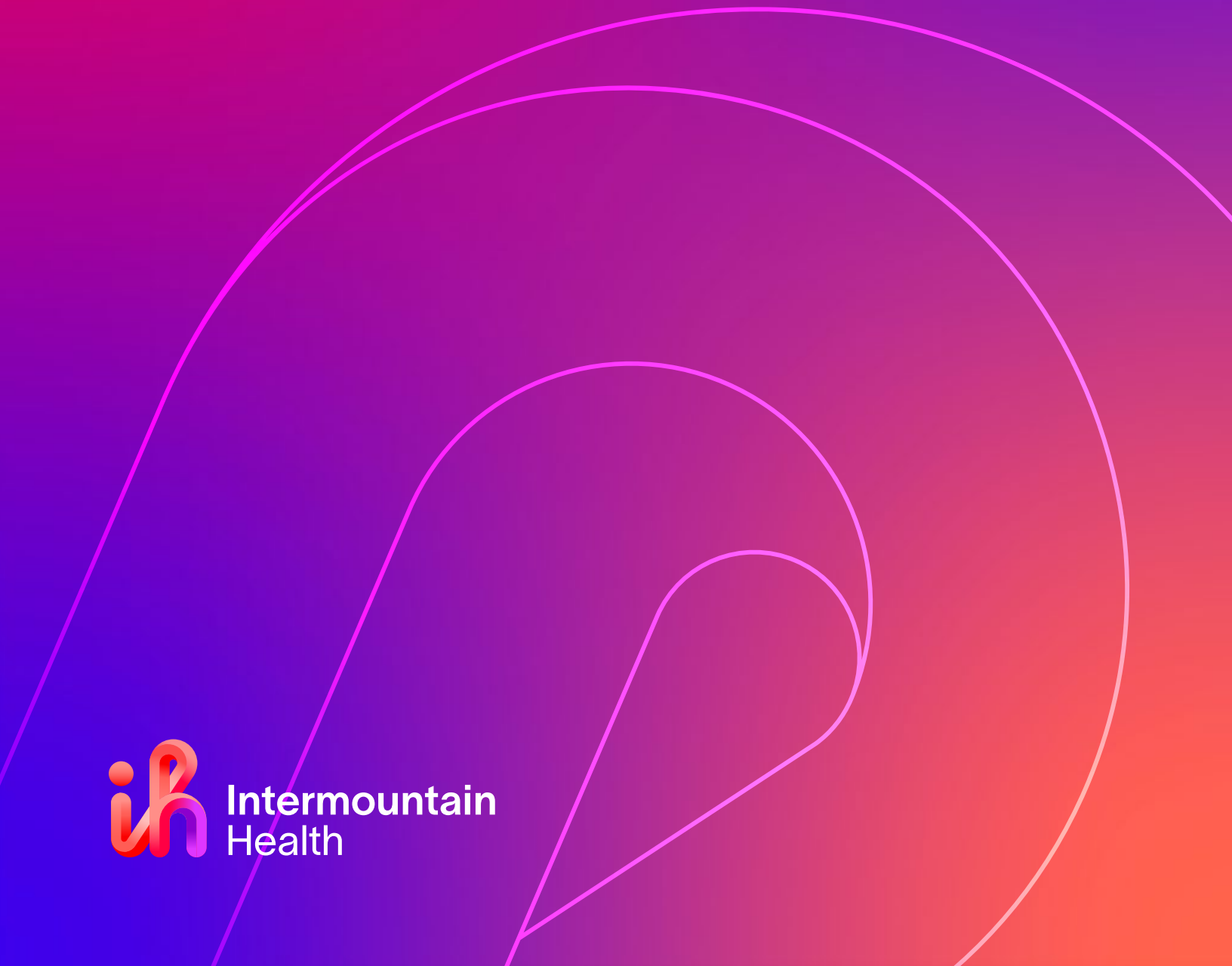
Intermountain Health | Holy Rosary Hospital

2026 Community Health Needs Assessment



Intermountain Health

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Executive Summary

The Power of We

Dear neighbors,

For more than a year, our Intermountain Health Community Health team worked to understand the unmet health needs of the service area through our Community Health Needs Assessment (CHNA). This report shares those findings. The CHNAs are the backbone of our mission of helping people live the healthiest lives possible, and our Catholic mission to reveal and foster God's healing love by improving the health of the people and communities we serve, especially those who are poor and vulnerable.

A wealth of quantitative and qualitative health data informed this assessment, including public health indicators, stakeholder and resident surveys, public meeting discussions, and interviews with subject matter experts. To the individuals and organizations who worked with us to understand the community's significant health needs: thank you. We are grateful for your collaboration.

This report outlines our process and the key lessons we have learned. It also serves to highlight our community's significant health needs, which will be prioritized for investment over the next three years. Specifically, we aim to improve behavioral health, invest in social drivers of health, increase access to care, and promote childhood wellness and injury prevention.

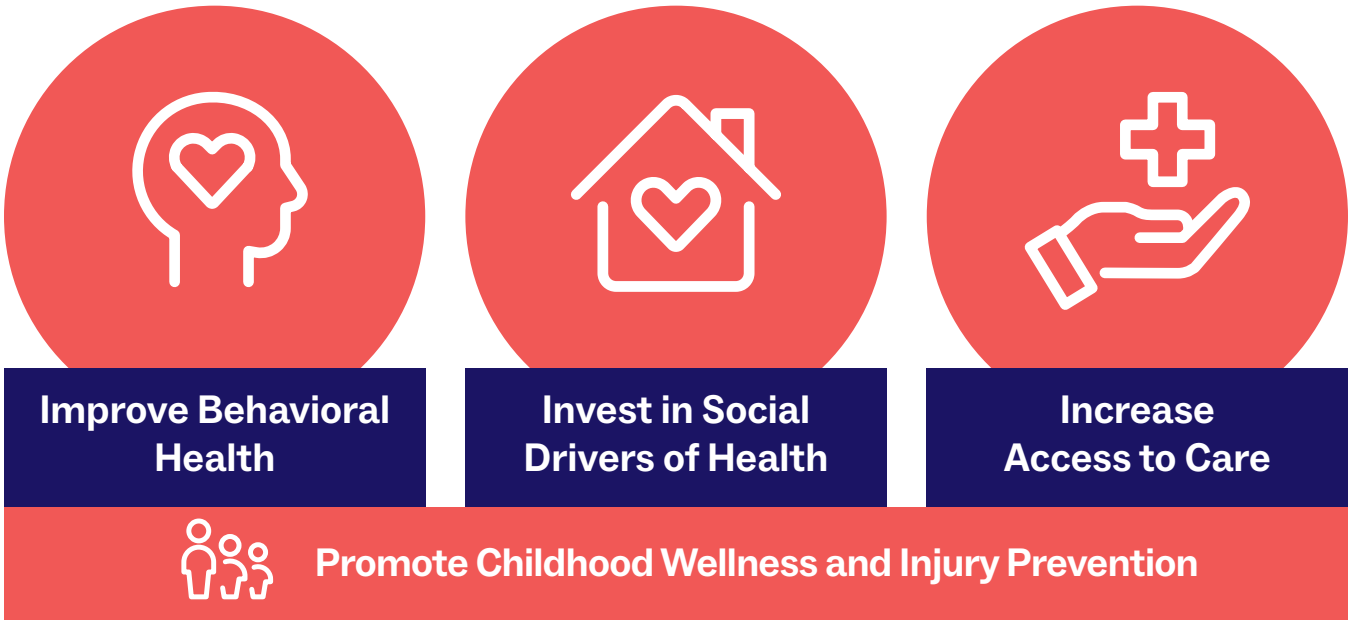
Our efforts now shift from assessing needs to developing an Implementation Strategy to meet those needs. We know that having an impact means working together – the Power of We. As we consider how Intermountain's resources can be allocated in the service area, we want to collaborate with community-based organizations, local government agencies, and area leaders to improve community health.

