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INTRODUCTION

In the United States, public health departments play a critical role in promoting and preserving the health of people in communities across the country; however, until now, there has not been a system in place to ensure their accountability and quality. In 2007, the Public Health Accreditation Board (PHAB) was incorporated to develop a voluntary public health accreditation program in order to advance the quality and performance of health departments. Over the past three years, leading health practitioners and organizations have come together and created a system of common standards used to measure performance. These standards will drive public health departments to continuously improve the quality of the services they provide and subsequently contribute to the improved health of communities throughout the nation.

The accreditation process is comprised of 31 proposed standards and 109 proposed measures that local health departments will have to meet and document. Included in these is a focus on the promotion of strategies to improve access to health care services. In particular, the standards outline the need for local health departments to assess community need and the availability of health care services, identify underserved and at-risk populations and those who may experience barriers to health care services, as well as to identify gaps in access to such services. Committed to being an accountable and credible health agency, the Richland County Health Department has begun to assess its readiness to apply for accreditation and included in these efforts is the implementation of a health status and health access assessment of the county. As a frontier community with a small population spanning over 2,000 square miles, the county faces unique challenges in the delivery of health care service. The findings from this assessment will help the health care service community in Richland County better understand the current health status of county residents; significant financial, structural, and personal barriers to care;
and help to inform the development of strategies to improve access and availability of services for all county residents.

DATA AND METHODOLOGY

The specific aims of this assessment are to examine Richland County’s health status and the availability of health care services and to identify underserved and at-risk populations as well as gaps in and barriers to accessing care. Towards this end, demographic and health status data has been compiled. Furthermore, interviews were conducted with residents in collaboration with a survey to explore and document their experiences accessing health care services, factors driving their health access behavior, and their perceptions of health care in the community. Interviews were also conducted with health care service professionals to document available services as well as these individuals’ experiences working in the county and their perceptions of challenges to care.

From August 2009 through February 2010, a total of thirty-three interviews were conducted with residents and health care service professionals residing in towns and communities throughout the county. Of the thirty-three individuals interviewed, sixteen were residents and seventeen were professionals working in the health care field including: physicians, nurses, public health practitioners, social workers, and emergency medical technicians. Two strategies were employed to recruit this participant sample. Prior to the start of this study, Health Department staff developed a list of community contacts. All of these individuals were contacted and many chose to participate in the assessment. Individuals interviewed also often identified other potential contacts for the assessment. Additionally, health care service providers and agencies throughout the county were contacted and asked to participate. The interviews
conducted took two main forms: in-depth semi-structured interviews and informal, informational interviews. Table 1.1 below provides more detailed information on the assessment’s sample.

### TABLE 1
Sample Population Interviewed

<table>
<thead>
<tr>
<th>Participant #</th>
<th>Community of Residence</th>
<th>Gender</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Sidney</td>
<td>M</td>
<td>Primary Care Physician</td>
</tr>
<tr>
<td>P2</td>
<td>Sidney</td>
<td>F</td>
<td>Specialist</td>
</tr>
<tr>
<td>P3</td>
<td>Sidney</td>
<td>M</td>
<td>Primary Care Physician</td>
</tr>
<tr>
<td>P4</td>
<td>Sidney</td>
<td>M</td>
<td>Specialist</td>
</tr>
<tr>
<td>P5</td>
<td>Sidney</td>
<td>F</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>P6</td>
<td>Fairview</td>
<td>F</td>
<td>Emergency Medical Technician</td>
</tr>
<tr>
<td>P7</td>
<td>Sidney</td>
<td>F</td>
<td>Nurse</td>
</tr>
<tr>
<td>P8</td>
<td>Sidney</td>
<td>F</td>
<td>Nurse</td>
</tr>
<tr>
<td>P9</td>
<td>Lambert</td>
<td>F</td>
<td>Nurse</td>
</tr>
<tr>
<td>P10</td>
<td>Sidney</td>
<td>F</td>
<td>Public Health Practitioner</td>
</tr>
<tr>
<td>P11</td>
<td>Sidney</td>
<td>F</td>
<td>Public Health Practitioner</td>
</tr>
<tr>
<td>P12</td>
<td>Sidney</td>
<td>F</td>
<td>Public Health Practitioner</td>
</tr>
<tr>
<td>P13</td>
<td>Fairview</td>
<td>F</td>
<td>Public Health Practitioner</td>
</tr>
<tr>
<td>P14</td>
<td>Savage</td>
<td>F</td>
<td>Public Health Practitioner</td>
</tr>
<tr>
<td>P15</td>
<td>Sidney</td>
<td>M</td>
<td>Emergency Medical Technician</td>
</tr>
<tr>
<td>P16</td>
<td>Sidney</td>
<td>F</td>
<td>Mental Health Counselor</td>
</tr>
<tr>
<td>P17</td>
<td>Sidney</td>
<td>F</td>
<td>Social Worker</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participant #</th>
<th>Community of Residence</th>
<th>Gender</th>
<th>Age Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>P18</td>
<td>Sidney</td>
<td>F</td>
<td>25-44</td>
</tr>
<tr>
<td>P19</td>
<td>Sidney</td>
<td>M</td>
<td>65+</td>
</tr>
<tr>
<td>P20</td>
<td>Fairview/Sidney</td>
<td>F</td>
<td>45-64</td>
</tr>
<tr>
<td>P21</td>
<td>Fairview</td>
<td>F</td>
<td>25-44</td>
</tr>
<tr>
<td>P22</td>
<td>Girard</td>
<td>F</td>
<td>45-64</td>
</tr>
<tr>
<td>P23</td>
<td>Savage</td>
<td>F</td>
<td>45-64</td>
</tr>
<tr>
<td>P24</td>
<td>Four Mile</td>
<td>F</td>
<td>45-64</td>
</tr>
<tr>
<td>P25</td>
<td>Elmdale</td>
<td>F</td>
<td>45-64</td>
</tr>
<tr>
<td>P26</td>
<td>Sue Pass</td>
<td>F</td>
<td>45-64</td>
</tr>
<tr>
<td>P27</td>
<td>Sidney</td>
<td>F</td>
<td>45-64</td>
</tr>
<tr>
<td>P28</td>
<td>Sidney</td>
<td>M</td>
<td>45-64</td>
</tr>
<tr>
<td>P29</td>
<td>Sidney</td>
<td>F</td>
<td>65+</td>
</tr>
<tr>
<td>P30</td>
<td>Sidney</td>
<td>F</td>
<td>65+</td>
</tr>
<tr>
<td>P31</td>
<td>Sidney</td>
<td>M</td>
<td>25-44</td>
</tr>
<tr>
<td>P32</td>
<td>Sidney</td>
<td>M</td>
<td>45-64</td>
</tr>
<tr>
<td>P33</td>
<td>Elmdale</td>
<td>F</td>
<td>65+</td>
</tr>
</tbody>
</table>
**Demographic and Health Status Information**

The demographic and health status section of the report provides an examination of trends in the population over the past half century, the economic profile of the county and its residents, maternal and child health, as well as data on primary causes of death. This data has been compiled using numerous reliable sources including Montana Vital Records; County Health Profiles published by the Montana Department of Health and Human Services; Center for Disease Control data; Sidney Health Center data; and Census data. This data provides a profile of the county and its residents’ health status in comparison to both Montana and the United States so as to provide insight into specific needs within the county as well as areas where disease burden and mortality are particularly high.

**Availability of Health care Services Information**

The seventeen interviews conducted with health care service professionals were informal and extensive hand-written notes were taken. These were primarily preliminary interviews aimed at better understanding the overall health care service environment in Richland County. In particular, these interviews, which lasted from fifteen to ninety minutes, focused on documenting what services are available and examining the challenges that these individuals perceive county residents facing in trying to access available services. In addition, many of these individuals spoke to the challenges that they themselves face in providing health care services in the community. The information gathered in these interviews helped guide the more in-depth and semi-structured interviews conducted with residents.

---

1 View Appendix A for a list of health care providers and services in Richland County
2 View Appendix
Residents' Health Access Experiences and Behavior Information

Data on residents’ health access behavior in Richland County and experiences accessing health care services were obtained through a survey as well as through in-depth semi-structured interviews with residents. This data provides insight into how residents interact with the county’s health care delivery system and potential gaps in and barriers to care.

