



# Addressing Health Needs in Rural Montana

An Aggregate Summary of Community Health Needs Assessments and Implementation Plans of Montana Critical Access and Rural Hospitals 2015-2017

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August 2017

Montana Office of Rural Health and  
Area Health Education Center

## Introduction

The Community Health Services Development (CHSD) project, a Community Health Needs Assessment process, was created over 30 years ago by the Montana Office of Rural Health (MORH) in partnership with the University of Washington when many small rural hospitals were under the threat of closure. This process has helped Montana's Critical Access Hospitals (CAHs) understand what their community perceives as the top health needs, how the community views current available services, to conduct meaningful program planning, and to engage the community in strengthening the healthcare system. To date, over 40 communities in Montana have used the CHSD process with many having utilized the process 2-3 times over.

In 2010, with the passing of the Patient Protection and Affordable Care Act (ACA), a Community Health Needs Assessment (CHNA) became mandated once every three years for all charitable 501(c)(3) hospitals. In addition, a detailed implementation plan must be developed which outlines how the facility plans to address health issues identified. The CHSD process created by MORH, delivers a comprehensive CHNA report and detailed implementation plan in compliance with IRS regulations.

The following report contains aggregate information from Community Health Needs Assessments and Implementation Reports conducted with the Montana Office of Rural Health (MORH) and Montana Critical Access and rural hospitals from 2015-2017. Montana communities included in the data set are: Anaconda, Baker, Big Timber, Circle, Chester, Columbus, Culbertson, Cut Bank, Deer Lodge, Dillon, Ekalaka, Flathead County (Kalispell and Whitefish) Forsyth, Glendive, Hardin, Harlowton, Lewistown, Livingston, Philipsburg, Plentywood, Poplar-Wolf Point, Ronan, Scobey, Townsend and White Sulphur Springs.

## Methods

Members of MORH staff met with each facility and a steering committee group with representatives and stakeholders from various organizations and populations within the community to design the survey instrument. The survey was sent to a random sample based on inpatient and outpatient encounters by zip code from each facility. Those zip codes with the greatest number of encounters were selected to be included in the survey. A random list of residents was then selected from Prime Net Data Source. Residence was stratified in the initial sample selection so that each area would be represented in proportion to the overall served population and the proportion of past encounters. (Note: although the survey

samples were proportionately selected, actual surveys returned from each population area varied which may result in slightly less proportional results.) Survey responses were entered into SPSS statistical software and responses from each community were aggregated and analyzed for statistical significance between survey years. In addition to survey data, qualitative data was collected with focus groups and key informant interviews and grouped into themes. Implementation data in the following report includes top goals, top needs addressed and needs not addressed. During the implementation phase, CAHs typically pick 3-5 goals with several strategies to focus on during the next three years. Each facility's implementation strategies and goals were paired with the needs found in the CHNA surveys and focus group/key informant interviews and input in a Microsoft Access data base for simplified data retrieval.

## Sample

Montana has 48 Critical Access Hospitals. The data presented is taken from CHSD survey data, focus groups, key informant interviews and implementation plans conducted by MORH for 27 of the 48 Montana CAHs from January 2015-June 2017, representing 56% of Montana CAHs. Many of these CHNA and implementation plans are publicly available on each facilities website as required by IRS Form 990, Schedule H.

In 2015-2017, the Montana Office of Rural Health sent a total of 16,702 surveys to 27 communities in rural Montana. Of those sent, 851 surveys were returned undeliverable, bringing the total number of surveys sent to 15,851. The number of surveys completed and returned was 4,163 out of 15,851 for a 26.58% response rate. Based upon the sample size, we can be 95% confident that the responses to the survey questions are representative of the population, plus or minus 1.3%.

In addition to survey data, MORH collected qualitative data by conducting focus groups and key informant interviews with each of the participating communities. Between 2015 and 2017, 47 focus groups and 35 key informant interviews were conducted with a total of 444 participants. Focus groups and key informant interviews followed the same line of questioning regarding perception of greatest health issues in the community, perception of local services, and suggestions for what would make their community a healthier place to live.

Furthermore, data was collected regarding priorities selected as well as goals and strategies each facility utilized to address the health needs found in the CHNA process.

Implementation data from 22\* communities is included in this data set.

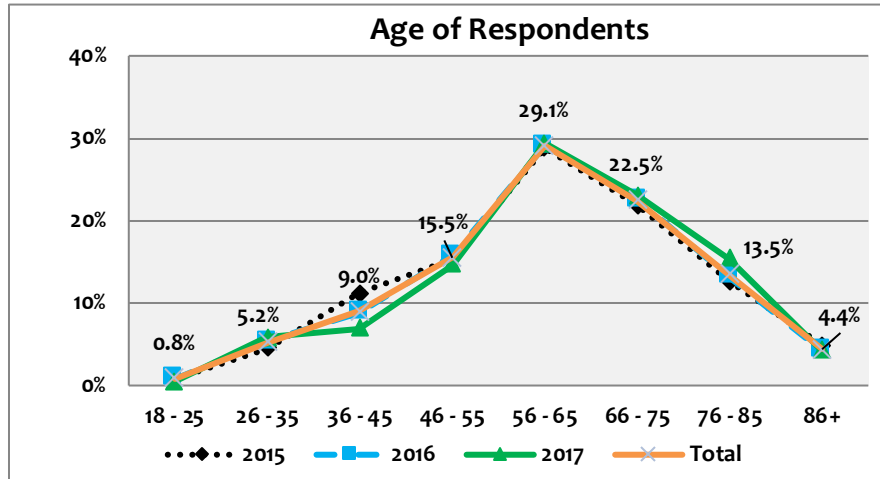
**\*Note:** some facilities choose to do the implementation process separate from the CHSD process with the Montana Office of Rural Health, and vice versa. Some facilities do a CHNA alone but partner with MORH for their implementation plan. Only data from CHNA and Implementation reports created by MORH are included in the data.