Sincerely,

Benjamin A Uhlich,
President and Chief Nursing Officer
Holy Rosary Hospital

Lisa Nichols,
Vice President of Community Health

2026 CHNA Significant Health Needs



Intermountain Health

Headquartered in Utah with locations in six primary states and additional operations across the western U.S., Intermountain Health is a nonprofit system of 34 hospitals, 400 clinics, a medical group of over 5,100 employed physicians and advanced care providers, a health plan division called Select Health with more than one million members, and other health services.

With more than 69,000 caregivers on a mission to help people live the healthiest lives possible, Intermountain is committed to improving community health and is widely recognized as a leader in transforming healthcare. We strive to be the model health system by taking full clinical and financial accountability for the health of more people, partnering to proactively keep people well, and coordinating and providing the best possible care.

Our Mission

Helping People Live the Healthiest Lives Possible®

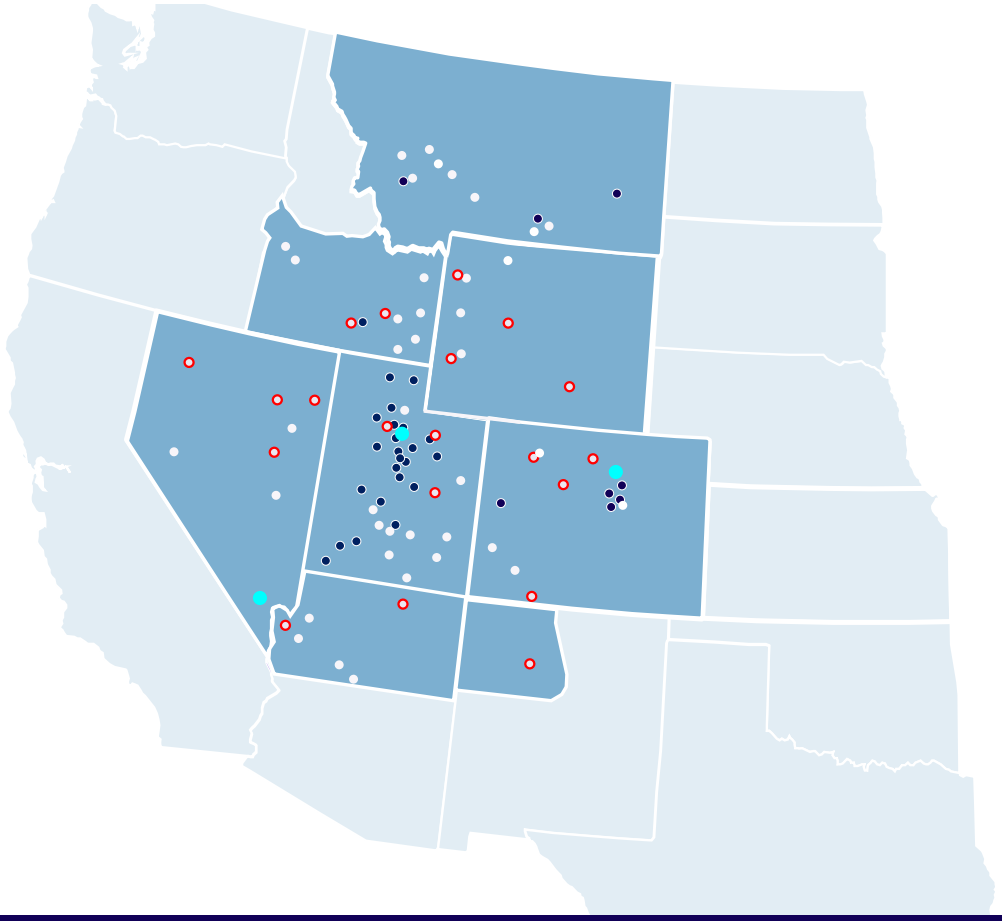
Our Catholic Mission

We reveal and foster God's healing love by improving the health of the people and communities we serve, especially those who are poor and vulnerable.

Our Values

Our Catholic health Ministry and Mission is entrusted to us to honor the sacred dignity of human life and the inherent worth of every person and are aligned with our common values.





Intermountain is headquartered in Salt Lake City, Utah, with regional offices in Broomfield, Colorado, and Las Vegas, Nevada.

- Hospitals
- Region Headquarter
- Affiliate/Outreach Partnerships
- Classic Air Medical Bases

Intermountain Health's 400+ clinics are not highlighted on the map

Intermountain Health by the Numbers

6 Primary States
(CO, ID, MT, NV, UT, WY)

34 Hospitals
Including One Virtual Hospital

4,700+
Licensed Beds

1.1 Million
Select Health Members

400
Clinics

69,000+
Caregivers

$18.51 Billion[1]
Total Revenue

5,100+
Employed Physicians & APPs

[1] Revenue for the year ended December 31, 2025

Holy Rosary Hospital

Founded in 1910, Intermountain Health Holy Rosary Hospital is a comprehensive critical access acute-care hospital in Miles City, Montana, that serves the eastern region of the state as a ministry of the Catholic Church. It offers essential emergency, maternity, behavioral health, and chronic disease care. Holy Rosary also includes physician clinics, a residential living center, hospice, and palliative care services. Holy Rosary expands access through virtual care and community collaboration to help people live the healthiest lives possible.

To submit comments on the 2026 CHNA Report or to request a paper copy, please email IH_CommunityHealth@imail.org.



Acknowledgments

The Patient Protection and Affordable Care Act (ACA) requires each nonprofit hospital to conduct a Community Health Needs Assessment (CHNA) every three years to identify significant health needs and develop an Implementation Strategy in response. Intermountain Health adheres to all applicable laws and continuously reviews regulatory requirements to ensure compliance. Accordingly, we may adjust our CHNA processes and Implementation Strategy as regulations change.

The Intermountain Health CHNA process examines unmet health needs and health disparities in geographical areas by analyzing primary and secondary data. Intermountain determines significant health needs through an objective, evidence-based prioritization process with final approval by Regional Boards.

The identified needs guide efforts to align strategies and leverage resources with other public health and community organizations. By regularly assessing and prioritizing community health needs, the hospital can work collaboratively to improve overall health.

Both the CHNA and Implementation Strategy, which is developed and adopted to address health needs, are publicly available on Intermountain's website.

The Value of the Collaborative

Intermountain Health participates in the Custer County Community Health Needs Assessment Collaborative, alongside One Health, the local public health agency serving Custer County. Conducting the assessment together resulted in shared opportunities to improve the quality of health data, reduce duplication, and align health needs.

The assessment adopted an evidence-based process that streamlined data collection and prioritization. It also improved the mechanisms for gathering community input by collectively designing surveys, presenting at the input meeting, and engaging public and local stakeholders through distinctive community connections. Both the quantitative and qualitative data were made available to participating organizations for use in their own needs assessments.

What Is Health Equity at Intermountain Health?

Intermountain Health's mission – helping people live the healthiest lives possible – includes everyone and requires valuing, understanding, and including the backgrounds and experiences of people in the communities we serve. Health equity is the principle of pursuing the highest possible standard of health with a focus on improving the well-being of our most vulnerable communities.

