS regulations is provided assistance without cost. APS serves approximately 50-60 qualified persons per month.
- **Deer Lodge County Caregivers (DLCC)**. DLCC is a public organization that offers monthly training to professional caretakers. Additionally, DLCC promotes new care giving agencies and service providers in Deer Lodge County. The organization is targeted towards general consumers of public services and private needs based agencies.
- **Adult Basic and Literacy Education Program (ABLE)**. ABLE is a public organization under the Office of Public Instruction. ABLE has 18 locations across the state of Montana serving participants aged 16 years or older. The program is centered on academics and provides the following classes: math (primarily), reading, writing, and language skills to prepare for the GED exam or college courses. Eligible participants must not be enrolled in school and do not currently possess a GED. ABLE does not have income restrictions and services are free of charge. Additionally, ABLE covers the cost of the GED exam, which is $55.00. In the year 2014, the cost of the GED exam will be raised to $120.00 and all classes must be retaken. Approximately 45-55 people are served each year; however, in 2011, only 30 participants completed 12 or more GED classes required by federal law.

  ABLE has established many networking relationships with other facilities/organizations in order to maximize learning experiences for participants. Networks established include but are not limited to: START program, Montana State Prison, Lions Club (distributes reading glasses), health insurance for

children, Career Futures, Opportunity Learning Center, and the Montana Workforce Investment Act (WIA).

- **The Anaconda/Deer Lodge County Office of Public Assistance (OPA).** OPA is a public organization offered through the Montana Department of Public Health and Human Services that provides several programs in order to help low-income or poverty-stricken citizens become more self-sustaining. The Office of Public Assistance offers the following programs:
  - ***Child Care Assistance*** . OPA helps qualified low-income families receive licensed or certified childcare. The program requires each participating family to formulate a co-payment based on income. Additionally, the Temporary Assistance for Needy Families (TANF) provides cash assistance and scholarships to working low-income families to obtain affordable licensed childcare. Early Childhood Services Bureau also assists low-income families acquire accessible and affordable childcare.
  - ***Healthy Montana Kids (HMK).*** This program, previously called CHIP, helps qualified children, up to 19 years of age, receive reduced-cost health insurance. The following qualifications apply: Must be a Montana resident and U.S. citizen or qualified non-native, have been without health insurance coverage for at least three months, and meet income guidelines.
  - ***Montana Medicaid***. This is a program that is cooperatively funded by the state and federal government, and is managed by the state of Montana, respectively. Each state has the authority to establish eligibility qualifications and regulations. In Montana, the Department of Public Health and Human Services (DPHHS) manages the Medicaid program. Medicaid provides full or basic financial coverage for qualified low-income citizens seeking medical services or long-term care. In order to receive medical coverage provided by Medicaid, the recipient must be a Montana resident and U.S. citizen or a qualified non-citizen and must meet financial requirements based on income, assets, and resources. Additionally, the recipients must fall into one of the following criteria: Parents or other related adults with dependent children under age 19, children, pregnant women, women diagnosed with breast or cervical cancer or pre-cancer, people aged 65 or older, or people who are blind or disabled (using Social Security criteria). Medicaid provides full or basic coverage based on the established criterion. Approximately 80 percent of the people who utilize the Office of Public Assistance are uninsured.
  - ***Supplemental Nutrition Assistance Program (SNAP).*** SNAP, previously called the Food Stamp Program, provides supplemental food assistance for low-income families. SNAP distributes food assistance electronically by utilizing Electronic Benefit Transfer (EBT) cards. Recipients use their EBT cards, which function as debit cards, to purchase food at accredited retail stores. In order to be eligible for SNAP, applicants must be United States citizens or

qualified non-native citizens, whom intend to reside in Montana and possess a Social Security number.

- ***Temporary Assistance for Needy Families (TANF).*** TANF provides low-income families with tentative financial assistance up to a maximum of 60 months. Eligible applicants must fall into one of the following criteria: minor children, certain relatives with whom minor children are living (including siblings), women in their last trimester of pregnancy who have no other eligible children, and refugees with minor dependent children. Additionally, recipients must acquire a restricted income established by TANF, be United States citizens or qualified non-native citizens, who intend to reside in Montana, and possess a Social Security number.
- ***Women, Infants, and Children (WIC).*** WIC is a supplemental nutrition program targeted towards low income, pregnant, lactating and postpartum women, infants and children up to age five, at nutritional risk. Montana WIC provides the following services: nutrition information and tips for eating well to improve health, breastfeeding promotion and support, health and social service referrals, and benefits to buy healthy foods. Roughly 21,000 participants in Montana are currently receiving services through 27 local WIC Programs, including seven Indian Reservations.

- **Anaconda Family Resource Center (AFRC).** AFRC is a non-profit organization that provides families and children with education, support, stability and encouragement to obtain a healthy, fulfilled life. AFRC offers several programs to ensure the success of families and children in need. Programs are funded by grants and community donations. The center is open Monday-Friday from 9:00am-7:00pm and the staff consists of full time employees and volunteers.

  Less than half of the families and children who utilize the center are uninsured. Aside from the Stress Management class and the Boys and Girls Club membership, the following programs are free of charge.

  Programs include:

  - ***Guardian Ad Litem Services.*** When a child needs to have representation in the court system the Anaconda PCA Family Resource Center provides a Guardian Ad Litem for adolescents and children who are clearly deemed incapable of self-representation. The Guardian Ad Litem's role is to provide advocacy services (in the court system) for abused, neglected and/or abandoned children. As can be expected, these services require a significant amount of time. Children are assigned a pro bono Guardian Ad Litem who is responsible for the following duties: investigating the case, attending meetings pertinent to the children, and providing input to and monitoring of the parents' treatment plan (http://www.anacondafrc.org/gal.html). Approximately 45 children per year are assigned a Guardian Ad Litem due to abuse or neglect.