The sixteen interviews conducted with Richland County residents not involved in health care services were structured as guided conversations lasting between forty-five minutes and two and a half hours. Recognizing that an individual’s health access behavior is the product of a diverse set of circumstances, attitudes and past experiences, open-ended questions that evoked narratives of living in the area and accessing care were asked. These questions helped to uncover residents’ temporal and historical associations with the county and reveal how these associations shape their patterns of accessing health care and their present-day feelings towards the health care service community in the county. These interviews were recorded, with respondents’ consent, and then transcribed. Individual names have been omitted as well as some other identifying details to ensure confidentiality.

After exploratory thematic analysis, a common framework of ‘sub-narrative’ themes was developed. These themes included: primary care; emergency care; insurance coverage; and senior issues. In addition to drawing connections between the interviews through thematic coding, the data analysis presented in this report includes links drawn between these interviews and the findings from two surveys.
Survey Information

During this assessment process, two surveys were conducted in conjunction with the interviews. Recognizing that insurance coverage plays a critical role in health care access, the first survey, which was completed in September, 2009, surveyed a total of 414 people at the Richland County Fair about health insurance coverage and types of plans. The results from this survey provide a baseline understanding of the percentage of county residents who are insured as well as the types of insurance plans and range of yearly deductibles that residents have.

The second survey includes more detailed questioning about insurance coverage as well as questions regarding health status, health care access behavior and levels of satisfaction with available services in the county. This survey has continuously been disseminated between January and July 2010 through tabling in stores, restaurants and public facilities throughout the county.

3 View Appendix B and C for a copy of these surveys
DEMOGRAPHIC AND HEALTH STATUS INFORMATION

Founded in 1914, Richland County, which is located in northeast Montana on the border of North Dakota, has a comparatively short but indelibly rich history as a primarily ranching and agricultural community grounded by strong familial ties and a deep connection to the land. Spanning 2,084 square miles, the county is the twenty-first most populous in Montana, with a population of 9,270 and a population density of 4.4 people per square mile. Richland County is subsequently classified as frontier. Sidney, the county seat, is the State’s eighteenth largest city with a population of 4,746. Four additional municipalities are located within the county: Crane, Fairview, Lambert and Savage.

Demographic and Economic Data

As Table 2 below illustrates, the population of Richland County has fluctuated between 1950 and 2008 and overall, has experienced a decline. This data however, only counts permanent residents and not temporary workers and as a result, most likely undercounts the true population of the area as the county has experienced multiple waves of oil and gas development. For example, the Census estimates below show a decline in population between 2000 and 2008 despite an influx of workers related to a new oil and gas boom that has occurred since 2000.

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5 Richland County Planner Office, Richland County Growth Policy, January 2007.
Furthermore, Richland County’s population is 96.8% white, 1.9% American Indian, and 1.3% other and is increasingly aging. The proportion of persons over the age of 65 in Richland County is 17% compared to 14.2% in Montana and since 1990, the median age for the county has continued to increase from 33 to 42 years of age in 2009. Table 3 below shows that in the county, median age is not evenly distributed along gender and race lines. At 49.8% and 50.2% respectively, the gender distribution between females and males in Richland County is nearly equal; however, this distribution is less equal within the 65+ population in the county because women are living on average longer than men. The distribution of gender is subsequently an important component of the aging of the population that has implications for the future health care condition of the area as it indicates an increasing need for health care education and services for elderly females.

### TABLE 2
Population of Richland County 1950-2008

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>10,366</td>
<td>10,504</td>
<td>9,837</td>
<td>12,243</td>
<td>10,716</td>
<td>9,667</td>
<td>9,270</td>
</tr>
<tr>
<td>% Change</td>
<td>+1.3</td>
<td>-6.3</td>
<td>+24.5</td>
<td>-12.5</td>
<td>-9.8</td>
<td>-4.1</td>
<td></td>
</tr>
</tbody>
</table>

Source: US Census of Population

### TABLE 3
Median Age and Median Age at Death by Gender and Race

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>White</th>
<th>American Indian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Age</td>
<td>38</td>
<td>40</td>
<td>49</td>
<td>19</td>
</tr>
<tr>
<td>Median Age at Death</td>
<td>77</td>
<td>82</td>
<td>80</td>
<td>44</td>
</tr>
</tbody>
</table>

Source: Richland County Health Profile

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6 Montana Department of Public Health and Human Services, 2009 Richland County Health Profile, December 2009.

7 North Carolina Department of Commerce Division of Policy, Richland County (MT) Profile, January 2010 <https://edis.commerce.state.nc.us/docs/countyProfile/MT/30083.pdf>.

8 Montana Department of Public Health and Human Services, 2009 Richland County Health Profile.
Moreover, though the general U.S. population is aging, Richland County is experiencing higher rates of aging than the State of Montana and the overall U.S. population as evidenced in Table 4 below.

### TABLE 4
Aging of Richland County’s Population 1990-2008

<table>
<thead>
<tr>
<th>Years</th>
<th>1990</th>
<th>2000</th>
<th>2008</th>
<th>% change in number of persons aged 65+ from 1990 to 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richland County</td>
<td>11.5%</td>
<td>15.5%</td>
<td>17%</td>
<td>+32.4%</td>
</tr>
<tr>
<td>Montana</td>
<td>13.3%</td>
<td>13.4%</td>
<td>14.2%</td>
<td>+6.3%</td>
</tr>
<tr>
<td>U.S.</td>
<td>12.5%</td>
<td>12.4%</td>
<td>12.8%</td>
<td>+2.3%</td>
</tr>
</tbody>
</table>

Source: US Census of Population

Of residents twenty-five years of age and older in the county, approximately 16.5% have less than a high school diploma, 35.4% have a high school diploma or equivalent, and 48.2% have some college education and above. Table 5 below more fully illustrates the educational attainment of Richland County residents.
TABLE 5
Highest Level of Educational Attainment
*Population 25 years and older*

<table>
<thead>
<tr>
<th>Educational Attainment</th>
<th>Richland County</th>
<th>Montana</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School Diploma</td>
<td>16.5%</td>
<td>12.8%</td>
<td>19.6%</td>
</tr>
<tr>
<td>High School Diploma (or equivalent)</td>
<td>35.4%</td>
<td>31.3%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Some College</td>
<td>24.4%</td>
<td>25.6%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Associates Degree</td>
<td>6.5%</td>
<td>5.9%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Bachelors Degree</td>
<td>14.1%</td>
<td>17.2%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>1.7%</td>
<td>4.6%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Professional Degree</td>
<td>0.8%</td>
<td>1.7%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>0.7%</td>
<td>0.9%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Source: U.S Census Bureau, Census 2000

Located north of the interstate highway system, Richland County is only accessible by narrow, two-lane roadways. In addition to the five municipalities, there are over a dozen small communities within the county that were settled by homesteaders in the late nineteenth and early twentieth centuries. These communities are separated by long distances and can often only be reached by unpaved roads. In recent years, census estimates report a growth away from the smaller communities; however, as the size of these communities become smaller and the medium age of the population older, it is increasingly challenging to ensure that residents have access to the services they need. In particular, these very small and isolated communities in the county have undergone a demographic shift where younger family members have moved to acquire education or pursue better employment opportunities and the seniors have remained. Delivering health care services (especially emergency medical services) and public health

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9 Richland County Planner Office, Richland County Growth Policy.
education to residents in these rurally isolated and increasingly aging communities poses a significant challenge to the county’s health care services community.

Moreover, seniors in Richland County live in a diverse set of housing environments. The county has three assisted living facilities, an extended care facility, and a significant proportion of seniors continue to live independently. As noted above, the small, isolated communities in the county are increasingly aging, and in recent years, there has been a decline in seniors moving into town from these communities. Historically, as farmers and ranchers retired, they frequently moved into town to be closer to services and often a family member would continue to farm and ranch on the family’s land. However, with the growing exodus of children and family members from the small farming communities to town or to larger areas, many seniors are choosing to stay on their farms for longer. The changing demographics of communities within the county coupled with increased life expectancy has altered senior needs and placed new strains on local services for the aging. Table 6 below illustrates the utilization of three different senior services between 2003 and 2009.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Life Line</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Home Delivery Meals</td>
<td>83</td>
<td>86</td>
<td>93</td>
<td>94</td>
<td>88</td>
<td>87</td>
</tr>
<tr>
<td>Congregate Meals</td>
<td>578</td>
<td>681</td>
<td>623</td>
<td>584</td>
<td>480</td>
<td>446</td>
</tr>
</tbody>
</table>

Source: Richland County Commission on Aging and Sidney Police Department

This data demonstrates that from 2003 – 2009, demand for Life Line services increased 300% and home delivery meals overall increased 4.8%, though numbers in 2009 are down from
numbers between 2005 and 2007. Moreover, congregate meals showed increased demand until 2006 and then decreased thereafter. The relative decline in congregate meals is largely due to increased infirmity among the elderly, which in turn reflects the increased longevity of the population. Additionally, many younger seniors in the county are choosing to work longer and therefore do not utilize the service.