Our Community Health Needs Assessment process is driven by data. We look carefully at public health data to understand the prevalence of health issues in our communities and where those issues create the greatest disparities or differences in health outcomes.

We talk with residents, community-based organizations, and local leaders to understand how health disparities connect and how they affect individuals and families across the lifespan. With an understanding of the needs our communities face, we develop a Community Health Implementation Strategy that directs our resources to remove barriers and invest resources where they will have the greatest impact. Using data and community input to identify the greatest needs and targeting our approach to meeting those needs is health equity in action.

As a healthcare system, employer, and community leader, Intermountain is committed to improving health equity in the communities we serve.

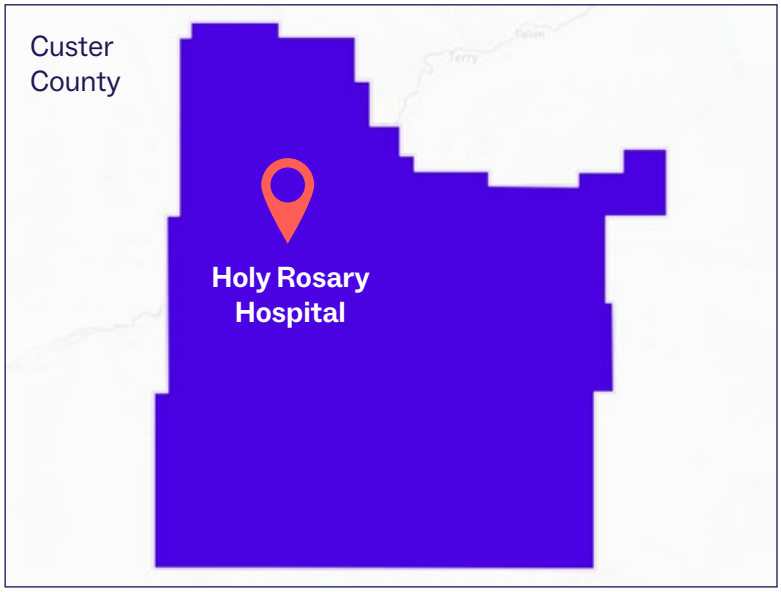
APPENDIX: INTERMOUNTAIN HEALTH CHNA GLOSSARY

Community Profile

Service Area

The primary service area is determined geographically by the ZIP codes where most patient admissions originate. It is also defined by the populations served at the hospital including underrepresented, underserved, and low-income community members.

County	Zip Code
Custer	59301
	59336
	59338
	59351



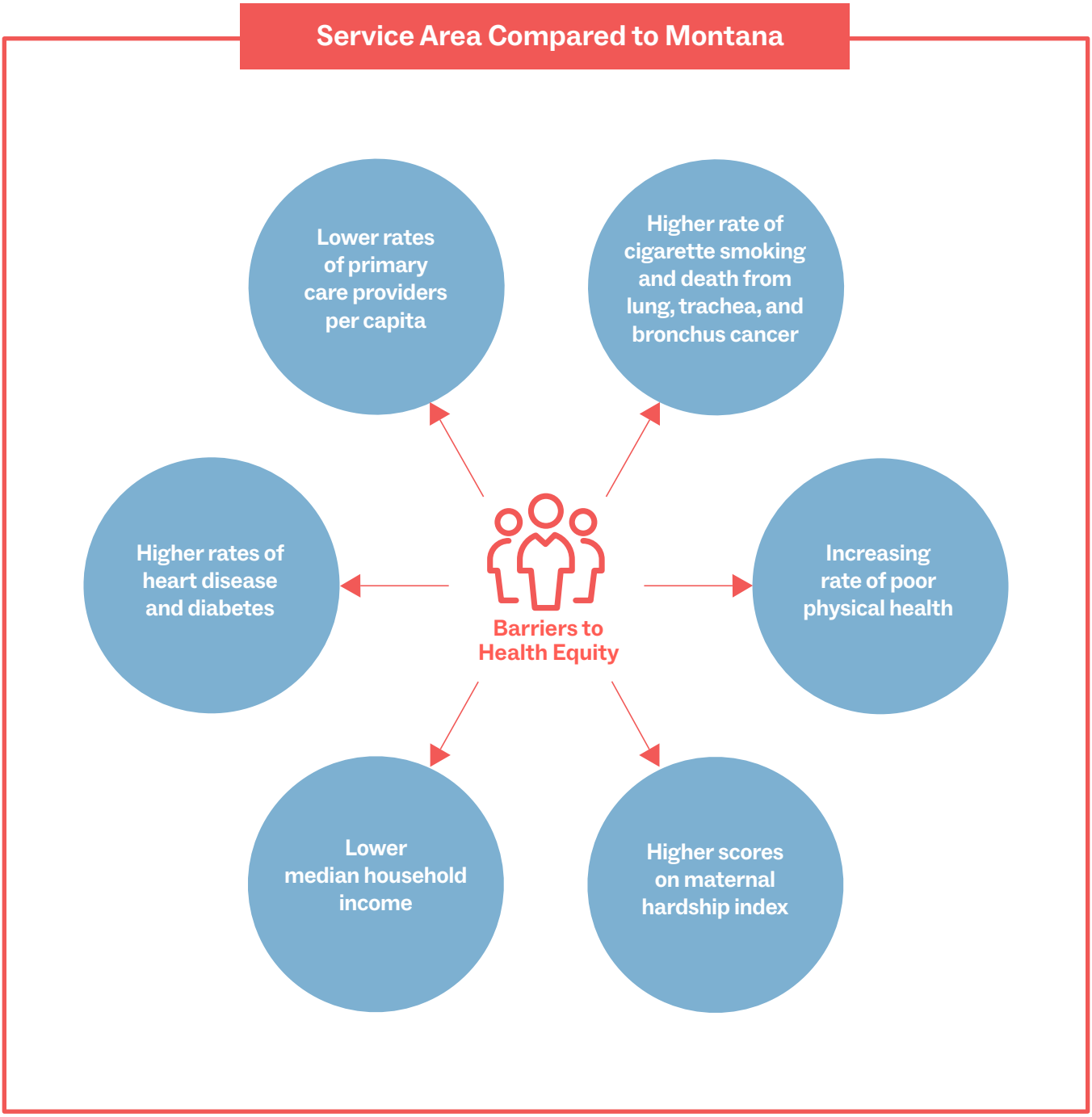
Community Demographics

Demographic Factors	Hospital Service Area	Montana	United States
Population	11,961	1,116,875	334,992,449
Persons Under 18 Years	19.8%	21.0%	22.0%
Persons 65 Years and Over	20.8%	20.1%	17.2%
Female Persons	49.7%	49.3%	50.5%
High School Graduate or Higher (age 25 years+)	95.7%	94.6%	89.6%
Persons in Poverty (150% Federal Poverty Level)	19.7%	20.9%	20.1%
Median Household Income (2024 dollars)	$70,605	$72,509	$80,734
Persons without Health Insurance (under age 65)	7.7%	8.6%	8.4%
White, not Hispanic or Latino	89.0%	83.6%	57.4%
Hispanic or Latino	3.4%	4.6%	19.3%
Black or African American	0.0%	0.4%	11.9%
Asian	0.5%	0.8%	5.9%
American Indian and Alaska Native	1.8%	5.3%	0.5%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%	0.2%
Two or More Races	5.1%	4.7%	4.3%
Limited English Proficiency	0.6%	0.9%	8.6%

A demographic snapshot of the service area compared to Montana and the United States (Source: U.S. Census Bureau: American Community Survey, 2020-2024)

Data-Driven Needs

The CHNA process involves a data-driven comprehensive analysis of the unique health needs of the communities served. By identifying county level health disparities through primary and secondary data, Holy Rosary can better understand how they affect our communities and direct our resources to remove barriers and invest resources where they will have the greatest impact. The following barriers to health were identified in the CHNA secondary data.