- ***Parenting Classes.*** AFRC provides various courses that teach parents how to effectively discipline their children while developing positive communication skills. Approximately 14 parents participate in parenting classes per year. Additionally, AFRC offers an Anger Management course, which helps people change behavioral patterns that are inappropriate, counter-productive, and/or dangerous to themselves or others (http://www.anacondafrc.org/gal.html). Approximately 30 people participate in Anger Management courses per year. All participants are required to pay a standard fee.
- ***Boys and Girls Club***. AFRC collaborates with the Boys and Girls Club of Anaconda/Deer Lodge County, which offers additional support to children. The club provides a positive place for young people after school and during the summer. The staff and volunteers create a caring atmosphere, fun and educational activities, and necessary support for a successful future (http://www.anacondafrc.org/gal.html). Approximately 150 children and adolescents are actively involved with the Boys and Girls Club. All members are required to pay a standard fee.
- ***In-home and Supervised Visitations***. In-home visitations are provided on a regular basis throughout the duration of services. Initially, they are performed on a weekly basis for two to four hours per visit. As time and services progress, the time duration can be modified considerably. During Home Visits, the Family Development Specialist discusses the Family Service Plan as well as topics pertinent to the client's success. This includes but is not limited to budgeting, time management, family interaction and behaviors, work related issues, or other needed services (http://www.anacondafrc.org/gal.html). Supervised visitations are for those families whose children have been removed from the home. Family Development Specialists supervise the visits because the parent(s) have failed to properly care for their children. These children have been abused or neglected to the extent that the state needs to become involved. During these visits, parents are being observed for parent/child interaction, potentially harmful behaviors, appropriate behaviors/responses and overall attentiveness (http://www.anacondafrc.org/gal.html). Additionally, AFRC offers parent support groups to help parents deal with daily stressors and challenges. This support group is beneficial by providing ongoing support for parents and allowing them to assist each other in times of crisis; reinforce positive coping behaviors; help focus anger and turn that energy into positive experiences; as well as share information, ideas, and resources. Meetings are held on a bi-weekly basis (http://www.anacondafrc.org/gal.html). Approximately 25 families participate in the Partnership program.
- ***Out of School Time***. AFRC developed four separate programs to prevent unsupervised children from being alone after school hours. The programs include: Homework Help, Educational Enhancement Activities, Summer Programs, and Youth Quest.

- ***Other Programs***. AFRC offers Christmas giving and summer feeding. Approximately four children participate in these programs per year.

Note: The approximated numbers of people who participate or are involved in these programs are living in one of the served areas (Anaconda/Deer Lodge County, Powell County, or Granite County)

- **Human Resources Council, District XII (HRC).** HRC is a Community Action Agency whose mission is to develop and implement local solutions to poverty. The agency has been providing services to poor and low-income people in a six county area of southwestern Montana for 48 years. The service area includes Beaverhead, Deer Lodge, Granite, Madison, Powell and Silver Bow counties. Services provided in Deer Lodge County include;
  - ***Low-Income Energy Assistance***. Eligible low-income households can receive assistance with a portion of home heating costs during winter months. The program operates from October through April.
  - ***Emergency Heat Assistance***. Through the Energy Share of Montana program, households facing heat shut-offs can receive emergency assistance with a heat bill to avoid shut-off.
  - ***Section 8 Rental Assistance***. Eligible low-income families, seniors and disabled people can receive assistance with monthly rent through this program.
  - ***Weatherization***. Eligible low-income households can get their homes weatherized in order to make them more energy efficient.
  - ***Youth Employment and Training***. Youth, aged 14-21, can get case management, training and work experience through this program.
  - ***Transitional Housing***. Although the facility is located in Butte, people who are homeless or imminently homeless throughout the region can get shelter and supportive services through the Homeward Bound program. The program aims to help people get and maintain permanent housing. The minimum stay is 3 months and people can stay up to 24 months. The program serves both families and individuals.

HRC headquarters are located in Butte, Montana. All HRC programs require income qualification to determine eligibility.

12.0 ADDICTION SERVICES

- **The Anaconda Community Intervention Program (ACI).** ACI is a non-profit organization, providing prevention services in the areas of substance abuse and suicide. Funding for its programs are provided through the Drug Free Community and Stop Act Grants. ACI is governed by a volunteer board of directors and is served by a staff of three high school students and three adult adults. (One

of the adult positions is currently vacant.) Students work in programs that target youth in the community and also develop and manage ACI's media campaign, which is directed to businesses and area groups and organizations.

- **Western Montana Tri-County Addiction Services (WMAS).** WMAS is a private, community-based, and non-profit organization targeted towards adults, adolescents, and their families who are faced with substance abuse or dependency problems. The following services are provided in an outpatient setting: treatment, rehabilitation, prevention, and intervention assistance. In the first "start-up" year, approximately 53 residents of Anaconda/Deer Lodge County were served. WMAS relies on public grants, local dollars, private pay, insurance, and Medicaid for all service costs.

  WMAS offers a sliding fee service, for private or self/paying residents seeking treatment. All clinical services are reviewed and licensed annually by the State of Montana. Public funds are available to offset the cost of services for consumers who are financially eligible (200% of poverty or lower). Services are billed to Medicaid, CHIP, and other insurances. Prime for Life group for DUI offenders is 100% private pay. Cognitive principles and restructuring group is 100% private pay. County earmarked alcohol tax dollars per county varies from year to year. During the fiscal year (2012) Anaconda/Deer Lodge County alcohol tax funding was approximately $8,800. During an interval period from September 2011 to August 2012, approximately 36% of residents were insured, while 64% of residents did not possess any form of insurance.

- **Tabaco program.** The Anaconda-Deer Lodge Public Health Department recently received a grant through the Montana Tobacco Use Prevention Program (MTUPP). The program has four goals which are:
  1. Increase community capacity
  2. Prevent youth initiation
  3. Promote quitting of tobacco use
  4. Eliminate exposure to second hand smoke.