In regard to available transportation, a county-wide public transportation system does not exist. The Richland County Commission on Aging operates a shuttle service in collaboration with the Department of Transportation that operates Monday through Friday in Sidney and services the other municipalities on a very limited basis. Some county agencies and community-based organizations also provide transportation services, but these are limited to their individual clients. The lack of county-wide public transportation makes it difficult for individuals who do not have reliable access to an automobile to keep routine medical appointments with health care providers within the county. Furthermore, the lack of public transportation makes it difficult for residents of many income levels to schedule treatment at major hospitals and specialized medical facilities – all of which are located outside of Richland County. Strategies to expand transportation for residents accessing medical care outside of the county are currently in development.

Agriculture and oil production are two of the staples of Richland County’s economy, and these industries have influenced the changing demographics of the area. The confluence of the Missouri and Yellowstone Rivers lies close to the county and creates a 75-mile-long irrigated valley in which grains, sugar beets, corn, beans, and hay are produced. With 548 farms spanning 1,279,300 acres, farming and ranching represent the largest industry in the county and have deeply shaped the culture and strong sense of independence of the area. In addition, much of the
county is located in the Williston Oil Basin, and oil pumping and exploration takes place throughout the area. Gas and oil development has been very lucrative for the county during various booms over the past half century and continues to expand both within Richland County and across the state line in western North Dakota.

In particular, Richland County has undergone three large oil booms since the late 1950s, and with each boom comes an influx of workers. Many of these workers are temporary, though some do move to the area as demonstrated by the spike in population between 1970 and 1990, which coincided with the second oil boom that occurred in the late 70s and early 80s. During the third oil boom, which is currently ongoing, there has been a shortage of housing in the county, and many of the oil workers stay in local hotels or rent apartments and homes in surrounding counties. This housing shortage has subsequently impacted the economic growth of the area and made it challenging for temporary workers to make Richland County their primary residence.

In regard to agricultural workers, Richland County has traditionally experienced an influx of migrant workers during the summer and fall months. Over the years, there have been numerous services within the county to support this community including, a Migrant Health Clinic and a school for children of migrant workers. However, the migrant population in the area has decreased immensely over the past decade which has led to the closing of the migrant school. The Migrant Clinic remains open and provides comprehensive medical exams and preventative services to migrants as well as uninsured individuals in the agricultural sector.

Though Richland County is aging, recent years have seen a simultaneous increase in the county’s most economically productive labor force – the 21-64 age group. This age group is critical to the county’s economy and provides the majority of the tax revenue to operate county government and health and human services. Between 2000 and 2008, this age group increased
from 54.4% to 61% of the population. This significant increase has contributed to the growth of the local economy and improved quality of life in the community as indicated in a recent ranking of counties in Montana. In this report, Richland County ranked 7th out of 44 in the social and economic factors category which include measures of education, employment, income, family and social support, and community safety.

The personal income situation of Richland County is a critical factor shaping residents’ health care access. When viewed in a comparative context, the personal income levels of county residents are higher than the State of Montana but slightly lower than the national averages as of 2007. Table 7 below compares the median household income and per capita income of Richland County, the State of Montana, and the U.S. in 2000 and 2007 and illustrates the extensive economic growth that has occurred in the county during that period of time.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Richland County</td>
<td>$39,348</td>
<td>$16,006</td>
<td>$49,168</td>
<td>$39,360</td>
</tr>
<tr>
<td>Montana</td>
<td>$33,024</td>
<td>$17,151</td>
<td>$43,000</td>
<td>$33,225</td>
</tr>
<tr>
<td>United States</td>
<td>$42,000</td>
<td>$30,318</td>
<td>$52,029</td>
<td>$39,439</td>
</tr>
</tbody>
</table>

Source: 2000 Census; U.S. Department of Commerce; and Richland County Health Profile

10 Montana Department of Public Health and Human Services, 2009 Richland County Health Profile, U.S. Census Bureau, Richland County, MT, 2000.
11 University of Wisconsin Population Health Institute, County Health Rankings, Mobilizing Action Towards Community Health, Feb. 2010.
Moreover, Figure 1 below highlights the percent change in employment from 1997 to 2007 and demonstrates that employment in the county has also increased significantly more compared to the State and nation.

FIGURE 1

As reflected in Table 7 and Figure 1 above, the growth of the oil and gas industry beginning around 2004 has improved the county’s economy and brought wealth to many residents through new employment opportunities and drilling revenues. However, since 2007, there has been a decline in oil and gas development within Richland County as drilling is expanding on the North Dakota side of the Williston Oil Basin at a faster rate. The impact of this decline on the county’s economy and on personal income has not yet been captured in data.

Despite the growth that has occurred, many individuals and families in Richland County continue to live under the federal poverty level; specifically, 12% of the population and 8% of families. In addition, the percentage of female-headed households with children under the age of 18, who are in poverty, is 29.9%, while the percent of female-headed households in poverty with children under the age of 5 is 30.9%. Though these numbers are slightly lower than state and
national rates, this is an important segment of the population which needs public health service support. In particular, there is a significant need within the preventative health care areas of prenatal care and nutrition as children in poverty are much more likely than children in higher income families to experience poor health, malnutrition, and anemia. Additionally, children in poverty are more likely to live in substandard housing, which is typically old and it also often harbors the hazards of lead paint as well as other forms of indoor pollution.

Furthermore, Richland County’s population is served by 10-school districts. Local schools are an integral part of the community and contribute to building community pride and evoking a sense of community in a variety of ways. The Richland County Public Health Department views schools as a valuable partner in their efforts to implement collaborative strategies for the delivery of public health education and services to children and families throughout the county.

Maternal and Child Health Data

In terms of maternal and child health, Table 8 below indicates that Richland County has a higher fertility rate than the state of Montana and the United States though the actual live birth rate falls between the State’s rate and the national rate.

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Live Birth Rate</th>
<th>Fertility Rate Females 15-19</th>
<th>Fertility Rate Females 15-44</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richland County</td>
<td>15.6</td>
<td>38.3</td>
<td>72.9</td>
</tr>
<tr>
<td>Montana</td>
<td>16.1</td>
<td>37.9</td>
<td>66.8</td>
</tr>
<tr>
<td>United States</td>
<td>14.2</td>
<td>35</td>
<td>68.7</td>
</tr>
</tbody>
</table>

TABLE 8
Births of Women and Teens, 2008

Source: Richland County Health Profile, CDC, and World Bank
Note: Rates are per 1000 population
In terms of pregnancy outcomes, Table 9 below summarizes four measures of birth outcomes including low birth weight (< 5 lbs. 8 oz.), short gestation or preterm birth, early prenatal care, and late/no prenatal care.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Richland County</th>
<th>Montana</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of infants born at low birth weight (&lt; 5lbs. 8 oz.)</td>
<td>11.5</td>
<td>7.3</td>
<td>8.2</td>
</tr>
<tr>
<td>Short gestation (&lt; 37 weeks)</td>
<td>12.2</td>
<td>9.8</td>
<td>12.7</td>
</tr>
<tr>
<td>% of mothers who smoked during pregnancy</td>
<td>23</td>
<td>18</td>
<td>10.7</td>
</tr>
<tr>
<td>Prenatal Care (% beginning care in the first trimester)</td>
<td>79</td>
<td>68</td>
<td>83.2</td>
</tr>
<tr>
<td>Late/ No Prenatal Care</td>
<td>19</td>
<td>25</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Source: Richland County Health Profile; Office of Vital Statics, DPPHS; US Health Resources and Services Administration; and the CDC

This table illustrates that Richland County has a higher percentage of babies being born at low birth weight than the State of Montana and the US. Additionally, it demonstrates that the percent of mothers who smoked during pregnancy in Richland County is over double the national rate as well as higher than the State’s rate. In regard to prenatal care, Richland County has a higher percentage of mothers beginning care in the first trimester than the State but lower than the nation and a significantly larger proportion of mothers in the county receive late or no prenatal care than nationwide. This data highlights specific outcomes that both Richland County and the State of Montana need to impact. In particular, this data shows that the county and state need to
work to decrease the number of mothers who smoke during pregnancy as well as expand prenatal care in the first trimester of pregnancy. Furthermore, Richland County needs to examine more fully factors effecting low birth weight and strategize on ways to improve this indicator.