APPENDIX: SECONDARY DATA SOURCES

Collaborating with Our Communities

Focus on Collaboration

Intermountain Health takes a collaborative approach with our community to improve health and address health equity through the CHNA. This approach incorporates evaluation of Intermountain's previous CHNA process and impact of Implementation Strategies. It also relies on working closely with local leaders and residents to understand unique health needs in each community. Intermountain and its collaborators invited a broad range of community members with diverse backgrounds, voices, and experiences to participate and offer input in the 2026 CHNA.



Participants

Intermountain collaboratively solicited participation from a variety of individuals and organizations representing local public health departments and the medically underserved, underrepresented, and low-income residents. There was a public request for written comments concerning the most recently conducted CHNA and Implementation Strategy, and no responses were received. The 2026 CHNA had intentional participation from these sectors:

- Healthcare consumers and consumer advocates
- Not-for-profit and community-based organizations
- Academic experts
- Local government officials
- Local school districts
- Healthcare providers and community health centers
- Public health professionals
- Faith community
- Private businesses
- Labor and workforce representatives
- Residents of the community

CHNA Timeline

The governance and decision-making process for the 2026 CHNA is data-driven and community-centric, following a cycle of data collection, analysis, and community feedback before final approval by the Intermountain Health Regional Board.

	Q2 2025	Q4 2025	Q1 2026	Q2 2026	Q3 2026	Q4 2026
Collaborative CHNA Planning	●					
Stakeholder & Public Surveys		●				
Secondary Data Analysis			●			
Community Input Meetings			●			
Analysis & Prioritization of Health Needs				●		
Board Approval of CHNA Report						●
CHNA Report Publication						●

APPENDIX: COMMUNITY INPUT PARTICIPANTS

CHNA Data Methodology and Prioritization

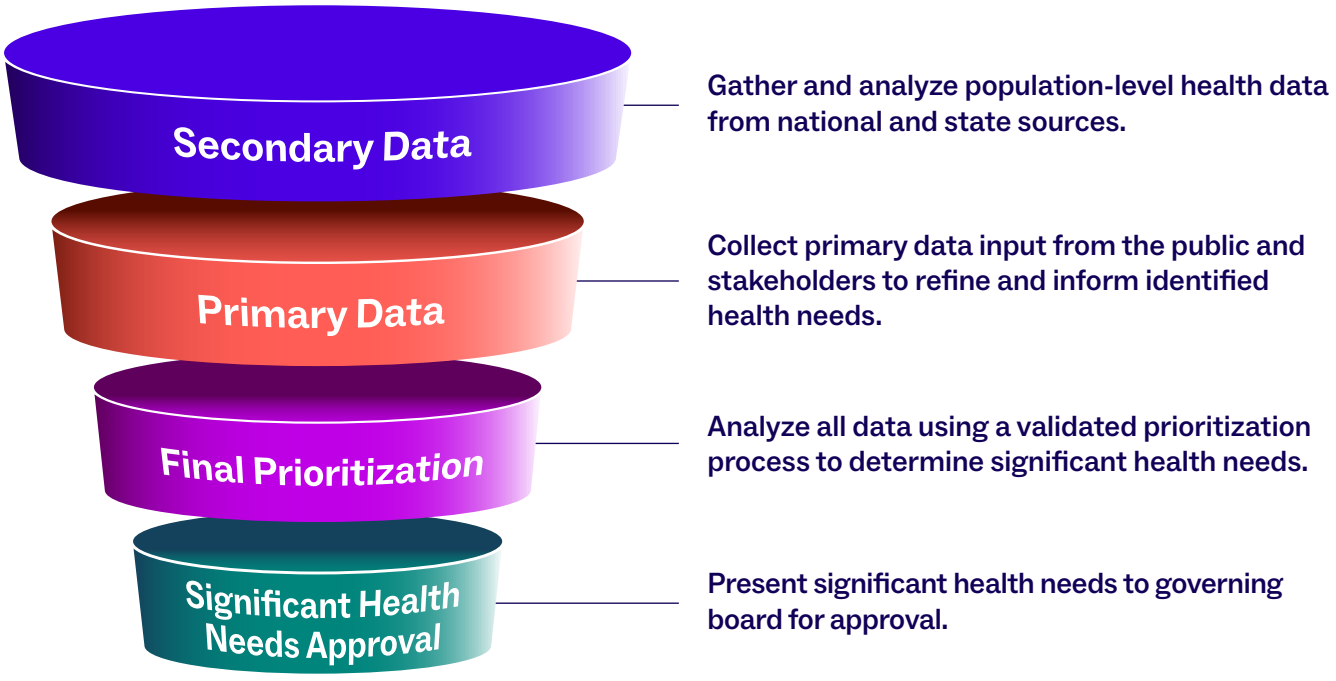
The CHNA prioritization methodology began with analyzing secondary data while concurrently gathering primary data through public and stakeholder surveys. This preliminary analysis took into consideration identifying the community's health needs for children and across the lifespan.

These findings were presented at community input meetings to inform the prioritization process. This valuable local involvement provided in-depth and diverse insight on the backgrounds and experiences of people in the communities we serve.

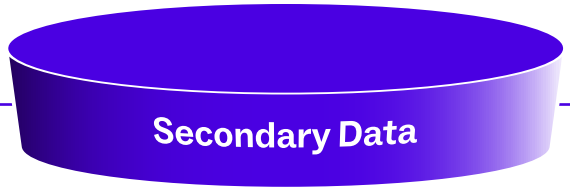
The CHNA concluded with the application of validated analysis and scoring models that produced the final significant health needs. The findings were presented to the governing board for approval.

The CHNA process also provided insight into current resources and community capacity to address significant health needs. This input informs the development of an Implementation Strategy.

Data Methodology & Prioritization Process



APPENDIX: PERSONS INVOLVED IN DATA COLLECTION AND ANALYSIS

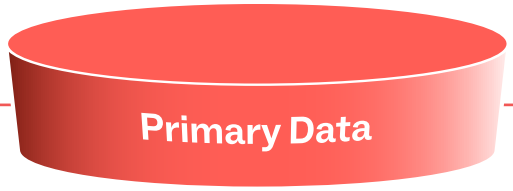


Intermountain Health generated secondary data from the data platform, Metopio™, to access data sources, including the American Community Survey, Behavioral Health Risk Factor Surveillance System, Centers for Medicare and Medicaid, and others inventoried in the appendix. The local health department provided supplementary data insights during community input meetings.

Where localized data were available, the analysis identified notable changes in health indicators over time and differences between select demographic, minority, and medically underserved groups.

Intermountain used the following criteria to analyze the larger body of health indicators and identify a narrower field for community input discussions and prioritization:

- Review leading causes of death by age group, with additional focus on leading injury-related deaths.
- Assess data relevant to the significant health needs identified in the hospital's previous CHNA to determine impact and inclusion in the current cycle.
- Identify emerging trends and patterns not included in criteria above regarding health outcomes, healthcare access, health behaviors, and social needs.