  The Anaconda MTUPP, will develop its program over time but could potentially offer a variety of services and activities with guidance from the State Department of Health and Human Services. A sampling of these includes:
  - The Quit Line
  - ReACT groups for youth
  - Smoke Free Housing
  - Clean Indoor Air Act
  - Tobacco Free Campus

- Tobacco Free High School Rodeos.

13.0 MENTAL HEALTH SERVICES

- **Western Montana Mental Health Center (WMMHC)**. WMMHC is a non-profit organization that serves primarily adults over the age of 17 ½ who are suffering from severe mental illness. During an interval period from September 2011 to August 2012, approximately 266 residents of Anaconda/Deer Lodge County were served. Approximately 61 residents (23%) did not possess insurance or had inadequate coverage. Approximately 77% of residents had possession of insurance with few exceptions that required self-pay. Insured residents were comprised of: 41 having private insurance, 76 by Medicare, 107 by Medicaid, 77 by Mental Health Services Plan (State of Montana Mental Health Coverage Program), 27 by the VA, and one by an alternative form of insurance.

  WMMHC provides the following services:
  - Mental health therapy
  - Medication management (presently, medication management appointments are limited to two days per month due to provider shortage)
  - Adult case management
  - Community based rehabilitation
  - Crisis services, which are directed by the Crisis Response Team serving large multi-county areas. Crisis services include:
    1. CRT (crisis team member-mental health professional) emergency evaluations in hospital ER once individual is medically cleared for evaluation
    2. Jail evaluations by Crisis Response Team member providing that the individual has been medically cleared of any condition that would compromise the evaluation process, (intoxicated, uncontrolled diabetic status, etc.)
    3. During community crisis, clients stay at Hays Morris House rather than an individual being unnecessarily hospitalized. Service costs are underfunded resulting in a low number of providers for large service areas. If a crisis service has a reimbursement source, certain aspects of the crisis service may be covered by insurance; however, other aspects of the service may not be covered. (Examples: eligible for counseling but not for emergency community crisis house placement; some limited hospitalization placement services.)

- **AWARE, Inc.,** located in Anaconda, manages 12 group homes for people with developmental disabilities. Its activities also include a work services program that places persons with developmental disabilities in work settings, a recycling program and a recently constructed school for children with

special needs. The school, called the Center for Excellence will serve Montana Children with complex behavioral and emotional needs.

- **BSW, Inc.,** provides services to persons at least 16 years of age (18 for residential services) who are vocationally handicapped resulting from a physical, developmental, and/or psychological disability and meet appropriate funding agency or private pay requirements. BSW finds living situations to meet special needs including specialized and services and supports in their home. It helps people access day services that offer support, work experience, socialization skills, activities of daily living and provides opportunities for cultural, leisure and community integrated activities. It also identifies employment opportunities including job development, job placement, job coaching and job accommodation supports.
- **Pintler Suicide Awareness and Prevention (PSAP).** PSAP is a public organization that helps educate the population regarding suicide awareness and prevention. PSAP provides support for those who have lost a loved one due to suicide or for those who struggle with their own suicidal thoughts. Additionally, PSAP offers various opportunities and resources to promote the importance of suicide awareness. Meetings are held the first Tuesday of each month and are free of charge.

  PSAP goals include:
  - Developing prevention resources that are available throughout the community
  - Reducing suicide through education
  - Supporting those who have lost a loved one to suicide
  - Providing referrals for crisis/long term services
  - Providing information and training to professionals and community members

  PSAP Events:
  - International Survivors of Suicide Day: bringing suicide survivors together
  - Remembrance Walk: participants sharing memories and joys
  - Support Group: support for survivors and families
  - ASIST Trainings (Applied Suicide Intervention Skills): learn applied intervention skills
  - QPR Trainings (Question, Persuade, Refer): learn techniques for intervention

14.0 VETERANS SERVICES

The VA Montana Health Care System provides a series of statewide community based clinics, a Community Living Center, and an Acute Care Medical Center for the eligible veteran population. Eligibility requirements are based on income levels.

Montana has two state veterans' homes, which are located in Columbia Falls and Glendive. The 30-bed Community Living Center (CLC), located in Miles City, provides general and ventilator dependent care. The 48-bed capacity Acute Care Medical Center, located in Fort Harrison, offers a wide range of acute, chronic, and specialized inpatient and outpatient services for both male and female veterans (http://www.montana.va.gov/about/). Specialized care includes internal medicine, gerontology, neurology, dermatology, cardiology, rheumatology, palliative care, pain management, medical oncology, surgery (general, vascular, laparoscopic, endoscopic), urology, orthopedics, plastic, ophthalmology, ENT, podiatry, gynecology, chiropractic care, psychiatry (including outpatient substance abuse treatment, PTSD, and MST specific care), and primary care. OEF and OIF ("Operation Enduring Freedom" and "Operation Iraqi Freedom) veterans suffering from severe PTSD are admitted to a 16-bed inpatient mental health facility to receive intensive treatment. Finally, the VA formulates contract agreements with private nursing homes around the state for veterans who are in need of long-term or palliative care (http://www.montana.va.gov/about/).

The Anaconda VA Montana Health Care System is a federal hospital exclusively for eligible veterans. Veterans with insurance are required to pay a co-payment for services; however, services costs are also based on income levels. The Anaconda primary care hospital/clinic has a 40-bed capacity and offers the following services:

- Primary Care
- Behavioral Health Unit (inpatient and outpatient)
- Surgery
- Radiology
- Specialty Care Clinics
- OEF/OIF veteran evaluation and referral

15.0 EMERGENCY SERVICES AND COMMUNICATIONS

- **Dispatch Services.** The County 911 Dispatch has ten (full-time and part-time) dispatchers. 911 Dispatch provides essential emergency and non-emergency dispatch and communications services to City-County law enforcement, fire departments and EMS services.
- **Fire Services.** A combination of fire departments, U.S. Forest Service and the Anaconda Division of the Department of Natural Resource and Conservation handle fire protection. Seven fire districts are located within Anaconda-Deer Lodge County.
- **The Disaster and Emergency Services**. The Coordinator for Anaconda Deer-Lodge County assists fire, law enforcement, EMS and other county department agencies during local or national disasters. The coordinator assists with obtaining resources in crisis situations and helps to assure orderly and safe evacuations.