In regard to immunizations, limited data is available at the county level; however, Figure 2 below shows that Montana has the lowest percentage of children between the ages of 19-35 months vaccinated with the 4:3:1:3:3:1 series in the country. Numerous efforts are currently underway at both the local and state level to improve immunization rates as well as the data system that tracks immunizations.

Source: Center for Disease Control
Mortality Data

In recent years, Richland County residents have experienced relatively high rates of addiction and disease as illustrated in Table 10 below, which compares a variety of community health indicators for Richland County with those from the State of Montana and the entire US.

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>Richland County</th>
<th>Montana</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease Death Rate</td>
<td>224.4</td>
<td>198.3</td>
<td>211(^{12})</td>
</tr>
<tr>
<td>Alcohol related motor vehicle fatalities</td>
<td>25%</td>
<td>45%</td>
<td>32%</td>
</tr>
<tr>
<td>Suicide Rate (per 100,000)</td>
<td>19.8</td>
<td>20.3</td>
<td>11.1(^{13})</td>
</tr>
<tr>
<td>Death Rate</td>
<td>10.9</td>
<td>9.0</td>
<td>8.1(^{14})</td>
</tr>
</tbody>
</table>

Source: Montana Department of Transportation; National Center for Health Statistics; CDC; Richland County Health Profile

In particular, this table shows that the county has a significantly higher heart disease death rate than the State and the nation as well as a higher overall death rate. However, Richland County’s high heart disease death rate is largely attributed to its increasingly aging population as this figure is not age-adjusted. In regard to suicide rates, the county’s rate is slightly lower than the State’s but significantly higher than the national rate. Suicides persists as a major public health

\(^{12}\) http://www.cdc.gov/nchs/fastats/heart.htm
\(^{13}\) http://www.cdc.gov/nchs/fastats/suicide.htm
\(^{14}\) http://www.cdc.gov/nchs/fastats/deaths.htm
problem in Montana, and as of 2007, Montana was ranked 48th in state rankings of suicide rates.15

Another important indicator connected to community health and safety is mortality and injuries related to motor vehicles. As noted previously, the county has mostly two-lane narrow roads in rurally isolated areas where driving speeds are often exceeded since traffic is light. Many of these roads are unpaved, have places with loose gravel and during the winter months, are often covered in ice and snow causing dangerous road conditions. The combination of road design, topography, weather, alcohol use, and no seatbelt law has led to high rates of motor vehicle mortality and injury in the county. In fact, Richland County has a significantly higher rate of unintentional injuries than the State of Montana and the U.S. and the rate of deaths from motor-vehicle accidents is over two times the national rate. Table 10 above shows that in regard to alcohol related motor vehicle fatalities, Richland County has a lower rate than the State and nation. However, Table 7 below illustrates that the unintentional injury death rate in Richland County from motor vehicle accidents is over double the national rate. Therefore, there are multiple factors in addition to alcohol consumption impacting the county’s high rate of motor vehicle fatalities and all of these factors need to be examined in detail and addressed in order to more fully ensure the health of county residents.

<table>
<thead>
<tr>
<th>Unintentional Injury Death Rate (per 100,000 population)</th>
<th>Richland County</th>
<th>Montana</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>77</td>
<td>61</td>
<td>40.6</td>
<td></td>
</tr>
</tbody>
</table>

In addition to unintentional injuries, the other two leading causes of death in Richland County are cancer and heart disease. Table 12 below more fully summarizes causes of death in the county.

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Total Cases (2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>23</td>
</tr>
<tr>
<td>Accidents</td>
<td>11</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>11</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>5</td>
</tr>
<tr>
<td>Nephritis</td>
<td>4</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1</td>
</tr>
<tr>
<td>All other causes</td>
<td>57</td>
</tr>
<tr>
<td>Total Deaths</td>
<td>112</td>
</tr>
</tbody>
</table>

Source: Office of Vital Statistics, DPPHS

The data presented in Table 12 above show that Richland County has high rates of mortality for pathologies closely linked to the environment. For example, heart disease, accidents, cardiovascular disease, and many cancers are linked to some degree to dietary practices, environmental, as well as geographic factors. Regarding cancer deaths, Table 13 below details the number of deaths between 2005 and 2008 for various types of cancer for males and females respectively.
In particular, this table shows that from 2005-2008 more men died of cancer than women.

Additionally, for both men and women, Trachea, Lung and Bronchus cancer accounted for more than 20% of the cancer mortality and Colon, Rectum, and Anus cancer also accounted for a high proportion of the cancer deaths. Many of these cancers are linked to unhealthy dietary factors and environmental factors and in general, preventative education in the areas of dietary practices and addiction as well as expanding screening efforts, may help to reduce cancer mortality in the county.
Summary of Demographic Factors and of Health Status in Richland County

The analysis in section 1 identifies major demographic factors impacting the public health of residents of Richland County. It also provides an overview of the county’s public health status. A summary of key demographic trends and health status indicators for residents of the county are summarized below.

- Richland County’s population has fluctuated between 1950 and 2008 and overall, has experienced a decline. However, the true population is estimated to be larger than indicated as census data only counts permanent residents and not the temporary workers in the agricultural and oil and gas sectors that are currently in the area.

- The large geographical size of Richland County, which is characterized by dispersed and isolated communities and households, raises many barriers to accessing health care facilities. Residents requiring specialized medical services often must travel long distances to facilities in other counties or across the state line to North Dakota. No transportation system is currently in place to facilitate this travel.

- Richland County’s population is increasingly aging and at a faster rate than the State of Montana and the US. As this population grows, it will place significant demand on the county’s public health care delivery system and social service organizations. In addition, particular attention will need to be paid to elderly women.

- From 2003 to 2009, Richland County saw a 300% increase in demand for Life Line services and a 4.8% increase in home delivery meals, while utilization of congregate meals has decreased. These shifts in utilization are largely due to increased infirmity among the elderly, which in turn reflects the increased longevity of the population.

- Though aging, Richland County has seen a simultaneous increase in the 21-64 age group from 54% in 2000 to 61% in 2008. This increase has strengthened the county’s economy and led to an increase in both median household income and per capita income.

- The percent of children and residents in poverty is lower than state and national averages. However, the situation of children in households headed by females which are in poverty is of pressing concern. In Richland County the percentage of female-headed households with children under the age of 18, who are in poverty, is 29.9%, while the percent of female-headed households in poverty with children under the age of 5 is 30.9%.

- In regard to pregnancy outcomes, Richland County has a higher percentage of babies being born at low birth weight than the State of Montana and the US and the percent of mothers who smoked during pregnancy in the county is over double the national rate as well as higher than the State’s rate. Additionally, Richland County has a higher percentage of mothers beginning prenatal care in the first trimester than the State but
lower than the nation and a significantly larger proportion of mothers in the county receive late or no prenatal care than nationwide.

- Montana has the lowest percentage of children between the ages of 19-35 months vaccinated with the 4:3:1:3:3:1 series in the country.

- Suicide persists as a major public health problem in Montana, and as of 2007, Montana was ranked 48th in state rankings of suicide rates. Between 2004 and 2008, Richland County had a significantly higher rate of suicide than the nation, but a slightly lower rate than the rest of the State.

- Richland County has a very high unintentional injury death rate in terms of both non-motor vehicle and motor vehicle related fatalities. In particular, its rate of motor-vehicle fatalities is over two times that of the US. These high rates are in part due to a combination of road design, topography, alcohol abuse, severe winter weather, and no seat belt law.