# Survey Findings

## Demographics

Of the 4,163 surveys returned, the majority of survey respondents were female (63.5%), 33.2% were male and 3.3% chose not to answer the question. The top three age groups were 56-65 (29.1%), 66-75 (22.5%) and 46-55 (15.5%). (Chart 1.1). Most survey respondents reported that they work full time (40.9%), followed closely with 38.7% of respondents indicating that they are retired (Chart 1.2). Although not statistically significant, the percentage of respondents selecting 'retired' has been increasing steadily since 2015. It is not unusual for survey respondents to be

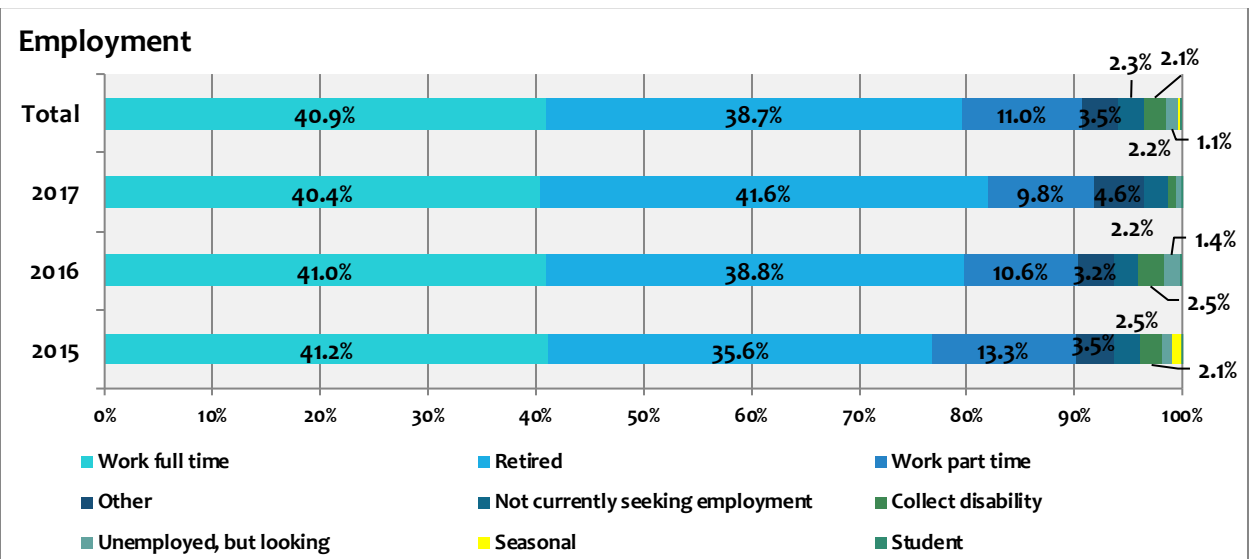
Chart 1.1



they work full time (40.9%), followed closely with 38.7% of respondents indicating that they are retired (Chart 1.2). Although not statistically significant, the percentage of respondents selecting 'retired' has been increasing steadily since 2015. It is not unusual for survey respondents to be

predominantly female, particularly when the survey is healthcare-oriented as women are frequently the healthcare decision makers for families. Additionally, as this is a healthcare related survey, it is not surprising that most respondents are between the ages of 46-75. This age group is likely more vested in the healthcare related field as they utilize the services more frequently than the younger demographic.

Chart 1.2



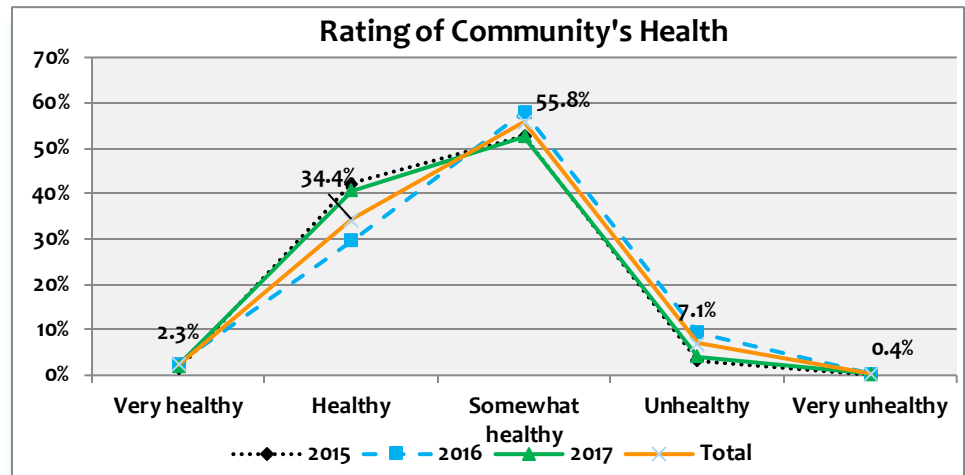
## Community Health

The subsequent section of the survey focused on the community's perception of health concerns in their area and asked various questions to gauge the current health status of the community.

Respondents

were asked to rate the general health of their community on a Likert scale ranging from very healthy to very unhealthy. Overall respondents indicated that they felt their communities where 'somewhat healthy' (55.8%) to 'healthy' (34.4%) (Chart 2.1).