CHAPTER THREE: HEALTH IMPROVEMENT PLAN

I. COMMUNITY HEALTH IMPROVEMENT PLAN

The Anaconda-Deer Lodge County Health Improvement Plan or CHIP provides a framework for implementing projects and activities that will enhance public health services and delivery systems throughout the county and ultimately contribute to a higher overall quality of life for all citizens. More specifically, the CHIP addresses the critical health related needs identified in the Community Needs Assessment. The assessment of need and the development of a citizen-based action plan are important to the development of sound public policy related to public health. This planning effort has as its purpose the following:

- To inform the allocation of resources – providing a foundation for the strategic planning process for participating entities
- To foster a shared vision for community health – informing a shared understanding of the problems
- To foster linkages among stakeholders to create a continuum of care and service and collaborating on solutions
- To create a sustainable public health system through cooperation, which can make measureable improvements in the health status of our citizens

While the Anaconda-Deer Lodge County Public Health Department facilitated the effort, implementation of the CHIP will rely on a cooperative effort among the agencies, organizations and health care providers in order to be successful. The following table represents the Anaconda-Deer Lodge County Health Improvement Plan and is the result of stakeholder meetings held between August of 2012 and March of 2013. Goals and strategies were identified for each of five focus groups, including:

- General Health
- Environmental Health
- Behavioral and Mental Health
- Youth
- Aging Population
- Low Income, Poverty and Housing
- Behavioral Health

FOCUS AREA: GENERAL HEALTH

GENERAL HEALTH GOAL: Improve health outcomes among citizens of Anaconda-Deer Lodge county in support of a healthier overall community.

Objective 1. Citizens will become more physically active in support of better overall health and in reduction of heart disease, obesity, diabetes and other diseases associated with inactivity.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Construct walking trails*		
Develop group physical activities for senior citizens*		
Develop a resource directory of recreational activities to raise public awareness		
Produce flyers promoting activities for distribution including in grocery store bags		

Objective 2. All citizens, regardless of income, will have increased access to healthy foods, including organic foods.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Establish community gardens, and encourage participation by lower income citizens **		
Develop public education methods to build understanding of the impact of diet on health*		
Increase awareness of the effect that food/nutrition has on educational achievement and attainment		
Promote alternative sources of healthy foods including farmers' markets and online cooperative ordering programs such as "Bountiful Baskets"		
Promote breast feeding as a local cultural norm		

Objective 3. The percentage of citizens engaging in preventative health care activities will increase in support of improved health outcomes.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Promote immunization in the community to increase the number of children receiving age-appropriate and		

CDC recommended vaccines*		
Develop a more aggressive in-home immunization program*		
Promote routine checkups –physical, dental, eye, etc. and tests – colonoscopies, labs, mammograms, etc.*		
Develop programs that enable lower income residents to receive preventative care		
Utilize public education/promotion methods regarding the benefits of preventative health care to increase participation in preventative medicine		
Educate healthcare providers to inquire as to the immunization status of patients		
Objective 4. Health outcomes will improve as patient compliance is improved.		
Strategies ***indicates priority project/activity** **** indicates high priority project/activity**	**Potential Lead Agency or Agencies/Champions**	**Suggested Time Frame** **Near Term(1-2 years)** **Long Term (3-5 years)**
Remove logistical and financial obstacles to obtaining prescribed medications including prescription delivery		
Promote provider follow-up		
Objective 5. Public Policy will reflect the connection between environmental health and overall general public health.		
Strategies ***indicates priority project/activity** **** indicates high priority project/activity**	**Potential Lead Agency or Agencies/Champions**	**Suggested Time Frame** **Near Term(1-2 years)** **Long Term (3-5 years)**
Combine public health, environmental health and Superfund related offices under the same roof**		
Support efforts to conduct studies determining the effectiveness of cleanup activities and the relationship of contaminants to overall public health		

FOCUS AREA: ENVIRONMENTAL HEALTH

ENVIRONMENTAL HEALTH GOAL: Restore Anaconda-Deer Lodge County's physical environment to one that is healthy in support of healthier citizens and more robust economic development.

Objective 1. Environmental Health will be achieved through the growth, promotion and coordination of existing county programs.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Find funding sources to promote environmental health programs **		
Develop environmental health education programs		

Objective 2. Data based on testing will support plans for environmental cleanup.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Test all homes and other structures for lead paint, dust, mold (overall environmental assessment)*		
Test all residential yards and areas around public buildings throughout the county for arsenic and lead and follow appropriate protocols when results are above federal action levels.		
Test all children under the age of 8 for heavy metals at least once and follow response protocols if results are positive.		
Create a centralized database for all environmental health related data collected		

Objective 3. Anaconda Deer Lodge will improve its image through the mitigation the stigma associated with Anaconda-Deer Lodge County's status as a Superfund Site.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Promote education regarding the economic, social and environmental history of Anaconda-Deer Lodge – "Anaconda 101" *		
Prepare information packets for real estate professionals and investors/developers		

Coordinate with local organizations in developing education programs		
Objective 4. Public education regarding Superfund best practices (institutional controls) will result in a reduction of contamination and/or exposure to contaminants.		
Strategies ***indicates priority project/activity** **** indicates high priority project/activity**	**Potential Lead Agency or Agencies/Champions**	**Suggested Time Frame** **Near Term(1-2 years)** **Long Term (3-5 years)**
Develop brochures on lead, arsenic and other contaminates in coordination with all appropriate departments**		
Develop education modules for school curriculum*		
Participate/Present at community activities and events, including those at schools*		

FOCUS AREA: BEHAVIORAL AND MENTAL HEALTH

BEHAVIORAL AND MENTAL HEALTH GOAL 1: Reduce the incidence of suicide in Anaconda-Deer Lodge County.