- Richland County has high rates of mortality for pathologies closely linked to the environment and preventative education in the areas of dietary practices and addiction as well as expanding screening efforts may help to reduce mortality from heart disease, cancer, and unintentional injuries - the three leading causes of death in the county.
ACCESS TO CARE

The past two decades have seen dramatic economic changes in the health care industry in the United States, and access to health care in Richland County has been impacted in regard to residents’ ability to afford services, the structure of the county’s health care delivery system, and types of services offered. During this assessment process, as residents navigated through their experiences living in the community and accessing health care services, it became evident that there is a mutually reinforcing and reciprocal relationship between people and the places they live. By assessing the current structure of the county’s health care services in conjunction with residents’ health access behavior, this section strives to more fully examine this relationship in order to identify financial, structural and personal barriers to accessing care.

Financial Barriers

Numerous financial barriers exist in Richland County that serve to limit access. During the assessment process, issues of insurance coverage were cited consistently as one of the most important barriers to accessing health care as 19% of the county’s population under the age of sixty-five is uninsured compared to the national average of 15.4%. 16 In addition, through the survey and interview processes, many residents who have coverage identified themselves as underinsured and often noted that they did not have dental and vision coverage. Health insurance is a critical factor in influencing timely access to health care. Research indicates that persons without insurance are less likely to have a “regular” health provider, to obtain preventative care, and to obtain needed tests and prescriptions. Moreover, the Department of

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Health and Human Services has recently identified health insurance as one of the 10 “leading health indicators” and as an important determinant of health status. ¹⁷

Due to the structure of health care and health insurance in the United States, the employment base of the county has a significant impact on the percentage of insured and type of insurance coverage that residents have. At 2.8% unemployment, the vast majority of residents are employed but many of these jobs do not provide adequate insurance coverage if any at all. The survey currently being conducted throughout the county will provide more detailed data about insurance coverage and how it is obtained. However, interviews with health care service professionals and residents did reveal some important aspects of the link between type of employment and insurance coverage within the county.

In particular, individuals spoke to the challenges that farmers and ranchers face acquiring health insurance at an affordable premium. Of the 548 farms in the county, 83% (455) are independently owned and financed.¹⁸ Unlike the corporately owned farms, private farms are responsible for covering all of their own health insurance expenses. Purchasing insurance privately can be a very expensive expenditure especially when farmers are struggling to make a living as one farmer notes below.

When we first got married [1982], our health insurance was $60 a month, gas was 60, 70 cents a gallon and we were getting $3 for a bushel of wheat. We are still getting $3 for a bushel of wheat but our insurance is $2000 a month and fuel is close to $3 a gallon. Imagine how much fuel it takes to fill up a truck or tractor.

(P25, 11/12/09)

With the rising expenses of operating a farm, many residents also spoke of rising debt. As it becomes harder for farmers and ranchers to stay in business in the area and to become debt free, it is becoming more challenging to afford health insurance coverage. This challenge is compounded by many federal assistance programs’ eligibility criteria, such as Medicaid, that count the value of assets. For farmers and ranchers, including the value of their farm’s assets into the eligibility equation serves as a major barrier in accessing needed assistance. Due to high premiums and the economic realities of farming and ranching today, 80% of the farmers and ranchers interviewed discussed not being able to afford a traditional insurance plan and instead, purchasing a major medical, high deductible plan. These individuals also noted that the high out-of-pocket expenses associated with these plans serve as a disincentive to going to the doctor especially for preventative services.

With 12.4% of families and 29.9% of female-headed households with children under the age of 18 living in poverty, individuals involved in the assessment identified this population as facing unique challenges in accessing care in the area. Many of the parents in these families do not have jobs that provide health insurance coverage and cannot afford to purchase insurance independently. The eligibility guidelines for Healthy Montana Kids (previously known as CHIP) have continued to expand over the past few years and as a result, more and more children qualify; however, there are still uninsured children who do qualify but are not enrolled in the program as well as ones in need, but do not qualify. As one woman noted, “We make too much for that, for Medicaid and CHIP, but we live in low income and we are living from pay check to pay check so tell me how do we not qualify for Medicaid when we live from pay check to pay check?” (P21, 12/15/09) This mother also reported having to skip her child’s cardiologist appointment to examine the hole in his heart because the specialist is in Bismarck and now that
she lost the Healthy Montana Kids insurance, she cannot afford the appointment. In addition, multiple health care service professionals discussed the challenges of insuring the low-income parents within the community, “If a woman was pregnant she could temporarily get Medicaid, but a month after the baby is born, the parent loses the Medicaid. So there are a lot of issues with the mom not being able to get insurance to cover her medical needs while their children often qualify for the CHIP program” (P17, 1/26/10).

For seniors insured by Medicare, health care service professionals and residents discussed the Medicare prescription drug coverage plan (Part D) and specifically, the “donut hole” between the initial coverage limit and the catastrophic coverage threshold, as a significant barrier to accessing needed medications. Medicare beneficiaries who surpass the prescription drug coverage limit are financially responsible for the entire cost of their prescription drugs until the expenses reach the catastrophic coverage threshold. This gap places a large financial burden on local seniors and was noted as leading to poor health management.

Additionally, dental and vision coverage is often not included in insurance plans and many working poor people (especially female-head-of-households) and their children lack access to these services. There is a substantial need throughout the area for these services, which was demonstrated when the agency Action for Eastern Montana received a $250,000 grant to provide residents of the region in need of dental, vision or hearing services money. This money was used to provide 145 people with treatment for medical needs that were impeding their ability to find and/or retain employment. Dozens more people applied, however the funds ran out within the first three weeks of the program. The success of this program speaks to the extent of need in the area and demonstrates that there is a significant proportion of people who do not have the money or insurance to receive medical care for conditions that are impacting their quality of life and
ability to work. Moreover, during the assessment process, individuals documented refraining from accessing preventative dental care and delaying visiting a dental practitioner until their condition became an emergency. Expanding access to these specialized services is necessary to address the needs of economically disadvantaged individuals throughout the county.

**Structural Barriers**

As a frontier community, there are numerous structural barriers in Richland County that impede access to health care services. These barriers include: limited availability of services and limited hours; locational pattern of health care services; no Veterans Affairs services within the county; limited first-response capabilities; and the evolving configuration of the health care delivery system.

Within Richland County, there are a variety of primary care providers and specialists (please see Appendix A for a detailed list). The majority of these providers are affiliated with the Sidney Health Center, a critical access hospital located in Sidney. There are also two clinics located in Fairview, the Migrant Health Clinic and MonDak Clinic which are both staffed by nurse practitioners. Additionally, the county has an emergency department located at the Sidney Health Center that is staffed by a registered nurse with an on-call Physician 24 hours per day. Given the size and structure of the county, these services are significantly more extensive than what is available in many similar communities throughout Montana; however, during the assessment process, residents discussed how access to these services is limited by the difficulty of making appointments with primary care providers, poor follow-up after emergency care, high physician turn-over, and limited hours.
Across the United States, there are health care workforce shortages, with the most severe being in rural areas and in medically underserved and at risk population groups. Rural health care workforce shortages have been documented as carrying a negative impact on health care quality through reduced health care access as well as through increased stress on providers.\textsuperscript{19} The health care service community in Richland County is understaffed and recruitment and long-term retention pose significant challenges. In recent years, there has been a high turnover of physicians and many of the physicians who are still working in the county are nearing retirement age. In addition, there is a current debate regarding the balance of specialists and primary care physicians and tensions regarding recruitment lie both within the medical community and between the medical community and local residents. This debate further compounds the challenges of recruiting and retaining providers.

Of residents interviewed during the assessment, 75\% reported finding accessing primary care challenging. As one individual noted,

Getting an appointment, uh, that’s the worst for people I think. We don’t have enough doctors and they don’t work on Fridays and Saturdays, maybe a half day on Friday, but they are difficult to get into. Because it is hard to get in, at times I have had to go to new doctors and pay the $180 new patient fee, simply because I couldn’t get into my primary care physician.

(P24, 12/8/09)

A shortage of providers has led to high patient loads and as a result, some of the primary care physicians in the county have stopped accepting new patients. Because of limited availability, when needing an appointment, many residents reported having to call around to the various physicians to find an opening or go to the emergency room, both of which result in extra costs. Recognizing this challenge, the Sidney Health Center created a hotline service for individuals to call and reach an operator who can then try to find an available appointment. Both residents and

health care service professionals discussed frustration with this system and noted that it does not resolve the problems of cost and continuity of care, as residents then have to develop a rapport with a new physician as well as sometimes pay the expensive new patient fee. These frustrations and challenges have been further exacerbated in recent months with the loss of two internal medicine physicians. Because of high turnover and difficulties making appointments, many residents documented going to Williston, Bismarck and/or Billings for general and specialized care.