Chart 2.1



Respondents were asked what they felt the three most serious health concerns were in their community. From 2015-2017, 46.1% of respondents indicated Cancer was a top health concern, followed by alcohol abuse/substance abuse (44.3%) and overweight/obesity (32%). (Table 1.1). Table 1.1 shows that while percentages between survey years have fluctuated significantly, cancer (indicated with an asterisk\*), alcohol/substance abuse and overweight/obesity have remained as the top 3-4 health concerns for community members. While not in the top 3

Health Concern	Percent			
	2015 (n=852)	2016 (n=2,487)	2017 (n=824)	Total (n=4,163)
<b>Cancer*</b>	<b>56.5%</b>	<b>40.2%</b>	<b>53.5%</b>	<b>46.1%</b>
<b>Alcohol abuse/substance abuse*</b>	<b>47.2%</b>	<b>61.1%</b>	<b>48.2%</b>	<b>44.3%</b>
<b>Overweight/obesity</b>	30.0%	<b>32.4%</b>	<b>32.5%</b>	<b>32.0%</b>
Heart disease*	<b>32.2%</b>	19.1%	29.9%	23.9%
Diabetes	18.1%	16.2%	17.5%	16.9%
Depression/anxiety*	14.2%	13.9%	18.0%	14.7%
Tobacco use	13.3%	15.1%	14.0%	14.5%
Lack of exercise	14.7%	12.5%	15.0%	13.5%
Mental health issues*	8.2%	15.7%	12.1%	13.5%
Lack of access to healthcare	8.6%	10.3%	9.1%	9.7%
Lack of dental care*	5.9%	6.3%	8.7%	6.7%
Child abuse/neglect*	2.5%	9.1%	3.4%	6.6%
Motor vehicle accidents	5.3%	5.7%	5.6%	5.6%
Stroke*	6.1%	3.8%	6.7%	4.8%
Domestic violence*	2.6%	5.7%	2.3%	4.4%
Recreation related accidents/injuries*	5.6%	2.9%	3.4%	3.6%
Work related accidents/injuries*	4.8%	1.6%	7.2%	3.3%

\*Indicates a significant difference between years. **Bold:** Top 3 responses

perceived health concerns, it should be noted that selection of ‘depression/anxiety’, ‘mental health issues’ and ‘lack of dental care’ have all increased significantly since 2015.

The survey also sought to assist rural communities in identifying which elements contributed most to the overall health of the community. Respondents were asked to identify the top components that they felt were important for sustaining a healthy community. ‘Access to healthcare and other services’ was the top selected response all three survey years, with an average of 60.5%. ‘Good jobs and healthy economy’ was also selected as an important component by 43.2% of respondents, followed by ‘healthy behaviors and lifestyles’ at 36.6% (Table 1.2).

Important Component	Percent			
	2015 (n=852)	2016 (n=2,487)	2017 (n=824)	Total (n=4,163)
<b>Access to healthcare and other services*</b>	<b>67.7%</b>	<b>58.4%</b>	<b>59.3%</b>	<b>60.5%</b>
<b>Good jobs and healthy economy*</b>	<b>39.3%</b>	<b>46.0%</b>	<b>38.6%</b>	<b>43.2%</b>
<b>Healthy behaviors and lifestyles*</b>	<b>33.1%</b>	<b>37.2%</b>	<b>38.6%</b>	<b>36.6%</b>
Strong family life	32.6%	31.6%	34.6%	32.4%
Religious or spiritual values*	25.4%	21.1%	26.2%	23.0%
Good schools*	25.8%	19.5%	20.9%	21.1%
Low crime/safe neighborhoods	16.0%	16.6%	18.9%	16.9%
Affordable housing*	15.7%	17.2%	12.4%	16.0%
Clean environment*	9.5%	12.9%	9.8%	11.6%
Community involvement	10.3%	8.5%	8.7%	8.9%
Tolerance for diversity	4.1%	4.3%	3.4%	4.1%
Parks and recreation*	2.3%	4.7%	3.6%	4.0%
Low death and disease rates	3.5%	3.5%	5.0%	3.8%
Low level of domestic violence	1.6%	2.8%	2.1%	2.4%
Arts and cultural events	0.8%	0.8%	0.7%	0.8%

\*Indicates a significant difference between years. **Bold:** Top 3 responses

To gain perspective on what changes the community members feel would improve their healthcare access, respondents were asked to select the top three items that they felt would make the greatest improvement. Thirty-nine percent of respondents indicated that more primary care providers would improve access to healthcare. ‘More specialists’ was another highly indicated response at 30.8%, followed by ‘improved quality of care’ at 24.6% (Table 1.3). These responses can be valuable to Critical Access Hospitals during the implementation phase of the CHSD process, as this question

Improvement	Percent			
	2015 (n=852)	2016 (n=2,487)	2017 (n=824)	Total (n=4,163)
<b>More primary care providers*</b>	<b>35.4%</b>	<b>43.7%</b>	<b>29.0%</b>	<b>39.1%</b>
<b>More specialists*</b>	<b>28.2%</b>	<b>33.1%</b>	<b>26.7%</b>	<b>30.8%</b>
<b>Improved quality of care*</b>	<b>26.3%</b>	<b>27.1%</b>	<b>15.5%</b>	<b>24.6%</b>
Greater health education services*	18.4%	23.0%	16.9%	20.8%
Outpatient services expanded hours*	20.4%	15.6%	<b>18.0%</b>	17.1%
Transportation assistance	15.3%	18.0%	16.3%	17.1%
Telemedicine*	10.6%	7.4%	12.5%	9.0%
Cultural sensitivity*	3.2%	4.8%	0.6%	3.6%
Interpreter services	1.2%	1.1%	0.5%	1.0%

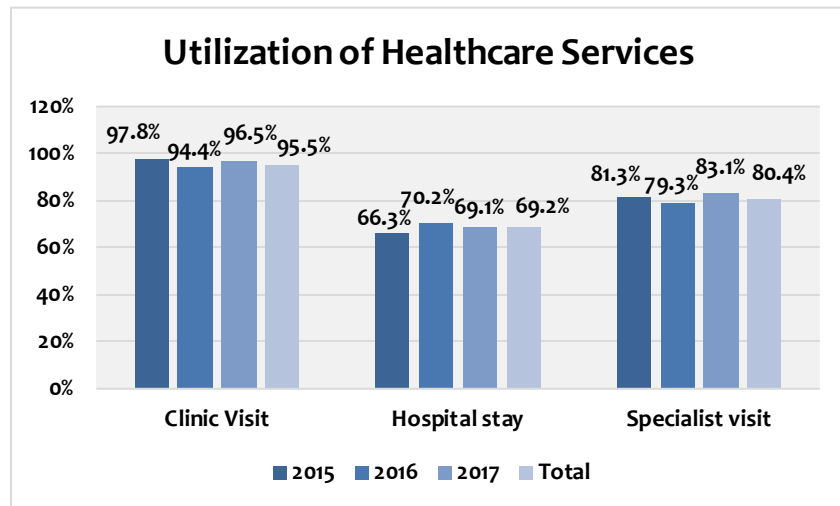
\*Indicates a significant difference between years. **Bold:** Top 3 responses

often acts as a catalyst in the beginning stages of priority development. Without doubt, access is an issue for all CAHs, so the ability to narrow in on what community members feel are the greatest barriers to receiving healthcare is an invaluable tool.