Intermountain used primary data to harness the community's voice and included a broad representation of perspectives and experiences. As part of the Custer County CHNA Collaborative, Intermountain Health collaborated with the local health department to engage local residents and stakeholders, which fostered a shared understanding of health needs and commitment to improving the communities we serve.

The CHNA tools and methods used to collect and analyze primary data were designed to engage populations across the lifespan and also understand the pediatric needs in all communities. Overall, the process was sequenced to identify, understand, refine, and prioritize the community's health needs.

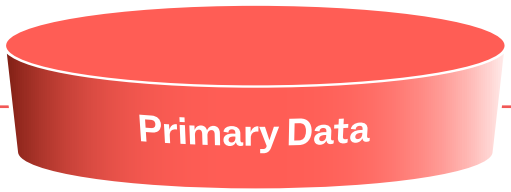
Public Survey

Intermountain Health administered the CHNA Public Survey via email using the Qualtrics® platform between October 13 to November 11, 2025. The technology allowed for panel management that produced responses from a representative and diverse sample of community members from the service area. The survey provided the public with an opportunity to voice their experiences regarding health needs, barriers to equal health opportunities, emerging needs not identified in secondary data, and community strengths.

Community Stakeholder Survey

The CHNA Community Stakeholder Survey was sent via email between October 13 to November 16, 2025, to stakeholders representing community organizations, healthcare, public health, education, and local government. The stakeholders were selected to ensure a diverse mix of representation.

The results expanded input gathered during the public survey and provided additional feedback and insight on health needs, including existing efforts and capacity to address needs.



Community Input Meetings

A community input meeting was held on March 4, 2026. It was co-facilitated by Intermountain Health and One Health, the local health department, which provided insights on current and emerging health needs. Invitees included representatives from the community and Holy Rosary Hospital.

During the meeting, the attendees thoroughly discussed the leading health needs identified through primary data surveys and secondary health data analysis. The input meeting was designed to understand the local impact of these health needs and to gain awareness of other health concerns not included in the preliminary analysis.

Preliminary Health Needs

The community input meeting concluded with participants ranking the identified health needs of highest concern in the service area. This ranking by community representatives resulted in the preliminary health needs that were scored by Holy Rosary Hospital during the final prioritization process.

Preliminary Health Needs

Access to healthcare services	Aging and senior needs	Economic stability
Food insecurity and hunger	Health insurance costs	Housing instability and affordability
Mental health	Substance use and addiction	Suicide

APPENDIX: SECONDARY DATA SOURCES

APPENDIX: COMMUNITY INPUT INVENTORY

APPENDIX: SUMMARY OF PRIMARY DATA FINDINGS

Final Prioritization

The hospital began the final prioritization of the preliminary health needs by applying the Hanlon Method for Prioritizing Problems.

The Hanlon Method is a nationally-recognized technique used in public health needs assessments and recommended by the National Association of County and City Health Officials. Its scoring process reliably develops objective, data-driven priorities.

Intermountain Health's system and hospital leaders, internal subject matter experts, and Community Health team members scored the preliminary health needs ranked by the communities served by Intermountain's three Montana hospitals. The final Hanlon Method score was calculated using a formula that weighted community prioritization and gave consideration to the size, seriousness, and feasibility of preliminary health needs statewide.

Following the scoring process, the team applied the PEARL test to screen out health needs based on feasibility to impact through community health improvement efforts. The PEARL test used these criteria:

- **P** **Propriety:** Is a hospital-led or -supported activity for the health need suitable?
- **E** **Economics:** Does it make economic sense for the hospital to address the need? Are there economic consequences if a need is not addressed by the hospital?
- **A** **Acceptability:** Will the community accept the hospital's intervention? Is the intervention wanted?
- **R** **Resources:** Is funding available or potentially available for the intervention?
- **L** **Legality:** Do current laws allow the intervention to be implemented?

This process determined Holy Rosary's significant health needs. Through this process there were instances where additional health needs were identified, unified under one heading, or prioritized.

Significant Health Needs Approval

With comprehensive data analysis, gathering of public and stakeholder input, and determination of the significant health needs, the Intermountain Health Regional Board approved the CHNA process, findings, and report as presented on November 12, 2026. It was published to the Intermountain Health website before December 31, 2026.

CHNA Significant Health Needs

PRELIMINARY HEALTH NEEDS

Access to healthcare services

Custer County has 67 primary care providers per capita, which is lower than Montana and the U.S.

Aging and senior needs

43% of Custer County seniors have a disability that makes daily tasks difficult, higher than Montana and the U.S.

Childhood injury

Motor vehicle crashes account for the majority of injury-related deaths among Montana residents under age 24.

Economic stability

20% of Custer County residents are living 150% below the poverty level.

Food insecurity and hunger

14% of Custer County residents experience food insecurity, which is higher than Montana at 12%.

Health insurance costs

One in ten Custer County residents had no health insurance coverage, a rate that is increasing.

Housing instability and affordability

10% of Custer County residents were unable to pay their housing costs in the past 12 months.

Mental health

One in four adults in the service area were diagnosed with depression, a rate higher than the U.S.

Substance use and addiction

23% of Custer County adults and 16% of youth report binge drinking, which is higher than the U.S.

Suicide

Montana has a suicide rate of 27 deaths per 100,000 people, about twice the U.S. rate. Among youth and teens, it is more than triple the national rate.

SIGNIFICANT HEALTH NEEDS



IMPLEMENTATION STRATEGY

Identify hospital and community resources to address significant health needs

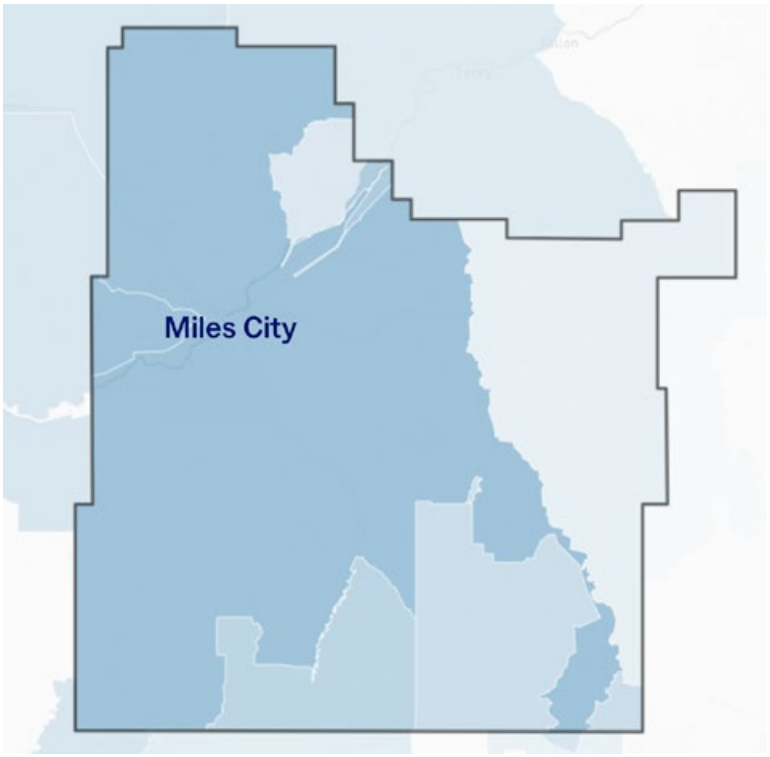
Develop strategies to address significant health needs with an emphasis on health equity and anticipated impact

Collaborate with other community organizations to have the greatest possible impact on data-identified needs

Improve Behavioral Health

The 2026 CHNA prioritizes improving behavioral health as a significant health need through addressing mental health, suicide, and substance use and addiction. This unifies the preliminary health needs identified during data collection and prioritization under Behavioral Health.