Objective 1. Barriers that inhibit access to mental health services in support of suicide prevention will be reduced.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Seek funding sources for people who are not currently being served**		
Monitor legislative action regarding Medicaid and communicate information to the public*		
Encourage community participation and leadership on local mental health advisory board		
Increase funding for mental health services overall		

Objective 2. Awareness of suicide and associated mental health issues, including the signs of depression, will be increased in support of suicide prevention.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Increase participation in suicide prevention classes by involving existing organizations as sponsors, e.g., the Chamber and other outreach efforts **		
Design **QPR (Question, Persuade, and Refer)** for lay people		

BEHAVIORAL AND MENTAL HEALTH GOAL 2: Reduce the incidence of addiction with regard to chemicals, tobacco and gambling

Objective 1. Prevention programs will become more effective as public awareness will be increased.

BEHAVIORAL AND MENTAL HEALTH GOAL 3: Reduce barriers to mental health services for children

Objective 1. Barriers that inhibit access to mental health services for children will be reduced.**

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Provide financial services for mental health assistance for the whole family*		
Expand capacity of local providers*		

Monitor legislative action regarding Medicaid and communicate information to the public		
Encourage the mental health advisory board to encompass children's related mental health issues in its mission		

FOCUS AREA: YOUTH

YOUTH GOAL: Improve opportunities for success among youth in Anaconda-Deer Lodge by decreasing risk for problem behaviors.

Objective 1. More youth will complete high school.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Support maintenance of Graduation Matters Program**		
Support 4-Track program, to make sure that students with a variety of career and academic goals graduate from high school*		
Support increase in age for permitted "drop out" to 19		

Objective 2. The teen birth rate will decrease.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Identify and develop programs that are evidence-based**		
Increase public awareness of available programs		
Raise awareness of the consequences of sexual activity		
Consider a program like the "Value of Childhood", being employed in Indian communities		

Objective 3. Substance abuse among youth will decrease.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Increase prosecutions and clarify consequences for MIPs**		
Develop and implement intervention strategies*		
Identify and develop programs that are evidence-based		
Support the passage of a "social host" ordinance		

Objective 4. Community and family protective factors will increase in support of decreasing high risk behaviors.		
Strategies ***indicates priority project/activity** **** indicates high priority project/activity**	**Potential Lead Agency or Agencies/Champions**	**Suggested Time Frame** **Near Term(1-2 years)** **Long Term (3-5 years)**
Provide mentoring programs**		
Develop programs (like the garden club, plant a flower program) to promote responsible behaviors**		
Increase alternative activities		

FOCUS AREA: AGING

AGING GOAL: Establish, expand and increase utilization of services that will allow people 65 and older to maintain a high quality of life in Anaconda-Deer Lodge County.

Objective 1. Seniors citizens in Anaconda-Deer Lodge County will maintain health and independence for as long as possible due to increased support services.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Expand availability of and funding for in-home healthcare and home maintenance services to seniors, including low-income seniors in support of independent living **		
Increase availability and accessibility of activities that support health including exercise activities and health education**		
Improve access to transportation to ensure access to healthcare services including consideration of a volunteer car pool		

Objective 2. Senior citizens will have more opportunities for socialization in support of improved quality of life.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Encourage programs like "helping hands" where high school students help seniors**		
Develop a youth mentoring program that earns students extra credit for interviewing and learning from seniors		
Improve transportation for activities/ social events		

Objective 3. Utilization of existing services will be increased through increased public awareness of services.

Strategies *indicates priority project/activity ** indicates high priority project/activity	Potential Lead Agency or Agencies/Champions	Suggested Time Frame Near Term(1-2 years) Long Term (3-5 years)
Create a directory of services **		
Review and mitigate costs of access to health care services for lower income residents**		
Increase availability and access to programs like Meals on Wheels and Senior Companions		

FOCUS AREA: LOW INCOME, POVERTY AND HOUSING		
LOW INCOME, POVERTY AND HOUSING GOAL: Improve and expand opportunities for economic enhancement among the poor and low-income population in Anaconda-Deer Lodge County.		
Objective 1. Awareness of and access to higher education for low-income people will be increased.		
Strategies ***indicates priority project/activity** **** indicates high priority project/activity**	**Potential Lead Agency or Agencies/Champions**	**Suggested Time Frame** **Near Term(1-2 years)** **Long Term (3-5 years)**
Develop mentoring programs**		
Bring speakers to groups such as boys and girls clubs to promote the value of education		
Objective 2. Employment opportunities will be increased.		
Strategies ***indicates priority project/activity** **** indicates high priority project/activity**	**Potential Lead Agency or Agencies/Champions**	**Suggested Time Frame** **Near Term(1-2 years)** **Long Term (3-5 years)**
Work with the county to invest in public works projects to create employment opportunities**		
Understand and address the roots and causes of poverty**		
Build energy and motivation to improve quality of life		
Develop an evidence-based empowerment plan		
Objective 3. Awareness of and participation in existing programs and services for low-income people will be increased.		
Strategies ***indicates priority project/activity** **** indicates high priority project/activity**	**Potential Lead Agency or Agencies/Champions**	**Suggested Time Frame** **Near Term(1-2 years)** **Long Term (3-5 years)**
Develop speaker and other promotional programs		
Work with local papers to publish articles about issues and programs		