To address some of these challenges to primary care access, the Sidney Health Center opened a Saturday walk-in clinic that operates from 9am to 12pm every week. This clinic has been extremely well received by community members as one resident noted,

I think that the Saturday Clinic is a wonderful thing! I have a high deductible plan and I don’t want to pay for the emergency room so I am not going to go unless I think it is life or death. I do go to the walk-in clinic though and if there is one thing that I could change, it would be that there is an everyday, all day walk-in clinic…if that were available it would be so helpful, because access to a physician in Sidney is the hardest thing.

(P22, 11/9/09)

This quotation demonstrates that the Saturday Clinic does not only expand access to care, but because of its accessibility, it encourages better health management as residents are more inclined to seek medical attention in a timely fashion. The success of this clinic therefore reveals that finding innovative ways to expand access to care in the community will have a positive impact on the health status of residents.

All medical services apart from the emergency department have limited hours and are generally open until 5pm on Monday through Friday. In addition, the majority of health care services are focused in Sidney including all dental and optometry offices. This locational pattern\(^\text{20}\) disproportionately affects residents of all ages who reside in municipalities and

\(^{20}\) View Appendix D for a map of Richland County that illustrates this locational pattern
communities outside of Sidney, particularly those who live in the small isolated communities dispersed throughout the area, and it also impacts poor people who lack transportation, elderly who have mobility problems and cannot drive, and the chronically ill who need to frequently visit health care facilities. This situation is unlikely to change as long as the regionalization of the health care delivery system continues and the county lacks a public transportation system, which is not an economically viable solution given the structure of the region.

The lack of VA medical facilities in Richland County is an additional structural barrier and specifically impedes access to care for veterans in the community. The closest VA facility in Montana is located approximately fifty miles away in Glendive and provides primary care as well as long-term care services. For more serious medical conditions and consultations, veterans in the community must travel over 250 miles to Billings or 500 miles to Fort Harrison in Helena. Without a transportation system, this travel is extremely costly and challenging for many residents, as evidenced by the story that one health care service professional told about her client:

We have an elderly veteran here who used to go to Glendive and he had to pay somebody because he couldn’t drive that far and his car wouldn’t hold up. Now he is too sick so he doctors here [Sidney] and uses his Medicare. He doesn’t have supplementary insurance anymore so he has huge bills and the little saving he had is almost gone because he has had to use it all to pay for what Medicare doesn’t cover and it’s just because he can’t go back and forth from Glendive anymore.

(P17, 1/26/10)

As a result of these transportation challenges, many veterans have “had to choose to stay at Sidney Health Center and have no coverage or try to find a way to get to Fort Harrison, and a lot of them are too sick and can’t afford an ambulance to drive them up there, so they are stuck” (P32, 2/3/10). Furthermore, for veterans in need of mental health services, it is very challenge to receive adequate care when living in Richland County. Though the number of veterans living in the county who have seen active duty since the beginning of the wars in Iraq and Afghanistan is
unknown, individuals in the military community have estimated that it is approximately forty to fifty people. There has been one deployment of the local National Guard platoon to Iraq. These guards were part of the infantry and as one guard member noted, “they saw a lot of bad stuff and there are some who do have issues and are seeing counselors but they have to drive… and it’s real challenging when the closest person is 60, 80, 100 miles away and they don’t feel safe driving” (P31, 2/2/10). Significant strides have been made by the VA to expand telehealth and video conferencing capabilities so that veterans in rural parts of the country can receive such services as mental health counseling, medical exams, and health education without having to travel. However, these telehealth services are not available within Richland County and the closest telehealth VA clinic is located in Glasgow which is over 100 miles away.

Additionally, Richland County’s team of Nationally Registered Emergency Medical Technicians (EMTs) who provide services throughout the county with ambulances in Fairview, Lambert, Savage and two in Sidney, face structural barriers to the provision of quality care. This service is county-owned with operations administrated by Sidney Health Center. Across the United States Emergency Medical Services (EMS) are struggling as one EMT noted, “Rural EMS is just about failing and we can’t really figure out why. Ambulance stations are shutting down across the nation because they can’t find EMTs, can’t find funding” (P15, 1/6/10). Richland County’s EMS team has become significantly stronger in recent years as a result of financial support from the county. However, the team continues to face challenges to providing timely, quality care because of the structure of the county and the fact that EMS is comprised of volunteers.

The rural topography and dispersed population of the area makes it difficult for EMTs to locate and travel to individual homes quickly. In recent years, there has been a trend among
residents to move away from the smaller communities and into town. As these rural communities continue to get smaller, they are also becoming more isolated and it is challenging for EMTs to develop familiarity with the extensive road system spanning the county. Some residents from these more rural areas documented times while being interviewed when ambulances were lost on a call. In an effort to make accessing these communities and homes more accessible for EMTS, the county developed a rural address system that is based on where in relation to county roads the home is located. This system is extremely difficult to understand however, and will soon be replaced by a GPS system.

Like many emergency services in rural communities, Richland County’s EMS is staffed by volunteers who are paid on a fee per call basis. Due to the fact that all EMTs are volunteers, their time is limited and subsequently, only one mandatory meeting is held a month during which all new trainings and updates must occur. Though EMTs study maps, it is difficult to become very familiar and comfortable with the vast network of roads in the county given the limitations of volunteer time. Furthermore, recruiting and retaining volunteers is challenging because of a number of factors including, less people volunteering and potential difficulties for certain individuals who may have to leave work in order to respond to a daytime call.

Another important structural barrier to access is the evolving configuration of the health care delivery system in the county. The economics of the health care industry has caused a significant realignment of health care services throughout the nation. Subsequently, small towns and communities across the country, which years ago had a medical doctor practicing and living in the community, no longer have any health care professionals. This development has reduced convenient access to health care professionals. In addition, because of this restructuring, current health care professionals often lack an understanding and awareness of local public health trends
and attitudes at the individual community level. When providers lived in or close to the communities they served, they came to know local families and became very knowledgeable about the communities and about individuals’ medical histories. This situation has changed dramatically as many health care professionals in the area work in communities throughout northeast Montana and at times northwest North Dakota, providing specialized medical services to area clinics and then returning to their home hospital. This situation leads to less community-level contact and impacts health care service professionals understanding of local health care conditions.

**Personal Barriers**

For residents of Richland County multiple personal barriers exist that impede access to health care services. In particular, the rural culture and heritage of Richland County has created a strong sense of personal independence and self-reliance. As a result, residents and health care service professionals discussed how many within the community do not accept public assistance and rather, rely on friends and family. Such individuals also discussed delaying seeking care until they are in need of serious medical attention and not being receptive towards preventative health care services. This cultural ideology subsequently serves as a barrier to the goal of public health officials to raise the level of public health in the county.

Interviews also revealed a pattern of misinformation or lack of information about public health programs and services in the county. A low level of public knowledge is a significant personal barrier to receiving public health services and counsel. Additionally, limited educational opportunities and a non-diverse professional sector have led young people to move away from the county, leaving many seniors without the support of their extended families.
Among these seniors, there is a need for medical advocacy to help individuals navigate through the medical system and ensure that their needs are met. Not having such an advocate serves as a personal barrier to accessing optimal care.

A summary of the commonly-identified barriers to accessing health care services as well as the affected sub-groups in the population are presented in Table 8.