### Use of Healthcare Services

The final section of the survey instrument inquired about utilization of healthcare services, barriers associated with not receiving care and insurance coverage. Survey data

Chart 3.2



\*Significantly fewer 2016 respondents received primary care in the past three years.

\*Significantly more 2017 respondents had seen a specialist in the past three years.

demonstrated that 95.5% of all respondents (2015-2017) used primary care services such as a family physician, physician assistant, or nurse practitioner at least once in the past three years, with a slight but statistically significant decline of utilization amongst 2016 respondents (Chart 3.1). Rates of hospitalization were much lower (as to be expected) with 69.2% of all respondents reporting use of a hospital in the last three

years (Hospitalization was quantified as hospitalized overnight, day surgery, obstetrical care, rehabilitation, radiology, or emergency care). Eighty percent of respondents reported utilizing speciality services, with significantly more 2017 respondents visiting specialists when compared to previous survey years.

To gain insight on why community members select one healthcare facility over another, respondents were asked to select the top three reason why they chose the

Reason	Percent			
	2015 (n=817)	2016 (n=2,290)	2017 (n=768)	Totals (n=3,875)
Closest to home*	<b>50.6%</b>	<b>48.7%</b>	<b>59.8%</b>	<b>51.3%</b>
Prior experience with clinic*	<b>57.4%</b>	<b>46.0%</b>	<b>53.1%</b>	<b>49.8%</b>
Appointment availability	<b>33.2%</b>	<b>29.2%</b>	<b>29.3%</b>	<b>30.0%</b>
Clinic's reputation for quality*	26.2%	21.4%	23.6%	22.9%
Recommended by family or friends*	15.2%	19.2%	13.8%	17.3%
Referred by physician or other provider	9.7%	11.6%	8.9%	10.6%
Length of waiting room time*	9.2%	7.0%	5.2%	7.1%
Cost of care	6.4%	6.0%	4.4%	5.8%
Required by insurance plan*	1.6%	5.1%	6.3%	4.6%
VA/Military requirement*	2.1%	4.0%	2.7%	3.4%
Indian Health Service*	0.9%	2.6%	0.0%	1.7%

\*Indicates a significant difference between years. **Bold:** Top 3 responses

primary care provider and hospital that they most utilized in the past three years. Not surprisingly, the top reasons for selecting primary care for all respondents (2015-2017) were, ‘closest to home’ at 51.3%, followed by ‘prior experience with clinic’ at 49.8%, and ‘appointment availability’ at 30%

(See Table 2.1). Reasons for selecting a hospital were very similar with ‘closest to home’ and ‘prior experience with hospital’ in the top two followed closely by ‘referred by physician’ (38.8%) (Table 2.2).

Tables 2.1 and 2.2 often inform Critical Access Hospitals why community members may be traveling to other facilities to receive care. For instance, if people who live closer to the CAH or rural hospital indicate that they receive hospital care at a different facility because of their reputation for quality, the CAH/rural hospital can implement strategies to improve their image within the community. Maintaining local patients not only improves healthcare access but also the sustainability of healthcare services in rural communities.

Another common approach to improve access to care is to increase the number of specialists

Reason	Percent			
	2015 (n=540)	2016 (n=1,695)	2017 (n=544)	Totals (n=2,779)
<b>Closest to home*</b>	<b>41.5%</b>	<b>51.3%</b>	<b>51.3%</b>	<b>49.4%</b>
<b>Prior experience with hospital</b>	<b>46.7%</b>	<b>42.8%</b>	<b>45.6%</b>	<b>44.1%</b>
<b>Referred by physician*</b>	<b>44.8%</b>	<b>38.1%</b>	<b>34.9%</b>	<b>38.8%</b>
Hospital’s reputation for quality*	38.1%	30.5%	28.5%	31.6%
Emergency, no choice	25.7%	31.0%	29.4%	29.7%
Recommended by family or friends	10.0%	11.4%	9.2%	10.7%
Closest to work	3.7%	5.5%	5.5%	5.1%
Required by insurance plan	4.4%	4.6%	5.5%	4.7%
Cost of care*	2.0%	4.7%	2.9%	3.9%
VA/Military requirement	2.4%	4.4%	3.5%	3.9%