"Drugs, substance abuse, and addiction are probably one of the biggest issues here." — *Community Member*



Metopio | Tiles © Mapbox, Data source: Centers for Disease Control and Prevention (CDC) PLACES

Mental Health

Self-Reported Poor Mental Health | 2023
Custer County: **18.4%**
± 2.1% of adults

About 18% of residents in Custer County reported poor mental health; the highest rates were in Miles City.

Low — High

HEALTH DISPARITIES, HEALTH EQUITY & BEHAVIORAL HEALTH

Mental Health

94% of community stakeholder surveys prioritized mental health for community improvement.

Suicide

The suicide mortality rate in Montana is higher than the U.S. across all age groups and higher among men than women.

Substance Use and Addiction

Drug overdose deaths in Montana increased 23% over the past decade, primarily due to fentanyl and methamphetamine related deaths.

COMMUNITY STRENGTHS

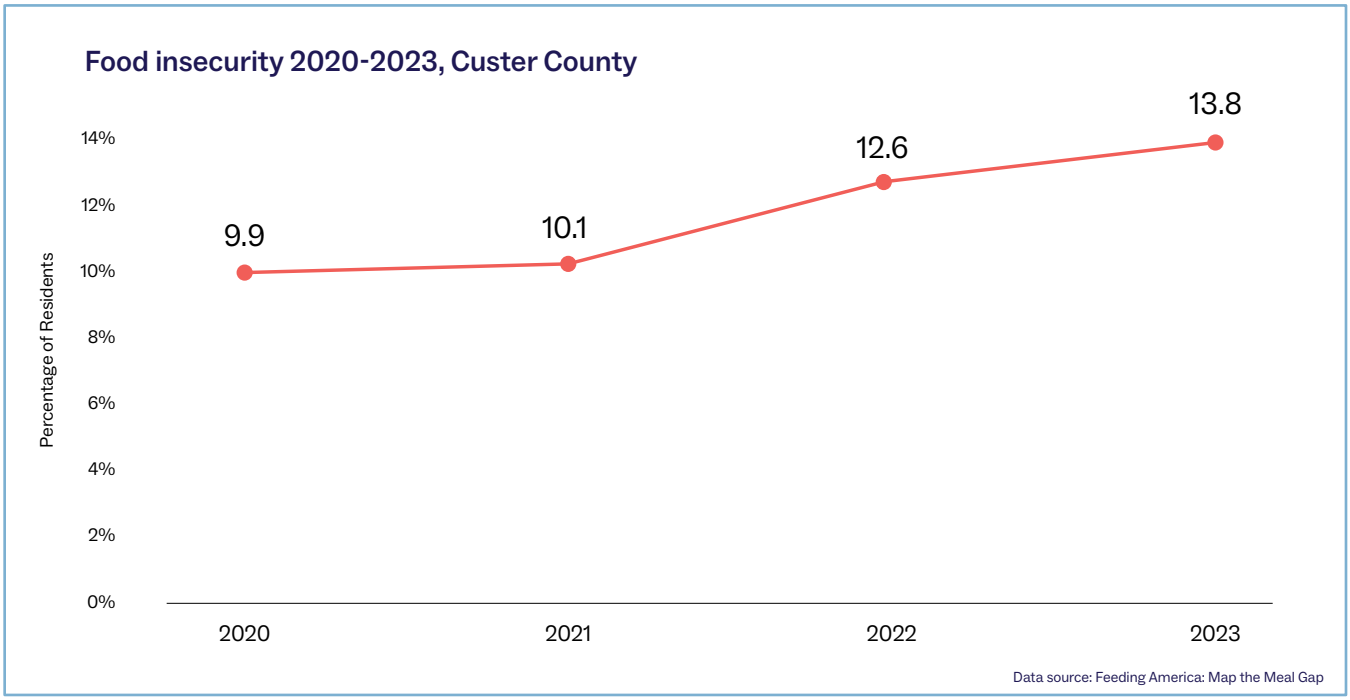
- Strong community connections and supportive networks provide protective factors.
- Consensus among public health agencies and other community stakeholders on behavioral health as a significant health need.
- Sustaining and expanding current community collaborations and programming from previous Implementation Strategy to address behavioral health.

APPENDIX: RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Invest in Social Drivers of Health

The 2026 CHNA prioritizes investing in social drivers of health as a significant health need through addressing nutrition and food security and housing instability and affordability. This unifies the preliminary health needs identified during data collection and prioritization under Social Drivers of Health.

"Due to the lack of housing, our clients are forced to move away from their families and the communities they know." *— Community Stakeholder*



The rate of food insecurity was 10% in 2020 and 2021, then sharply increased to 14% in 2023.

HEALTH DISPARITIES, HEALTH EQUITY & SOCIAL DRIVERS OF HEALTH

Nearly one in four households are spending more than 30% of their income on their housing costs in Custer County.

The food insecurity rate is 18% higher among children compared to the overall service area.

One third of public survey respondents ranked housing insecurity as a high community concern.

COMMUNITY STRENGTHS

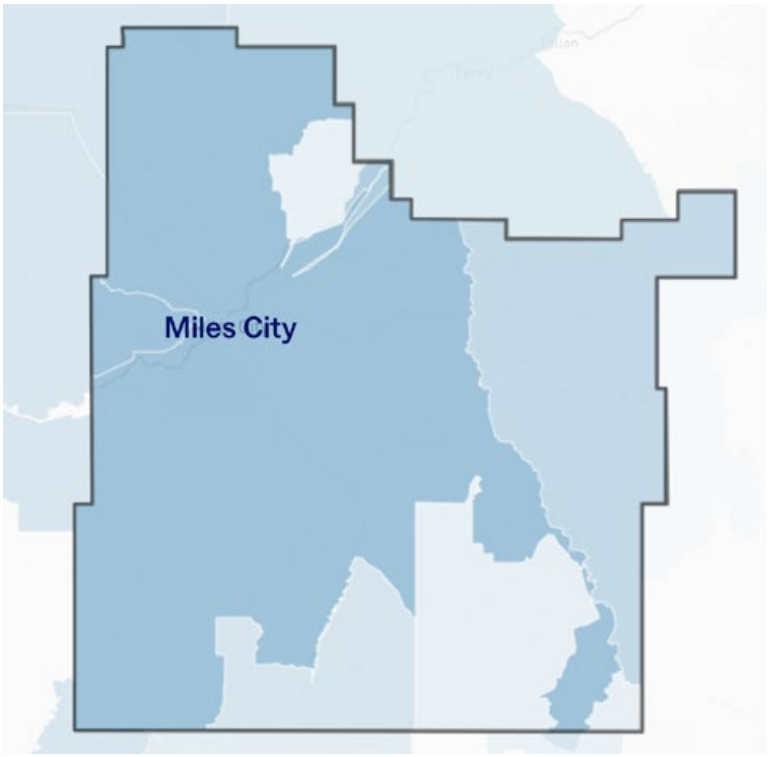
- Family-oriented and a strong community identity that promotes sharing of resources and self-sufficiency.
- Low rates of unemployment and high rates of high school graduation.
- Sense of safety, access to public lands, and clean air and water that provide quality of life.