### TABLE 14
Summary of Barriers to Health Care

<table>
<thead>
<tr>
<th>Type of Barrier</th>
<th>Population Group Impacted</th>
<th>Nature of Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial Barriers</strong></td>
<td>Farmers and Ranchers</td>
<td>- Inadequate health insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No health insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No dental and vision insurance coverage</td>
</tr>
<tr>
<td></td>
<td>Families living below the poverty line, Female-Headed Households</td>
<td>- Inadequate health insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No health insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No dental and vision insurance coverage</td>
</tr>
<tr>
<td></td>
<td>Seniors</td>
<td>- Inadequate prescription drug coverage</td>
</tr>
<tr>
<td><strong>Structural Barriers</strong></td>
<td>All residents (especially rurally isolated, seniors without transportation, and the chronically ill)</td>
<td>- Too few primary care physicians</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Lack of specialized medical services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Long travel distances to access health care services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Limited hours of operation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Lack of county-wide transportation system</td>
</tr>
<tr>
<td></td>
<td>Veterans</td>
<td>- No VA medical facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Long travel distances to access VA services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No transportation to VA facilities</td>
</tr>
</tbody>
</table>
| **Personal Barriers** | **All residents** | **- Rural culture and heritage of Richland County**  
|                     |                 | **- Lack of information and misinformation about public health programs and services** |
| **Seniors**         | **- Lack of medical advocates** |
Appendix A: Richland County Medical Providers and Services

Medical Providers

Family Medicine:
  Dr. O. Pete Council, Sidney Clinic Suite # 104
  Additional Specialties: Critical illness, Obstetrics, Emergency Room Medicine, & Pediatrics
  (406) 488-2370

  Dr. Carlos Trevino, Sidney Health Center Medical Arts Building
  (406) 488-2574

Pediatric Medicine:
  Dr. George Skordalakes, Sidney Clinic Suite # 111
  (406) 488-3921

Internal Medicine:
  Dr. Rajohn Karanjai, Sidney Clinic Suite # 110
  Additional Specialties: Heart Disease, Cardiac Monitoring, Sleep Disorders, Stroke,
  High Blood Pressure, Diabetes, Thyroid Disorders, Arthritis, Chronic Pain, Fibromyalgia, Skin
  Cancer and Diseases, Family Health, Weight Management, & Anti-Aging Advice
  (406) 488-2560

  Dr. Edward Pierce, Sidney Clinic Suite # 112
  Additional Specialties: Geriatrics & Nuclear Cardiology
  (406) 488-2231

Obstetric/ Gynecology:
  Dr. Constantine Scordalakes, Sidney Clinic Suite # 102
  Additional Specialties: Pelvic Reconstruction Surgery, Minimally Invasive Surgery, &
  Surgery for Urinary Incontinence
  (406)-488-2577

  Dr. Robert Hardy, Sidney Clinic Suite # 102
  (406) 488-2577

General Surgery:
  Dr. Edward Bergin, Sidney Clinic Suite # 105
  (406) 488-2278

Orthopedic Surgery:
  Dr. Lotfi Ben-Youssef, Sidney Clinic Suite # 108
  Additional Specialties: Joint Replacement, Sports Medicine, Shoulder and Upper
  Extremities Surgery, Knee Surgery, & Fracture Repairs
  (406) 488-2277
Ear-Nose-Throat/ Head & Neck:
   Dr. Brett Bennion, Sidney Clinic Suite # 101
   Additional Specialties: Otolaryngology, Head & Neck Surgery, Facial Plastic &
   Reconstructive Surgery, Pediatric Surgeries, Middle Ear Surgeries, Rhinoplasty, & Septoplasty
   (406) 488-2380

Podiatry:
   Dr. Michael LaPan, Sidney Clinic Suite # 103
   (406) 488-2241

Radiology:
   Dr. Gregory Faul, Sidney Clinic Suite # 107
   (406) 488-2280

Pathology:
   Dr. John Andelin, Sidney Health Center Laboratory
   (406) 488 – 2158

Radiation Oncology:
   Dr. Lyle Harrison, Sidney Clinic Suite # 106
   (406) 488-2504

Family Nurse Practitioners:
   Patti Iverson, FNP, Medical Arts Building
   Additional Specialties: Wellness Exams, Short Term Illness & Injuries, & Chronic Health
   Conditions
   (406) 488 – 2501

   Wendy Wiltzen, FNP, MonDak Family Clinic
   Additional Specialties: Family Practice, Annual Exams, Chronic Health Problems, & Repair of
   Simple Lacerations
   (406) 742- 5261

   Jacquelyn Free, FNP-C, Sidney Health Center
   (406) 488-2560

   Joan Turek, FNP, Migrant Health Clinic
   (406) 742-5201

Dentistry:
   Dr. Richard L. Fink, 122 2nd St. SE Sidney, MT 59270
   (406) 433 – 4422

   Healthy Smiles Dental Group, 203 2nd Ave. SW Sidney, MT 59270
   (406) 433-7645

   Dr. Curtis N. Christensen, 1405 4th St. Sidney, MT 59270
   (406) 482-2666

   Dr. Martineau, 401 N. Central Ave, Sidney, MT 59270
   (406) 482-2423
Optometry:
Dr. Cavanaugh, 112 2nd Street Southeast Sidney, MT 59270
(406) 482-2609

Dr. O’Brien, 112 2nd Street Southeast Sidney, MT 59270
(406) 482-2609

Dr. Anderson, Ste 2, 1405 4th Street Southwest, Sidney, MT 59270
(406) 488-2705

Services

Assisted Living:
The Lodge is an assisted living facility designed for senior adults who wish to maintain their independence and provides 24-hour security, service as needed, companionship, home-cooked meals, wellness programs, medication services and nurse-directed programs.

Audiology & Hearing Aid Services:
Provides comprehensive diagnostic audiological services for patients of all ages including hearing aid evaluations, fittings and repairs. Aural rehabilitation, hearing conservation and assistive listening devices (ALDs) are also offered.

Cardiac Rehabilitation:
Cardiac rehabilitation is an outpatient service of Sidney Health Center for individuals who are recovering from a heart attack or related heart condition.

Diabetes Education:
Diabetes Education at Sidney Health Center promotes self-management of diabetes and other chronic diseases through patient education and training in nutrition and diabetes self-management skills.

Eastern Montana Mental Health Center
Provides counseling and possible referral to day treatment, case management (adult and child/adolescent), and therapeutic aide services (child/adolescent).

Emergency Department:
Sidney Health Center’s emergency department is staffed by a team of physicians, nurses, hospital personnel and EMTS who are all trained in emergency care. The department is staffed 24/7 by a registered nurse with an on call-physician.
Emergency Medical Services (EMS):

A team of Nationally Registered Emergency Medical Technicians provide services throughout Richland County with ambulances in Fairview, Lambert, Savage and two in Sidney. The service is county-owned with operations administrated by Sidney Health Center.

Extended Care:

This nursing home facility provides care to those in need of intense physical care, professional nursing, as well as respite care.

Family Planning:

Provides comprehensive women’s healthcare in all aspects of reproductive and preventative health including physical exams; STI testing; cervical cancer screenings; counseling; pregnancy testing; and health education and promotion.

Migrant Health Clinic:

Provides comprehensive medical exams and preventative services to migrants as well as individuals in the agricultural sector.
1015 Highway 200, South Fairview, MT 59221, (406) 747-5201

Outpatient Oncology:

Sidney Health Center’s outpatient oncology clinic provides prescribed chemotherapy treatments, education and support for patients and/or their families.

Rehabilitation Services:

The rehabilitation staff at the Sidney Health Center provides services in inpatient, outpatient, extended care, home health/hospice, and school settings. These services treat patients with various musculoskeletal, neurological, metabolic, systemic, genetic, integumentary and general medical problems.

Richland County Health Department:

Provides a variety of health education and promotion services for children, adults, and families of all income levels. Direct client services include: WIC, immunizations, breast and cervical health program, home visiting, diabetes education and support, tobacco prevention, and vision and hearing screenings for school children.

Saturday Walk-in Clinic:

Operates from 9A.M to 12 Noon at the Sidney Health Center and is staffed by a rotating schedule of medical providers.