END NOTES

[i] The U.S. Department of Health and Human Services, Bureau of Primary Health Care, defines counties with populations of 50 or more people per square mile as 'urban', fewer than 50 and more than 6 people per square mile as 'rural' and 6 or fewer people per square mile as frontier.
[ii] Beyond Rural; Montana; Montana State Rural Health Plan, Department of Health and Human Services, Quality Assurance Division, July, 2008
[iii] *"Top Ten Rural Issues for Healthcare Reform; A series examining healthcare issues in rural America*"; No. 2; John M. Bailey, Center for Rural Affairs, March, 2009
[iv] Beyond Rural; Montana; Montana State Rural Health Plan, Department of Health and Human Services, Quality Assurance Division, July, 2008
[v] *"Top Ten Rural Issues for Healthcare Reform; A series examining healthcare issues in rural America*"; No. 2; John M. Bailey, Center for Rural Affairs, March, 2009
[vi] "*Depression in Rural Populations: Prevalence, Effects of Life Quality and Treatment-seeking Behavior*"; Rural Health Resource Center; 2005
[vii] "*Depression in Rural Populations: Prevalence, Effects of Life Quality and Treatment-seeking Behavior*"; Rural Health Resource Center; 2005
[viii] *"Top Ten Rural Issues for Healthcare Reform; A series examining healthcare issues in rural America*"; No. 2; John M. Bailey, Center for Rural Affairs, March, 2009
[ix] "Top Ten Rural Issues for Healthcare Reform; A series examining healthcare issues in rural America"; No. 2; John M. Bailey, Center for Rural Affairs, March, 2009
[x] *"Top Ten Rural Issues for Healthcare Reform; A series examining healthcare issues in rural America*"; No. 2; John M. Bailey, Center for Rural Affairs, March, 2009
[xi]Woods and Poole Economics, Population Projections for People 65 and older
[xii] The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care: A Report from the American College of Physicians, January 30, 2006
[xiii] "Top Ten Rural Issues for Healthcare Reform; A series examining healthcare issues in rural America"; No. 2; John M. Bailey, Center for Rural Affairs, March, 2009
[xiv] U.S. Census Bureau; 2010 Decennial Census
[xv] Montana Department of Commerce; Area of Montana Counties
[xvi] The U.S. Department of Health and Human Services, Bureau of Primary Health Care, defines counties with populations of 50 or more people per square mile as 'urban', fewer than 50 and more than 6 people per square mile as 'rural' and 6 or fewer people per square mile as frontier.
[xvii] Based on 2010 Census data by Census Block Group
[xviii] Source: eREMI - a product of Regional Economic Models, Inc. (www.remi.com) - Released April 2013
Compiled by the Census & Economic Information Center, MT Dept. of Commerce (www.ceic.mt.gov)
[xix]U.S. Census Bureau; 2010 Decennial Census
[xx]U.S. Census Bureau; 2010 Decennial Census
[xxi] U.S. Census Bureau; 2010 Decennial Census
[xxii]U.S. Census Bureau; 2010 Decennial Census
[xxiii] Wood and Pool Economics, Inc.; 2006
[xxiv] The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care: A Report from the American College of Physicians January 30, 2006
[xxv] U.S. Census Bureau; American Community Survey; 5-year estimates ; 2007-2011
[xxvi] U.S. Census Bureau; 2010 Decennial Census
[xxvii] U.S. Census Bureau; 2010 Decennial Census
[xxviii] U.S. Census Bureau; 2010 Decennial Census
[xxix] County Health Rankings, 2010; Robert Wood Johnson Foundation, University of Wisconsin Institute of Public Health
[xxx] U.S. Census Bureau; American Community Survey; 5-year estimates ; 2007-2011
[xxxi]U.S. Census Bureau; American Community Survey; 5-year estimates ; 2007-2011
[xxxii] U.S. Census Bureau; American Community Survey; 5-year estimates; 2007-2011
[xxxiii] Diane Rowland; The Gale Group Inc., Macmillan Reference USA…. Gale Encyclopedia of Public Health, 2002; http://www.healthline.com/galecontent/poverty-and-health#ixzz1QggepcbQ
[xxxiv] Medical News Today; Article Date: 04 Jan 2006
[xxxv] Medical News Today; Article Date: 04 Jan 2006

[xxxvi]The poverty line is an arbitrary income level established by the federal government that is based on an income required for the purchase of basic necessities and is adjusted for household size. Thus, for those living below the poverty line, income is inadequate for the purchase of even basic necessities.

[xxxvii] U.S. Census Bureau; Small Area Income and Poverty Estimates, 2011

[xxxviii] U.S. Census Bureau; Small Area Income and Poverty Estimates, 2000-2011

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[xlvi]Montana Department of Public Health and Human Services; Statistical Report, Fiscal Year End 2010, 2012

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APPENDIX A: GLOSSARY OF TERMS AND ACRONYMS

ADULT OBESITY MEASURE

The adult obesity measure represents the percent of the adult population (age 20 and older) that has a body mass index (BMI) greater than or equal to 30 kg/m2. Estimates of obesity prevalence by county were calculated by the CDC's National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using multiple years of Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone.

Obesity is often the end result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, and osteoarthritis.

ADULT SMOKING PREVALENCE

Adult smoking prevalence is the estimated percent of the adult population that currently smokes every day or "most days" and has smoked at least 100 cigarettes in their lifetime. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

Each year approximately 443,000 premature deaths occur primarily due to smoking. Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birth weight, and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs.

BINGE DRINKING

The binge drinking measure reflects the percent of the adult population that reports consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days. The definition of binge drinking for women changed from 5 drinks on an occasion to 4 drinks in 2006.

This measure was obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

CEREBROVASCULAR DISEASE

Cerebrovascular disease Includes subarachnoid, intracerebral, and intracranial hemorrhage, cerebral infarction, other strokes and certain other forms of Cerebrovascular diseases and their sequelae.

CHRONIC LOWER RESPIRATORY DISEASE MORTALITY RATE

Chronic Lower Respiratory Disease death rate is a death from bronchitis, emphysema, asthma or certain other obstructive pulmonary diseases. This group of causes is very similar to Chronic Obstructive Pulmonary Diseases (COPD). The categories differ in that CLRD does not contain "extrinsic allergic alveolitis," i.e. allergic alveolitis and pneumonitis due to inhaled organic dust.