APPENDIX: RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Increase Access to Care

The 2026 CHNA prioritizes addressing access to care as a significant health need based on data-driven needs specific to the service area.

"We need more providers in rural health care. We need better mental health options." *— Community Member*



Metopio | Tiles © Mapbox, Data source: U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)

Uninsured Rate | 2020-2024
Custer County: **7.7%**
±1.4% of adults

In the service area, 8% of residents are uninsured. The rate is double among young adults ages 18 to 39 years and highest in Miles City.

0.0% **14.2%**

HEALTH DISPARITIES, HEALTH EQUITY & ACCESS TO CARE

Custer County has 589 mental health providers per capita, compared to Montana at 669 and the U.S. at 690, and also fewer primary care providers per capita.

Both the public survey and stakeholder survey ranked health insurance costs as the highest community concern.

69% of Custer County adults visit a primary care provider for routine care, compared to 70% in Montana and 72% in the U.S.

COMMUNITY STRENGTHS

- Community transportation services for older adults that support access to healthcare services.
- Existing community-based primary care, diagnostic, and specialized cancer services.
- Neighborly service and quality care from healthcare providers.

APPENDIX: RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Promote Childhood Wellness and Injury Prevention

Proactively addressing children's health can have an upstream and life-long impact. Holy Rosary prioritized promoting childhood wellness and injury prevention as a significant health need. Using child-specific morbidity and mortality data and community input, the 2026 CHNA identified and prioritized health needs that differ from the adult population.

> *"Our school-aged children are showing signs of depression, worthlessness, lack of empathy, bullying."* — *Community Member*

TOP CAUSES OF INJURY-RELATED DEATH IN CHILDREN (2020-2024)

Injuries are the leading cause of mortality and disability among children (ages 0 to 18 years). Injuries are classified by their intent: unintentional, suicide, and homicide/assault

Ages 0 to 1 year	Ages 1 to 4 years	Ages 5 to 9 years	Ages 10 to 14 years	Ages 15 to 19 years
Unintentional • Suffocation (sleep related)	**Unintentional** • Motor vehicle incidents	**Unintentional** • Motor vehicle incidents	**Unintentional** • Motor vehicle incidents **Suicide** • Firearm	**Unintentional** • Motor vehicle incidents **Suicide** • Firearm • Asphyxia **Unintentional** • Drug overdose **Homicide** • Firearm

Data Source: CDC, National Center for Injury Prevention and Control, WISQARS online database, 2020-2024.

HEALTH DISPARITIES, HEALTH EQUITY & CHILDHOOD WELLNESS & INJURY

The infant mortality rate is 10.5 deaths per 1,000 live births in Custer County, compared to 5.0 in Montana and 5.7 in the U.S.

Suicide is a leading cause of death for adolescents and young adults in Montana; most deaths involved a firearm.

23% of Montana children (ages 0 to 17 years) experienced two or more adverse childhood experiences (ACEs), which is the second highest rate in the nation.

COMMUNITY STRENGTHS

- Family-focused communities and a readiness to collaborate on issues relating to children's health.
- Strong community engagement from rural and community organizations and services.
- Cross-sector collaboration to support childhood wellness.

APPENDIX: RESOURCES TO ADDRESS SIGNIFICANT HEALTH NEEDS

Evaluation of Prior CHNA

The previous CHNA was conducted in 2023, and the significant health needs were identified as access to healthcare services, behavioral health, and chronic disease prevention and management. A companion Implementation Strategy was also developed to address these health needs identified among the medically underserved, underrepresented, and low-income residents in the CHNA data. Notable outcomes from those activities are below.

2024 - 2026 Implementation Strategies and Outcomes

Significant Health Need	Strategies	Outcomes 2024-2025
 **Access to Healthcare Services**	• Increase opportunities for access to healthcare services, both in person and virtually • Increase workforce capacity to provide access to healthcare services	• Conducted 3,349 virtual health visits to eliminate barriers to healthcare services including transportation. • Opened a comprehensive cancer center, providing access to services previously unavailable in eastern Montana. • Provided student rotations, including physicians and advance practitioners, nursing, laboratory, certified nursing assistants, physical therapy, and pharmacy. • Provided funding to Custer County Transit to address transportation barriers.
 **Behavioral Health**	• Improve access to mental health services and resources • Improve supports for substance use treatment and prevention	• Improved access by integrating a licensed clinical social worker who provided behavioral health services in 2024. • Provided telecrisis services to 306 individuals experiencing a behavioral health crisis in 2025. • Distributed 425 gunlocks with suicide prevention resources. Promoted the 988 crisis line and Montana 211 resources. • Provided funding to Eastern Montana Community Mental Health Center to address behavioral health needs.
 **Chronic Disease Prevention and Management**	• Increase access to interventions for chronic disease prevention • Increase access to chronic disease interventions for individuals living with chronic disease	• Provided Healthy Lifestyles program to 753 community members to improve long-term health, approximately 55% achieved a weight loss of at least 5%. • Maintained a 2.5 mile community walking path. • Provided cardiac rehabilitation services to 136 individuals to improve health outcomes following a cardiac event. • Provided pulmonary rehabilitation services to 39 individuals to improve health outcomes for lung disease and other related diseases.

Conclusion

Intermountain is grateful for the support of community members and organizations for their valuable participation in the CHNA process. Their community voices offered a deeper understanding of unique local needs and health disparities identified through the CHNA data. Intermountain leverages this valuable input to develop an Implementation Strategy in collaboration and alignment with the community to create equitable opportunities for health.

Intermountain caregivers from Community Health and Consumer Experience worked with One Health to lead the 2026 CHNA process. We recognize the value of working collaboratively, which resulted in a more comprehensive, inclusive, and impactful CHNA.

Intermountain will conduct the next CHNA in 2029 and looks forward to continuing collaborations to improve the health of our communities.

For additional information about the CHNA, contact:

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To submit written comments on this CHNA or request a paper copy, please email IH_CommunityHealth@imail.org



Appendices

Intermountain Health

CHNA Glossary

Term	Definition
Activity or Program	Evidence-based actions to address each significant health need.
Community Health Needs Assessment (CHNA)	Tri-annual review and analysis of unmet or significant health needs in the communities served by Intermountain Health; it informs the development of the Implementation Strategy and all of Intermountain Health's Community Health work.
Evaluation	Assessment of results from actions taken to address significant health needs.
External Stakeholder	Organizations, government agencies, individuals, and other entities outside Intermountain Health that will be influential in the success of or impacted by the CHNA and Implementation Strategy.
Health Disparity	Data-identified and preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by communities.
Health Equity	Foundational and embedded across Intermountain Health's approach to health improvement is the principle of pursuing the highest possible standard of health by focusing on improving the well-being of our most vulnerable communities.
Health Needs	Unmet community health needs identified during the CHNA.
Health Indicators	Specific health discrepancies identified by data within the health needs (i. e. , frequent mental distress as an indicator within behavioral health).
Health Outcome	Anticipated impact of strategies on significant health needs.
Implementation Strategies (IS)	A written plan to address health needs prioritized in the CHNA; it includes activities, collaborations, resources, funding, and the anticipated impact on data-driven needs.
Internal Stakeholder	Departments, teams, and other functions of Intermountain Health that will be influential in the success of or impacted by CHNA and Implementation Strategy.
Primary Data	Information gathered directly from sources including stakeholder and resident surveys, interviews, and community and stakeholder meetings.
Secondary Data	Information gathered by third parties, typically public health agencies, government agencies, or large studies.
Significant Health Needs	Community health needs prioritized during the CHNA that are addressed in the Implementation Strategy.