\*Indicates a significant difference between years. **Bold:** Top 3 responses

Specialist Type	Percent			
	2015 (n=659)	2016 (n=1,872)	2017 (n=646)	Total (n=3,177)
<b>Dentist*</b>	<b>51.3%</b>	<b>43.4%</b>	<b>49.8%</b>	<b>46.4%</b>
<b>Orthopedic surgeon</b>	<b>26.9%</b>	<b>26.7%</b>	<b>27.9%</b>	<b>27.0%</b>
<b>Dermatologist*</b>	<b>23.2%</b>	<b>22.2%</b>	<b>28.9%</b>	<b>23.8%</b>
Cardiologist	21.2%	<b>22.9%</b>	21.4%	22.3%
Chiropractor	20.9%	21.0%	22.8%	21.3%
Physical therapist	<b>23.7%</b>	20.7%	19.7%	21.1%
Ophthalmologist*	19.4%	13.0%	20.4%	15.9%
OB/GYN	16.1%	15.3%	16.7%	15.7%
Radiologist	16.7%	14.2%	16.1%	15.1%
General surgeon	12.4%	15.2%	14.6%	14.5%
Urologist	14.7%	12.4%	<b>13.3%</b>	13.1%
ENT (ear/nose/throat)	12.3%	11.8%	13.0%	12.1%
Gastroenterologist	9.9%	10.9%	8.5%	10.2%
Neurologist	8.3%	9.5%	11.8%	9.7%
Oncologist	10.8%	8.2%	7.7%	8.7%
Podiatrist	7.6%	7.7%	7.0%	7.5%
Rheumatologist	5.6%	5.3%	5.4%	5.4%
Pulmonologist	6.1%	4.7%	6.0%	5.3%
Allergist	5.9%	4.5%	5.7%	5.0%
Endocrinologist	5.2%	4.0%	5.6%	4.6%
Pediatrician	4.7%	4.3%	5.6%	4.6%
Mental health counselor	3.2%	4.5%	3.4%	4.0%
Neurosurgeon	5.0%	3.3%	5.0%	4.0%
Occupational therapist	3.6%	3.3%	3.1%	3.3%
Psychiatrist (M.D.)	1.8%	2.6%	3.4%	2.6%
Dietician	2.7%	2.2%	2.5%	2.4%
Psychologist	2.3%	2.0%	2.3%	2.1%
Speech therapist	1.4%	1.8%	2.8%	1.9%
Social worker	1.4%	1.1%	0.5%	1.0%
Substance abuse counselor	0.2%	0.7%	0.9%	0.6%
Geriatrician	0.2%	0.4%	0.5%	0.3%

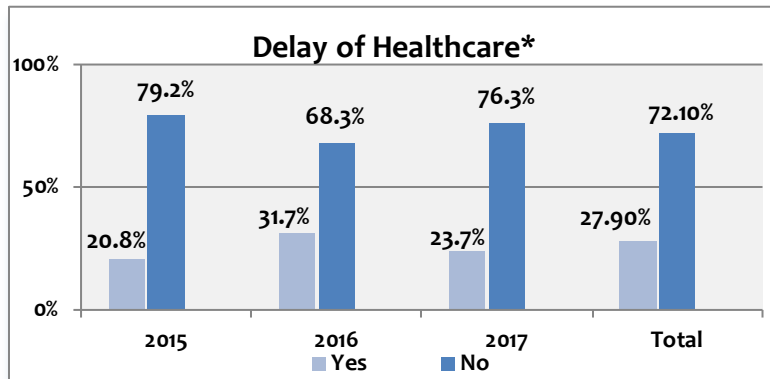
\*Indicates a significant difference between years. **Bold:** Top 3 responses

available in the community. This can be done through a traditional hiring process, bringing in traveling specialist, or through telehealth. To gauge which were the most frequently visited specialists, respondents were asked to select all the specialty services they had received in the past three years. Dentists were by far the most utilized specialty with 46.4% of all respondents indicating they had used their services. An orthopedic surgeon was used by 27% of participants, followed by a dermatologist at 23.8% (Table 2.3). People living in rural Montana often drive many hours to seek specialty care in the more densely populated areas.

As such, the ability to see a specialist in their home town would greatly improve the communities access to healthcare services.

To further investigate barriers that impact access to healthcare, we asked participants to indicate if they or a member of their household

**Chart 3.2**



thought they needed healthcare services but did not get them or had to delay getting them. Overall, 72.10% of respondents said ‘no’, signifying that they and their family members did not delay needed care. However, over a quarter (27.9%) of respondents indicated that they or a family member had delayed or not receive needed healthcare services, with 2016 respondents

selecting ‘yes’ significantly more often at 31.7% (Chart 3.2). Those who were not able to receive healthcare services or delayed receiving healthcare services, were asked to select the top three reasons why. Most respondents selected ‘it costs too much’ (42.7%), followed by ‘too long to wait for an appointment’ (22.3%)

Improvement	Percent			
	2015 (n=164)	2016 (n=735)	2017 (n=178)	Total (n=1,077)
<b>It costs too much</b>	<b>36.6%</b>	<b>44.5%</b>	<b>41.0%</b>	<b>42.7%</b>
<b>Too long to wait for an appointment*</b>	14.6%	22.7%	27.5%	22.3%
<b>My insurance didn't cover it*</b>	13.4%	21.5%	24.7%	20.8%
Could not get an appointment*	<b>18.9%</b>	18.5%	<b>29.8%</b>	20.4%
No insurance*	17.7%	16.7%	9.6%	15.7%
Don't like doctors	17.7%	14.6%	18.0%	15.6%
Office wasn't open when I could go*	<b>21.3%</b>	12.8%	11.2%	13.8%
Not treated with respect	14.0%	11.7%	10.7%	11.9%
Unsure if services were available	11.6%	8.8%	5.6%	8.7%
Could not get off work	8.5%	6.7%	5.6%	6.8%
It was too far to go	4.3%	6.1%	10.1%	6.5%
Too nervous or afraid	6.7%	6.5%	5.6%	6.4%
Didn't know where to go	4.9%	4.9%	6.2%	5.1%
Transportation problems	3.0%	4.8%	3.4%	4.3%
Had no one to care for the children	2.4%	1.6%	1.1%	1.7%

\*Indicates a significant difference between years. **Bold:** Top 3 responses



and ‘my insurance didn’t cover it’ (20.8%) (Table 2.4). While the selection of ‘no insurance’ has been significantly declining over the last three years, those who selected ‘my insurance didn’t cover it’ has been significantly increasing since 2015. This flip-flop in significance levels may indicate that while more Montanans are insured, their insurance coverage may be insufficient in meeting their healthcare needs.

To explore changes in insurance, we asked participants to select which type of medical insurance covered the majority of their families healthcare expenses. Most respondents (35.2%) have employer sponsored coverage, followed closely by Medicare (30.9%) and private insurance (10.3%) (Table 2.5.) Further indicating a rise in health insurance coverage, those who selected ‘none/pay out of pocket’ has significantly decreased from 5.9% in 2015 to 2.4% in 2017.