COUNTY HEALTH RANKINGS

Published by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, the Rankings help counties understand what influences how healthy residents are and how long they will live. The Rankings look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, access to healthier foods, air pollution levels, income, and rates of smoking, obesity and teen births. The Rankings, based on the latest data publically available for each county, are unique in their ability to measure the overall health of each county in all 50 states on the multiple factors that influence health.

The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. Building on the work of America's Health Rankings, the University of Wisconsin Population Health Institute has used this model to rank the health of Wisconsin's counties every year since 2003.

DRUG RELATED MORTALITY RATE

The "drug related mortality rate" refers to deaths for which the medical certifier of cause of death (usually a coroner, in such cases) believed the role of drugs to play important enough role in the death to mention them as one of several causes on the death certificate. Alcohol and tobacco use and abuse are not included in this measure. Because only a small percentage of death certifications have the benefit of autopsy findings or toxicology screens, this measure is likely under-reported.

ENTRANCE INTO PRENATAL CARE

"Entrance into prenatal care" is the number of live births with prenatal care (PNC) reported as starting in the first trimester (first three months) of pregnancy, divided by the total number of live births (records with unknown timing of PNC initiation excluded), times 100.

EXCESSIVE DRINKING MEASURE

The excessive drinking measure reflects the percent of the adult population that reports either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than 1 (women) or 2 (men) drinks per day on average.

Excessive drinking is a risk factor for a number of adverse health outcomes such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.

This measure was calculated by the National Center for Health Statistics using data was obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

FINE PARTICULATE MATTER STANDARD

The air pollution particulate matter measure represents the annual number of days that air quality was unhealthy for sensitive populations due to fine particulate matter (FPM, < 2.5 μm in diameter).

The Public Health Air Surveillance Evaluation (PHASE) project, a collaborative effort between the Centers for Disease Control and Prevention (CDC) and the EPA, used Community Multi-Scale Air Quality Model (CMAQ) output and air quality monitor data to create a spatial-temporal model that estimated fine particulate matter concentrations throughout the year. The PHASE estimates were used to calculate the number of days per year that air quality in a county was unhealthy for sensitive population due to FPM. The state and national values are an average of county values weighted by population size.

The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

GRADUATION RATE (Four-Year Adjusted Cohort)

The four-year adjusted cohort graduation rate is the number of students who graduate in four years with a regular high school diploma divided by the number of students who form the adjusted cohort for the graduating class. From the beginning of 9th grade, students who are entering that grade for the first time form a cohort that is subsequently "adjusted" by adding any students who transfer into the cohort later during the 9th grade and the next three years and subtracting any students who transfer out, emigrate to another country, or pass away during that same period.

HPSA: HEALTH PROFESSIONAL SHORTAGE AREA

Health Professional Shortage Areas (HPSAs) are designated by the U.S. Department of Health and Human Services' Health Resource Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility).

IMMUNIZATIONS

Aggregated results from clinic reviews - proportion of children 24-35 months who have received all age-appropriate vaccines (4:3:1:3:3:1) by 24 months as recommended by the Advisory Committee on Immunization Practices (ACIP).

JUVENILE STATUS OFFENSE

A status offender is a juvenile charged with or adjudicated for conduct that would not, under the law of the jurisdiction in which the offense was committed, be a crime if committed by an adult. The most common examples of status offenses are chronic or persistent truancy, running away, being ungovernable or incorrigible, violating curfew laws, or possessing alcohol or tobacco.

LIMITED ACCESS TO HEALTHY FOODS

Limited access to healthy foods captures the proportion of the population who are low-income and do not live close to a grocery store. Living close to a grocery store is defined differently in rural and non-rural areas; in rural areas, it means living less than 10 miles from a grocery store whereas in non-rural areas, it means less than 1 mile. Low-income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size.

MEDIAN AGE AT DEATH

The "Median Age at Death" is a figure that includes both sexes and all races and represents the age for which half the deaths in a population are at a younger age and half at an older age. In a population with an even number of decedents, the median is the average of the two "middle" ages.

MOTOR VEHICLE CRASH DEATHS

Motor vehicle crash deaths are measured as the crude mortality rate per 100,000 population due to on- or off-road accidents involving a motor vehicle. Motor vehicle deaths includes traffic and non-traffic accidents involving motorcycles and 3-wheel motor vehicles; cars; vans; trucks; buses; street cars; ATVs; industrial, agricultural, and construction vehicles; and bikes & pedestrians when colliding with any of the vehicles mentioned. Deaths due to boating accidents and airline crashes are not included in this measure. A strong association has also been demonstrated between excessive drinking and alcohol-impaired driving, with approximately 17,000 Americans killed annually in alcohol-related motor vehicle crashes.

These data were calculated for the County Health Rankings by National Center for Health Statistics (NCHS), part of the Centers for Disease Control and Prevention (CDC), based on data reported to the National Vital Statistics System (NVSS). NCHS used data for a seven-year period to create more robust estimates of cause-specific mortality, particularly for counties with smaller populations.

NATIONAL BENCHMARK (COUNTY HEALTH RANKINGS)

The National Benchmark is used in the County Health Rankings (see "County Health Rankings") to provide a point of comparison for counties. The benchmark represents the 90th percentile of counties included in the rankings and indicates that only 10% are better.

PHYSICAL INACTIVITY

Physical inactivity is the estimated percent of adults aged 20 and over reporting no leisure time physical activity. Estimates of physical inactivity by county are calculated by the CDC's National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation using multiple years of Behavioral Risk Factor Surveillance System (BRFSS) data.

POOR PHYSICAL HEALTH DAYS MEASURE

The poor physical health days measure represents one of four measures of morbidity used in the County Health Rankings, and is based on responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" The average number of days a county's adult respondents report that their physical health was not good is presented. The measure is age-adjusted to the 2000 U.S. population. In addition to measuring how long people live, it is also important to include measures of how healthy people are while alive; people's reports of days when their physical health was not good are a reliable estimate of their recent health.

This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. Seven years of data are used to generate more stable estimates of poor physical health days.