CHNA Participants

Community Input Participants

Action for Eastern Montana	CNADA	Custer County Commissioners
Custer County Council on Aging	Custer County Fire	Custer County Food Bank
Custer County Schools	Custer County Transit	Eastern Montana CASA/GAL
Eastern Montana Community Mental Health Center	Miles City Chamber of Commerce	Miles City Fire Rescue
Miles City Job Service	Miles City Library	Miles City Police
Miles City Star	Miles Community College	Montana Health Network
Montana Nonprofit Association	Notbohm Motors	One Health
Sisters of Charity of Leavenworth	Stockman Bank	Veteran's Navigation Network

CHNA Methodology

Persons Involved in Data Collection and Analysis

Organization	Name, Credentials	Title	Responsibilities
Intermountain Health	Kathryn Barker, MPH	Community Health Manager	Support secondary data analysis and evaluation
Intermountain Health	Anna Fondario, MPH	Community Health Organizational Consultant	Support secondary data analysis and evaluation
Intermountain Health	Chris Grosh, PhD	Strategic Research Senior Consultant	Gather and analyze data from public and stakeholder surveys

Methodology: Secondary Data

Secondary Data Sources

Unless noted otherwise, CHNA secondary data sources are accessible in the Metopio database at this link.

Data Source	Year(s)	Indicators
Centers for Disease Control and Prevention (CDC), PLACES: Local data for better health (for sub-state geographic levels) and CDC, Behavioral Risk Factor Surveillance System (for state and US)	2023 2024*	Binge Drinking, Cigarette smoking, Coronary heart disease, Diagnosed diabetes, Housing insecurity, No health insurance, Physician use delayed due to cost*, Self-reported poor mental health, Self-reported poor physical health
CDC, National Center for Injury Prevention and Control, WISQARS online database	2020-2024	Leading causes of injury-related death in children; Accessible at this link
CDC WONDER and WISQARS online databases CDC, National Center for Health Care Statistics, CDC WONDER, Natality and Underlying Cause of Death online databases	2017-2019* 2020-2024	Infant mortality rate*, Suicide mortality, Lung, trachea, and bronchus cancer mortality, Leading causes of death
Centers for Medicare & Medicaid Services, National Provider Identifier Registry	2025	Mental health providers per capita
Feeding America, Map the Meal Gap, 2024 Technical Brief	2020-2023	Food insecurity
Health Resources & Services Administration (HRSA), Area Health Resources Files (1-year estimates)	2023	Primary care providers per capita
HRSA, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024	Adverse Childhood Experiences; Accessible at this link
Metopio measure derived from Centers for Disease Control and Prevention, U.S. Census Bureau, and other federal sources	2016-2023	Maternal hardship index
U.S. Census Bureau, American Community Survey 5-Year Estimates, Decennial Census.	2020-2024	Below 150% of poverty level (C17002), Disability (S1810), High school graduation rate (B15002), Limited English proficiency B16004), Median household income (B19013), Population by age (B01001), sex (B03002), race and ethnicity (P012), Seniors living alone (B09020)

Methodology: Primary Data

Community Input Inventory

Input Types and Dates	Sample	Method	Topics Covered	Community Representation
Public Survey 10/13-11/11/2025	n=315	Web-based survey through email	• Health and well-being • Health insurance status • Health care access • Unmet social needs • Community concerns • Community strengths • Awareness of 988 crisis line	• 2% Ages 18 – 24 • 17% Ages 25 – 39 • 27% Ages 40 – 59 • 53% Ages 60 or older • 3% American Indian/Alaska Native • 0% Asian • 1% Black/African American • 3% Hispanic/Latino • 0% Native Hawaiian/Pacific Islander • 93% White, Non-Hispanic/ Latino • 71% Female • 27% Male • 4% LGBTQIA affiliation • 24% Child living in household • 22% Disability in household • 2% Unemployed • 35% Retired
Stakeholder Survey 10/13 - 11/16/2025	n=59	Web-based survey through email	• Community demographics • Community health focus • Community concerns • Community priorities • Community strengths	• Community leaders • Healthcare providers • Social services providers • Public health representatives • Physicians
Community Input Meeting 3/04/2026	n=24	In-person meeting	• Primary and secondary data review • Discussion of preliminary health needs and community impact • Identification of additional community health needs	• Community-based organizations • Education and government • Healthcare organizations • Older adult-serving organizations • Private sector • Public health departments • Youth-serving organizations

Summary of Primary Data Findings

Input Type	Findings
Public Survey	• Top Reported Unmet Health Needs in Service Area – Dental care, 17% – Specialty health care, 13% – Mental healthcare, 13% – Primary Care, 12% – Prescription Medications, 10% • Children with Unmet Healthcare Needs, 41% • Top Reported Household Needs for Service Area – Overwhelmed by caregiving, 10% – Social isolation, 5% – Food insecurity, 5% – Unreliable transportation 4% – Concern about utilities being shut off, 4% • Top Reported Community Concerns for Service Area – Health insurance costs, 65% – Mental health issues, 41% – Substance use and addiction, 40% – Childhood bullying, 38% – Suicide, 35% – Quality of K-12 education, 34% – Health access challenges, 34% – Housing insecurity, poverty 31% – Child abuse/neglect, 29% – Chronic disease, 26% – Community safety, 23% – Health literacy, 21%
Stakeholder Survey	• Top community concerns ranked in order were health insurance costs, mental health issues, substance use and addiction, childhood bullying, suicide, quality of K-12 education, healthcare access challenges, housing instability, financial insecurity/poverty, child abuse and neglect, chronic diseases, aging and senior related needs, community safety, health literacy, food insecurity and hunger, access to public transportation, and access to public recreation spaces. • Top health needs that should be prioritized were mental health including substance use/addiction and suicide, housing instability, healthcare access, food insecurity and hunger, aging and senior related needs, chronic diseases, and health insurance costs.

Community Resources

Resources to Address Significant Health Needs

Significant Health Need	Organization	Summary of Resources
Improve Behavioral Health	Local Mental Health Centers, Providers, and Nonprofit Organizations	Mental health therapy, substance use disorder treatment, case management, group therapy, and trainings. Individual and group services on a sliding fee scale that support access for low-income individuals.
	Mental Health Supports	988 suicide and crisis lifeline that supports suicide prevention, substance use, and mental distress.
Invest in Social Drivers of Health	Housing Authorities	Affordable housing and support, case management, and transition services.
	Local Government Programs	Government programs like Women, Infants, and Children (WIC) and the Montana Homeowner Assistance Fund.
	Nonprofit Organizations	Community-based organizations that provide food assistance programs, local food banks, pantries, and other emergency assistance.
Increase Access to Care	Federally Qualified Health Centers	Community-based organizations that provide comprehensive primary medical, dental, and behavioral healthcare regardless of ability to pay and insurance status.
	Healthcare Providers	Local and state healthcare that provides access to affordable care.
	Nonprofit Transportation Organization	Transportation services that improve access to care.
	Government Agencies	Enrollment assistance for numerous types of public benefits related to access, income, and insurance coverage.
Promote Childhood Wellness and Injury Prevention	Early Childhood Agencies	In-home services, health and wellness support, and child protection.
	Nonprofit Community-Based Organizations	Community-based organizations that provide services for children and families.
	Education Organizations and Schools	Youth mental health resources, promotion of injury prevention and mental well-being, and career pathways that address social drivers of health.



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