Insurance Type	Percent			
	2015 (n=699)	2016 (n=1,981)	2017 (n=678)	Totals (n=3,358)
<b>Employer sponsored*</b>	<b>32.2%</b>	<b>35.6%</b>	<b>37.2%</b>	<b>35.2%</b>
<b>Medicare*</b>	<b>32.6%</b>	<b>29.0%</b>	<b>34.7%</b>	<b>30.9%</b>
<b>Private insurance/private plan</b>	<b>12.4%</b>	<b>9.6%</b>	<b>10.0%</b>	<b>10.3%</b>
Health Insurance Marketplace	5.3%	5.7%	5.2%	5.5%
None/Pay out of pocket*	5.9%	4.2%	2.4%	4.2%
VA/Military	2.1%	4.3%	3.2%	3.6%
Medicaid	1.6%	3.4%	2.5%	2.9%
Other	2.1%	1.8%	1.9%	1.9%
Healthy MT Kids	1.4%	1.3%	1.2%	1.3%
State/Other	1.0%	1.6%	0.9%	1.3%
Health Savings Account	1.0%	1.1%	0.7%	1.0%
Indian Health	0.9%	1.3%	0.0%	0.9%
Medicare Advantage	0.0%	1.1%	0.0%	0.6%
Agricultural Corp. Paid	1.4%	0.2%	0.0%	0.4%
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100%</b>

\*Indicates a significant difference between years. **Bold:** Top 3 responses

For those without health insurance (4.2%, n=140), 70% selected ‘cost’ as the top barrier. Other barriers included ‘employer does not offer insurance’ (22.9%) and ‘choose not to have medical insurance’ (17.1%)(Table 2.6).

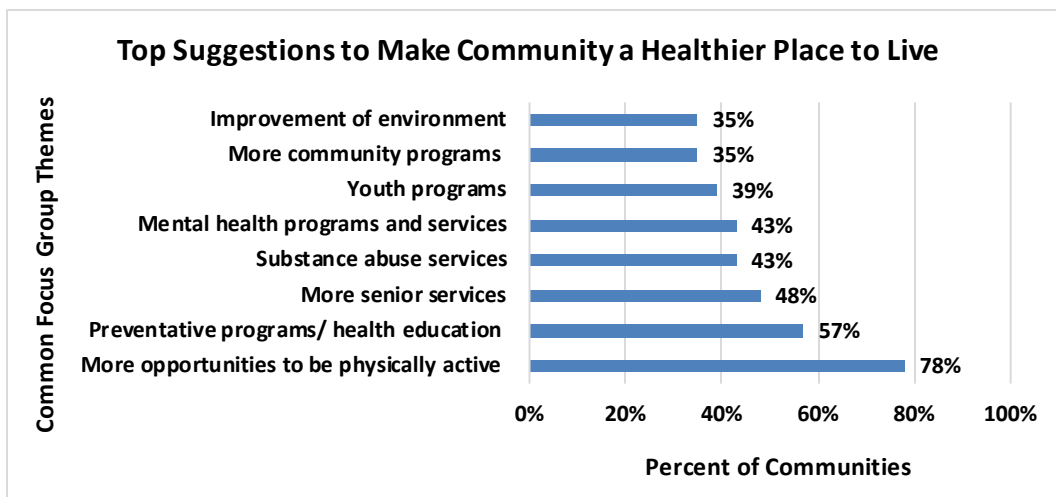
Barrier	Percent			
	2015 (n=41)	2016 (n=83)	2017 (n=16)	Total (n=140)
<b>Cannot afford to pay for medical insurance</b>	<b>63.4%</b>	<b>69.9%</b>	<b>87.5%</b>	<b>70.0%</b>
<b>Employer does not offer insurance</b>	<b>29.3%</b>	<b>22.9%</b>	<b>6.3%</b>	<b>22.9%</b>
<b>Choose not to have medical insurance</b>	<b>17.1%</b>	<b>16.9%</b>	<b>18.8%</b>	<b>17.1%</b>
Other	<b>22.0%</b>	10.8%	<b>12.5%</b>	14.3%

\*Indicates a significant difference between years. **Bold:** Top 3 responses

## Focus Group and Key Informant Interviews – Key Findings

Between January of 2015 and August 2017, the Montana Office of Rural Health conducted 47 focus groups and 35 key informant interviews with 444 participants from 23 rural communities around the state. Comprehensive transcripts were taken at each meeting. From these transcripts, themes emerged and were catalogued by community. While each community had unique needs, several themes were echoed from community to community. For instance, more opportunities to be physically active was the top suggestion to make the community a healthier place to live in 78% of the communities that MORH staff visited (Chart 4.1). Participants often suggested that access to walking trails, fitness centers, and workout programs would make the greatest impact. Another common suggestion that emerged in 57% of communities was access to more preventative health programs and health education. Chart 4.1 illustrates the eight most common suggestions to make Montana communities a healthier place to live.

**Chart 4.1**



We then asked participants to indicate what the top health issues are in their community. Mental health was a major health concern in nearly all the communities that we visited at 91% (Chart 4.2). This category included issues such as lack of access to mental health services, a need for more community education regarding mental health issues, concern for rates of depression, anxiety and suicides, and need for more crisis and intervention training for healthcare staff, school educators, parents and police force etc. Other common themes include drug and substance abuse, access to healthcare services, the inability to afford healthcare services and lack of senior services (including senior housing options) (Chart 4.2 below).

Focus group participants were asked what additional services were needed in their communities. Eighty-three percent of communities indicated that they needed more or improved mental health services. Other top suggestions included senior services, OBGYN/ pediatrics, more specialty services (in general) and addiction counseling (Chart 4.3. below).