POOR MENTAL HEALTH DAYS MEASURE

The poor mental health days measure is a companion measure to the poor physical health days reported in the County Health Rankings. The estimates are based on responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" We present the average number of days a county's adult respondents report that their mental health was not good. The measure is age-adjusted to the 2000 U.S. population. Overall health depends on both physical and mental well-being. Measuring the number of days when people report poor mental health represents an important facet of health-related quality of life.

The measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age

living in households with a land-line telephone. NCHS used seven years of data to generate more stable estimates of poor mental health days.

PREMATURE DEATH

Premature death is represented by the years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person dying at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost to a county's YPLL. The YPLL measure is presented as a rate per 100,000 population and is age-adjusted to the 2000 U.S. population.

Data on deaths, including age at death, are based on death certificates and are routinely reported to the National Vital Statistics System (NVSS) at the National Center for Health Statistics, part of the Centers for Disease Control and Prevention (CDC). NVSS calculates age-adjusted YPLL rates based on three-year averages to create more robust estimates of mortality, particularly for counties with smaller populations.

Age-adjusted YPLL-75 rates are commonly used to represent the frequency and distribution of premature deaths. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of death.

SELF-REPORTED HEALTH STATUS

Poor or Fair Health, a self-reported health status, is a general measure of health-related quality of life in a population. This measure is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percent of adult respondents who rate their health "fair" or "poor." The measure is age-adjusted to the 2000 U.S. population.

This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. Seven years of data are used to generate more stable estimates of self-reported health status.

UNINTENTIONAL INJURY (as a cause of death)

Unintentional injuries include those injuries that are of an external cause often but not necessarily due to drowning, fall, fire/burn, motor vehicle/traffic related incident, other transportation related incidents, poisoning and suffocation.

APPENDIX B:
RANKING OF COUNTIES BY SEVERITY OF TARGETED HEALTH BEHAVIORS

Methodology for

Ranking of Counties by Severity of Targeted Health Behaviors

Presentation prepared William Connell, Economist, Montana Department of Labor, wconnell@mt.gov (406)444-9284.

The table entitled: *Ranking of Counties by Severity of Targeted Health Behaviors* ranks each county by level of risk on six measures of the targeted health problems and/or consequences of the health problems. The measures are: 1) Suicide rate per 100,000 averaged: 2001-2009; 2) Prescription drug death per 1,000 averaged: 2008-2009; 3) Drug arrest per 1,000 residents averaged: 2005-2011; 4) DUIs per 1,000 residents averaged: 2005-2011; 5) Liquor Law violates per 1,000 averaged: 2005-2011; and 6) percentage of car crashes involving alcohol averaged: 2005-2009. Counties were also assigned a *composite severity score* (sum of the rankings for each measure) that is used to rank the counties from *very high risk to lowest risk*.

Using this table, the reader can quickly identify what targeted health problems are evident in the county based on these six measures. The lower the score for a health problem the more severe that problem is in the county. For example, Beaverhead County, has low scores in four out of the six health problems; that is: liquor law violations (ranked 1), prescription drug deaths (ranked 6), suicide rate (ranked 8), and DUIs per 1,000 (ranked 9). As a result, the composite score for Beaverhead is 54 (highest is 326) and is considered a very high risk county.

The measures used are the best available direct measures or indicators of the targeted health problems. Some health problems are considered emerging issues such as Prescription Drug misuse/abuse with fewer years of data collection and imperfect measures.

1. **Suicide rate per 100,000 averaged 2001-2009**
   County average suicide rate per 100,000 people from 2001-2009
   Source: (Montana Department of Health and Human Services)
   Note: Both due to data disclosure rules and because suicide rates can fluctuate considerably from year to year, suicide rates are averaged from 2001-2009 to get a clearer picture of the information.

2. **Prescription drug death per 1,000 average 2008-2010**
   Total number of deaths with State Crime Lab's "top 20 Rx drugs" in system by county – averaged 2008-2010
   Source: Montana Department of Justice
   Note: Drug is not known to be the exact cause of death, just in a person's system at the time of death.

3. **Drug arrest per 1,000 resident's average 2005-2011**
   Source: (Montana Board of Crime Control)

4. **DUIs per 1,000 residents average 2005-2011**
   Average DUI rate per 1,000 county residents 2005-2011
   Source: (Montana Board of Crime Control) [1]

5. **Liquor law violations per 1,000 average 2005-2011**
   The vast majority of "Liquor Law" violations are "Minor in Possession of Alcohol", someone under the age of 21 with or under the influence of alcohol. So this measure is intended to capture underage drinking prevalence within a particular county
   Source: (Montana Board of Crime Control)

6. **Percent of car crashes involving drugs or alcohol average 2005 – 2009**
   Source: (Montana Department of Transportation 2012)

Ranking System Methodology

In order to create the *composite severity score* based on all six measures, each county was first ranked 1-56 depending on how high the rate was on each measure in that county. For example, Beaverhead Country has the highest rate of underage drinking liquor law violations per 1,000 people; it is ranked "1".The lower the score, the more severe is the problem. The numbers in each column represent where a county is ranked relative to all the counties in the state. For example, the county with the most severe suicide ranking is Deer Lodge (ranked 1), Mineral County for prescription drug deaths, Toole County for drug arrests, and so on.

The column entitled *Composite Severity Score* is the sum of the rankings for each measure. As noted earlier, Beaverhead County has low scores in four out of the six health problems; that is: liquor law violations (ranked 1), prescription drug deaths (ranked 6), suicide rate (ranked 8), and DUIs per 1,000 (ranked 9). As a result, the composite score for Beaverhead is 54 (lowest is 326) and is considered a very high risk county.

By ranking each county on each variable, it is easier to compare counties to each other and to identify how severe of a problem exists within a respective county.

[1] Montana Board of Crime Control data do not include statistics from state or federal law enforcement agencies such as the Montana High Patrol, the U.S. Marshal's Office or Fish, Wildlife and Parks.

APPENDIX C: LIST OF MEETING PARTICIPANTS