Sleep Disorder Center:

A sleep lab is located at the Sidney Health Center and provides sleep studies to determine the cause and treatment for sleep problems.
Appendix B: Health Insurance Survey

Age _____  Gender: M  F  County of Residence ________________

1. Do you have health insurance? Yes or No

2. If yes, what kind of health insurance do you have?
   (Please circle all that apply)

   From your employer  Self-purchased  Medicare

   Military  Medicaid  HIS (Indian Health Services)

3. Do you have a child enrolled in Medicaid/CHIPS? Yes or No

4. How much is your yearly deductible?

   <$500  $500-$1000  $1000-$2000  >$2000
Appendix C: Health Access & Status Survey

Age _____  Sex:  M or F  Community of Residence ____________

1. How many people live in your household? __________

2. Which one or more of the following would you say is your race? (Circle all that apply)
   a. White
   b. Hispanic or Latino
   c. Black or African American
   d. Asian
   e. American Indian

3. Are you currently . . . ?
   a. Employed for wages
   b. Self-employed
   c. Out of work for more than 1 year
   d. Out of work for less than 1 year
   e. A Homemaker
   f. A Student
   g. Unable to work
   h. Retired

4. What is the highest grade or year of school you completed? __________

5. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs or government plans such as Medicare?  Yes  No  Don’t know

6. If no, what is the main reason you are without health care coverage? (Please circle one)
   a. Lost job
   b. Spouse or parent lost job or changed employer
   c. Employer doesn’t offer or stopped offering coverage
   d. Cut back to part time or became a temporary employee, so insurance is not available
   e. Benefits from employer or former employer ran out
   f. Couldn’t afford to pay the premiums
   g. Insurance company refused coverage
   h. Rarely sick; do not need or want insurance
   i. Insurance does not cover the health services that are needed.
   j. Waiting for Medicare SSID (disability)

7. If yes, what type of health care coverage pays for most (or all) of your medical care?
   a. Medicare
   b. Medicaid
   c. Railroad Retirement Plan
   d. The military, Tricare, Champus, or the Veteran’s Administration (VA)
   e. Indian Health Services (IHS)
   f. Health insurance through your work or employer
   g. Health insurance through someone else's work or union
   h. Health insurance bought directly by you
   i. Health insurance bought directly by someone else
   j. Other type of health care coverage ____________________________

8. Is your entire household covered?  Yes  No
9. Do you have a child enrolled in the Healthy Montana Kids Program (funded by Medicaid or CHIP)?
   Yes  No

10. Do you have one person you think of as your personal doctor or health care provider?
    Yes  No
    One person you think of as your personal optometrist?
    Yes  No
    One person you think of as your personal dentist?
    Yes  No

11. When you are sick or in need of routine health care, to which one of the following places do you usually
    go for health care services?
    a. A doctor's office
    b. A nurse practitioner's office
    c. A hospital emergency room
    d. Sidney Health Center's Saturday clinic
    e. Some other place _______________________
    f. No usual place

12. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a
    general physical exam, not an exam for a specific injury, illness, or condition.
    a. Within past year (anytime less than 12 months ago)
    b. Within past 2 years (1 year but less than 2 years ago)
    c. Within past 5 years (2 years but less than 5 years ago)
    d. 5 or more years ago

13. Was there a time in the past 12 months when you or household member needed to see a doctor but could
    not because you were unable to get an appointment?  Yes  No

14. Was there a time in the past 12 months when you or household member needed to see a doctor but could
    not because of cost?  Yes  No

15. Was there a time in the past 12 months when you or household member needed to take a prescription but
    did not fill it or follow the dosage because of cost?  Yes  No

16. How confident are you that you can get the health care you need? Are you….
    a. Very confident
    b. Somewhat confident
    c. A little confident
    d. Not confident at all

17. Would you say in general your health is:
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor
    f. Don't know

18. Regarding your physical health (includes physical illness and injury), for how many days in the past 30
    days was your physical health not good? ______ ______ Number of days

19. Regarding your mental health (includes stress, depression, and problems with emotions), for how many
    days during the past 30 days was your mental health not good? ______ ______ Number of days

20. During the past 30 days, for about how many days did poor physical or mental health keep you from
    doing your usual activities, such as self-care, work, or recreation? ______ ______ Number of days
Appendix D: Map of Richland County
### Appendix E: Clinician Findings

<table>
<thead>
<tr>
<th>Findings</th>
<th>Participants Supporting this Finding</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Many residents of the County have nominal insurance coverage or are uninsured | P1, P2, P3, P4, P5, P8, P10, P11, P13, P15, & P17 | - The donut hole in Medicare Part D is extremely problematic to seniors trying to access prescription drugs  
- There is a major gap in coverage of residents in the area b/c many patients have financial restraints and cannot afford insurance but do not qualify for Medicaid  
- There are many single mothers in the community that are struggling to cover themselves, but often can get their children covered through CHIPS  
- Assistance programs exist and are available, but many are reluctant to utilize them because of stigma and pride |
| Recruitment and retention of medical providers long-term is a significant challenge for the community | P1, P5, P10, P11, P15, & P17 | - Most of the health facilities in the County are understaffed  
- High turnover of doctors in recent years has been perceived by the community as a fault of the Health Center  
- The core of physicians still here is nearing retirement age.  
- There is a tension in the recruitment process regarding bringing in specialists versus primary care providers  
  - “the community is defective in having so many specialists”  
  - “A group of specialists were brought in 5 years ago that did not succeed and we are now seeing the consequences”  
  - “The community feels that there is a need for specialists and this view has greatly impacted the board of the Health Center in its recruitment decisions, but is actually a significant obstacle to competent and |
The Sidney Health Center really needs is a group of highly competent rural family health practitioners who can respond to the diverse medical needs of a rural community.

“Now that there is no longer room for an FP b/c of the numerous Specialists and NPs, it is important that the Health Center begin to recruit a general surgeon to replace Dr. Bergin for he is reaching retirement age.”

“Surgery is the backbone of keeping the hospital open, and there is therefore a need to keep specialists at the Health Center.”

“The county needs more generalized specialists such as internal medicine doctors”

There is a shortage of mental health counselors and services

P5, P9, P 11, P16, & P17

- There are not enough mental health counselors (The county only has 2 counselors)
- There is a substantial need for more pediatric mental health services – children can get outpatient care but no case workers
- There is a real shortage of mental health related hospital care throughout MT and it is extremely challenging for residents of the county to get admitted when needed and this challenge is compounded by issues of transportation
- There is currently a 6 month waiting period to see a psychiatrist in MT
- Due to these overall shortages, mental health care often falls to the primary care provider
- Finding transportation for
The senior population has unique needs in regard to accessing care and medical services

| The senior population has unique needs in regard to accessing care and medical services | P 5, P9, P11, P17 | - Respite care is a major need - particularly for middle class people in the community b/c it is so expensive  
- The nursing home needs more beds  
- Transportation assistance is limited for those who need help getting to and from the doctor  
- There is a need for all seniors to have informed medical advocates  
- There is a need for more home health related services |
| Health Literacy | P1, P3, P5, P7, P10, P12, & P17 | - Linguistic and cultural barriers to health information exist and need to be addressed  
- Where do people access their health information and how accurate is this information?  
- What is the average health literacy of the community and at what literacy level are the health materials that providers and the Health Department disseminate? |
Appendix F: Residents Findings

<table>
<thead>
<tr>
<th>Findings</th>
<th>Participants supporting this finding</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Residents find accessing primary care services challenging | P18, P20, P21, P22, P23, P24, P26, P27, P28, P30, P31, & P33 | - It is difficult to get an appointment with a primary care physician  
  - There are long wait times  
  - Many physicians are not accepting any new patients  
  - Physicians are frequently working outside of Sidney  
  - There is high physician turnover and concern that the doctors who have stayed in the community are nearing retirement  
  - There is limited trust among residents that newly recruited physicians will remain in the community for an extended period of time and as a result, many residents choose to go to Williston to receive their medical care. |
| Many residents are underinsured or uninsured       | P18, P20, P21, P22, P24, P27, P28, P30, P32, & P33 | - Many residents, particularly ranchers and farmers, have high deductable plans and have to pay out of pocket for the majority of their care.  
  - Employer based insurance is limited in the county  
  - Many residents’ do not have adequate prescription drug coverage in their plans  
  - There is a gap in the CHIPS program and as a result, there are still uninsured children in the County  
  - Many residents’ insurance plans do not include dental and vision coverage and residents often cannot afford to pay for these services out of pocket |
<p>| There are gaps in emergency room care              | P16, P19, P21, P22, P23 &amp; P25        | - Except for the walk-in clinic on weekends, there are limited options                                                                 |</p>
<table>
<thead>
<tr>
<th>There are gaps in the services provided to seniors</th>
<th>P16, P17, P21, P23, P27, &amp; P29</th>
</tr>
</thead>
</table>
| for residents when needing to receive treatment Monday-Friday for minor emergencies  
  - Residents documented going to the emergency room for non-emergencies because they were unable to make an appointment with a physician  
  - Residents documented poor continuity of care between initial emergency room visit and follow-up appointments and procedures |
| - There is not enough affordable housing for seniors in the county. In particular, there is a gap in available housing for middle class seniors who need some assistance.  
- The county bus schedule is not fully meeting the needs of seniors in Sidney.  
  - The bus does not run early enough in the morning and it does not run on Sundays. |
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