Chart 4.2

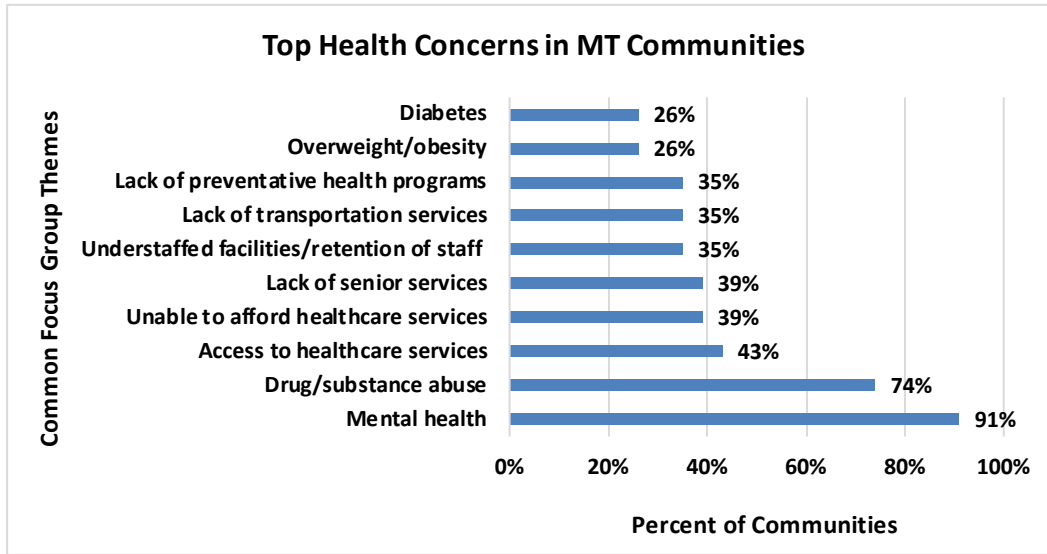
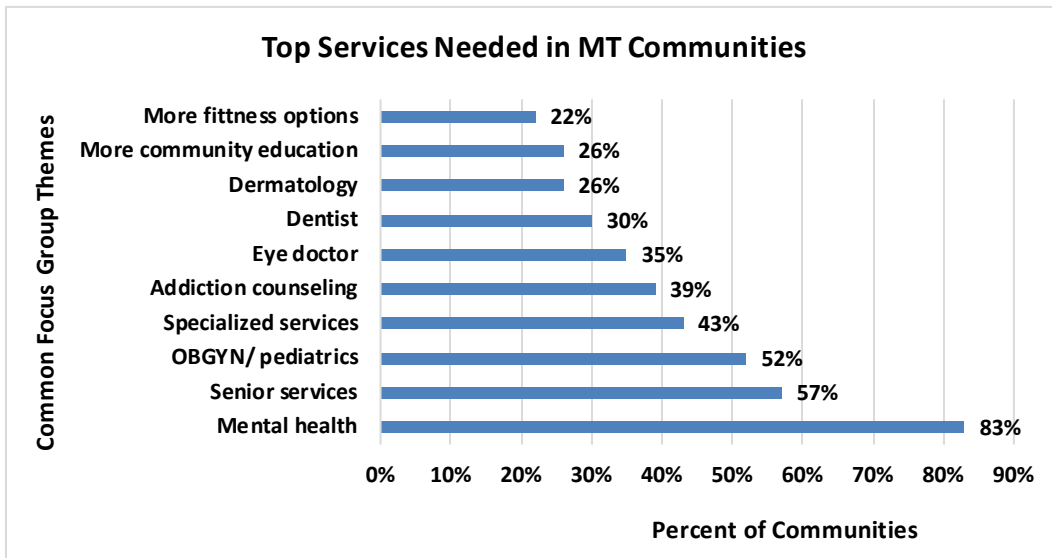


Chart 4.3



## Implementation Goals and Strategies

As per IRS requirement, non-profit 501 (c)(3) Critical Access Hospitals and rural healthcare facilities must use findings from their Community Health Needs Assessment process to prioritize the top needs they will address in their implementation report. The Montana Office of Rural Health uses the following process to assist each facility in the prioritization of top needs to address in their IRS compliant implementation report:

The community steering committee, comprised of staff leaders from the hospital and community members, convened to begin an implementation planning process to systematically and thoughtfully respond to all issues and opportunities identified through the Community Health Services Development (CHSD) Process.

The community steering committee determined the most important health needs to be addressed by reviewing the CHNA, secondary data, community demographics, and input from those representing the broad interest of the community.

Determination of need and priorities were 1) identified by the community through focus groups and random sample survey; 2) identified via secondary data; 3) validated by the community steering committee; 4) reviewed by the health experts on the community committee; 5) assessed to determine if other organizations in the community are addressing the issue; and 6) assessed to determine if the hospital has the capacity to address the issue. Implementation reports are written based on the prioritized health needs as determined through the assessment process.

Implementation data was collected from 22 of Montana CAHs and rural facilities that the Montana Office of Rural Health worked with. Most facilities, 77.27%, developed goals that aim to improve the community’s access to healthcare services. Other common goals selected by Montana CAHs and rural facilities focused on health and wellness and/or mental health with 59.09% each (Table 3.1). See Table 3.2 to view common strategies that were selected by facilities during their implementation process.

\*Please note that implementation data is from facilities who utilized the Montana Office of Rural Health’s Community Health Service Development Process (CHSD.) Some CAHs and rural hospitals choose to create implementation reports internally, or choose to contract with other organizations.

<b>Table 3.1: Implementation Goal Categories</b>		
	<b>Count</b>	<b>Percent</b>
<b>Improve access</b>	<b>17</b>	<b>77.27%</b>
<b>Health and wellness: Promote physical activity, healthy living and use of preventative services</b>	<b>13</b>	<b>59.09%</b>
<b>Mental and behavior health</b>	<b>13</b>	<b>59.09%</b>
Improve outreach and education	9	40.91%
Alcohol and substance abuse	8	36.36%

Aging services and senior housing	7	31.82%
Marketing and awareness of services	7	31.82%
Maintain a strong and stable medical center	6	27.27%

<b>Table 3.2: Common Strategies Used to Address Top Goals</b>		
<b>Goal 1 Improve access</b>	<b>Goal 2 Health and wellness</b>	<b>Goal 3 Mental and behavioral health</b>
<ul style="list-style-type: none"> <li>• Improve workforce retention and recruitment</li> <li>• Improve community knowledge of existing services</li> <li>• Expand services offered through telemedicine</li> </ul>	<ul style="list-style-type: none"> <li>• Provide education, resources, and activities that promote healthy living</li> <li>• Create/enhance worksite wellness programs</li> <li>• Enhance awareness of health and wellness resources in the community</li> </ul>	<ul style="list-style-type: none"> <li>• Improve access to mental health resources</li> <li>• Enhance education about mental health issues for staff and community members</li> <li>• Collaborate with local community organizations on addressing mental health issues</li> </ul>

### Needs Addressed by Goals and Strategies

As per IRS requirement, implementation plans must address the needs that were discovered in the Community Health Needs Assessment. The Montana Office of Rural Health uses survey data, focus group and key informant themes, community steering committee feedback and secondary data sources to determine the top needs in each community. Goals and strategies are formed with the intention of addressing these needs. Table 3.3 shows the top needs CAHs and rural facilities are addressing in their implementation plans. Of the communities that identified alcohol and substance abuse as a concern, 90.91% are implementing goals and strategies aimed at reducing rates of alcoholism and addiction. Survey respondents often indicated that healthy behaviors and lifestyles are an important component for a healthy community. As such, nearly all CAHs (90.91%) implemented goals and strategies to address the need to improve healthy behaviors and lifestyles. Another common need addressed in CAH implementation plans is access to healthcare and other services with 86.36% of facilities addressing this need (Table 3.3).

<b>Table 3.3: Top Needs addressed in Implementation Plans (n=22)</b>		
<b>Alcohol/substance abuse</b>	<b>20</b>	<b>90.91%</b>
<b>Healthy behaviors and lifestyles</b>	<b>20</b>	<b>90.91%</b>
<b>Access to health care and other services</b>	<b>19</b>	<b>86.36%</b>
Lack of knowledge about local services	18	81.82%
Low rating of community health	16	72.73%

Depression	16	72.73%
Interest in classes/programs: health and wellness	15	68.18%
Interest in classes/programs: fitness	15	68.18%
Healthcare access: more specialists	13	59.09%
Obesity overweight	13	59.09%
Interest in classes/programs: weight loss	13	59.09%

### Needs Not Addressed

While Critical Access Hospitals strive to address all major needs found through the CHSD process, it is often not feasible to address every need due to a variety of reasons including financial, population, or workforce limitations. CAHs may also not address a need specifically in their implementation plan because they feel it is being addressed by another organization or because they are already offering resources and services to address the need. For instance, many respondents indicated that they did not receive healthcare services because they cost too much, but nearly half of facilities are not implementing new strategies to address the need at this time (Table 4.1 below). However, many facilities explained that they do offer sliding fee scales and charity care for low income patients and that offering more services would not be feasible. Cancer as a top health concern and dermatology as a desired service, 36.6% and 31.82% respectively, were commonly not addressed in implementation plans. Often we found that many facilities do offer cancer related services such as preventative screenings but they indicated that including and expanding cancer services would not be possible because the small population and customer base in their service area would not be able to sustain the significant costs associated with the service expansion.

Reasons did not receive services:	Count	Percentage
<b>cost too much</b>	<b>10</b>	<b>45.45%</b>
<b>Serious health concern: cancer</b>	<b>8</b>	<b>36.36%</b>
<b>Desired services: dermatology</b>	<b>7</b>	<b>31.82%</b>
Healthcare access: more primary care providers	5	22.73%
Healthcare access: outpatient services expanded hours	4	18.18%
Desired services: senior services	4	18.18%
Desired services: mammography	3	13.64%
Low community awareness of programs that help with medical costs	3	13.64%
Appointment availability/Could not get appointment	3	13.64%
Desired services: ENT	3	13.64%

An interactive map of CAH and rural facility's top health needs and implementation goals was created from data collected by MORH and can be found at: <http://healthinfo.montana.edu/morh/chsd.html>. The interactive map also includes hyperlinks to each facility's CHNA report and implementation report. We invite readers to familiarize themselves with the CHNA reports and implementation plans.

## Discussion

While each rural community has unique findings in their CHNA and varied strategies to address needs in their implementation plans, this aggregate report highlights the common health issues that rural Montanans face, such as lack of access to care, alcohol and drug abuse, and a lack of mental health services. Often CAH and rural facilities use their CHNA report to guide the facilities overall strategic plan, leverage community partnerships for collaboration opportunities, and to assist in grant and funding opportunities. It is our hope, that the aggregate data be used in much of the same way. We see that many of the top perceived health issues in the state, such as cancer, alcohol and substance abuse and obesity, are largely preventable or can be greatly improved through behavioral, life style and environmental changes. These findings are hopeful considering the plethora of evidence based resources and strategies that support health promotion interventions. However, as we saw in the ‘needs not addressed’ portion of this report, many facilities cannot tackle all the health issues in their community alone. For this reason, it is immensely important for rural communities to utilize all available resources and to coordinate health promotion efforts.

Some CAH and rural facilities have started conducting joint needs assessments with local public health departments. Public health departments are required to conduct a similar process to the CHNA every five years if they wish to maintain their accreditation. We recommend that more CAH and rural facilities engage in a collaborative health needs assessment with their local health department as they often prioritize needs and formulate goals that are similar to those of the hospital. Collaboration between these two entities will likely provide various advantages such as shared costs for conducting the needs assessments, pooled resources, unified programs and messaging, and overall better coordination of community services. Furthermore, because there is no requirement for public health departments to wait five years in-between assessments, they could easily switch to three-year intervals so they are on the same schedule with the hospital. We invite all CAH and rural facilities to investigate the possibility of collaborating with the local public health department on their next CHNA.

While this report serves as a descriptive analysis of the current CHNA findings and implementation goals and strategies in the state, more research is needed to assess the effectiveness of the implementation interventions on the overall health of the community. CAH and rural facilities often express their difficulties in evaluating and tracking the activities outlined in their implementation reports. As such, CAH and rural facilities may benefit from more resources and training regarding the evaluation and outcomes of the implementation plans. Additionally, future research will need to examine if the outlined activities in the implementation plan are having a significant impact on the perceived health concerns of the community.