





2026 COMMUNITY HEALTH NEEDS ASSESSMENT

Big Sky, Montana

Sponsored by

Bozeman Health
Big Sky Medical Center

In partnership with

- *Gallatin City-County Health Department*
- *HRDC*
- *One Health*

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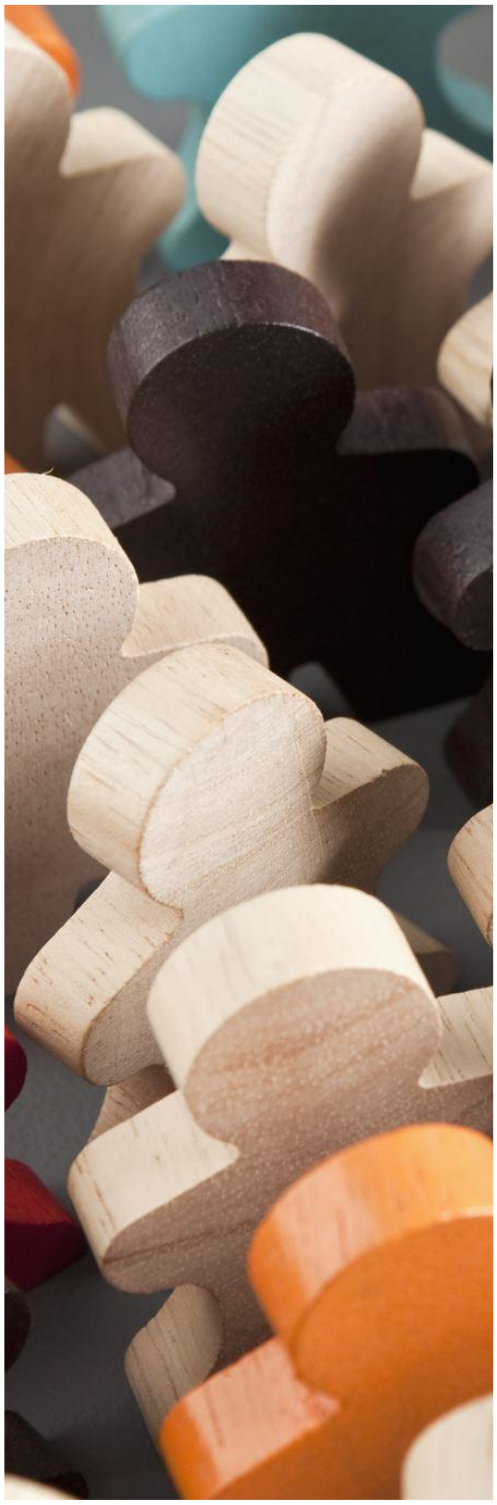
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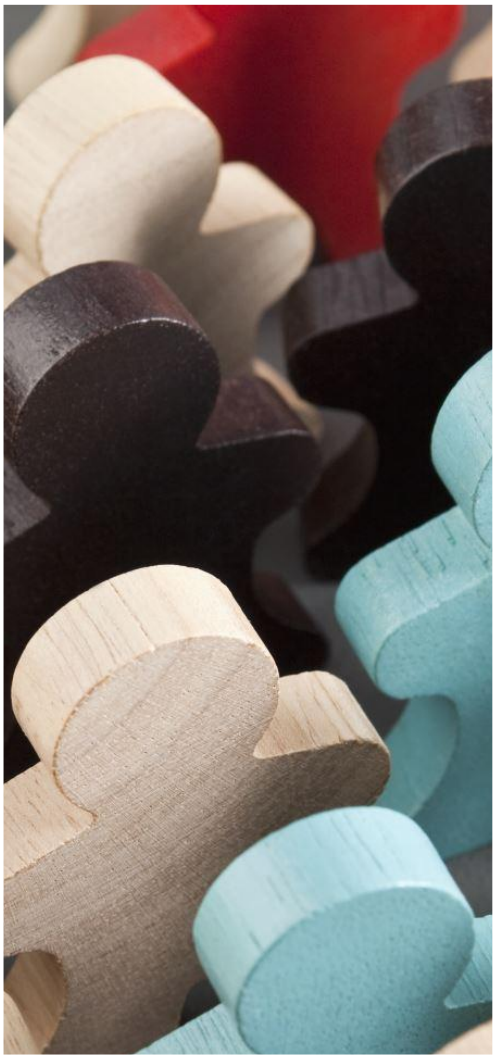
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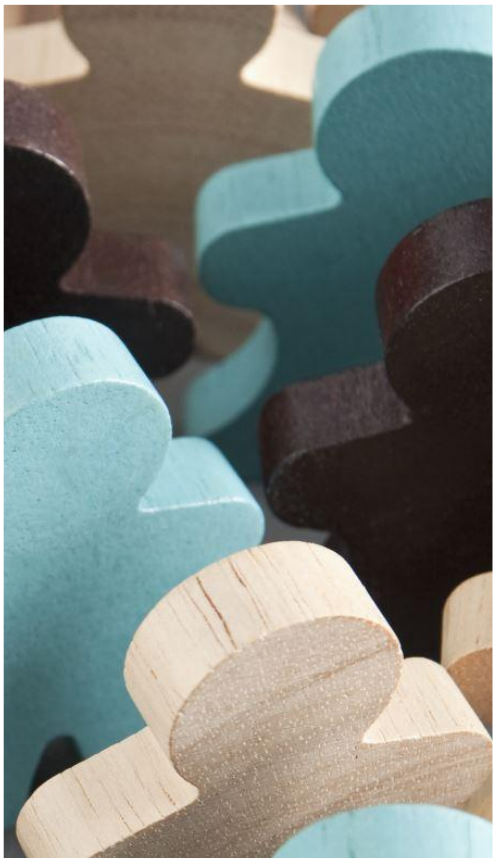
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INTRODUCTION

PROJECT OVERVIEW

This Community Health Needs Assessment — a follow-up to similar studies conducted in 2017 and 2020 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Bozeman Health Big Sky Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of Bozeman Health Big Sky Medical Center by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994. This study is part of a broader, regional project sponsored by Bozeman Health.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

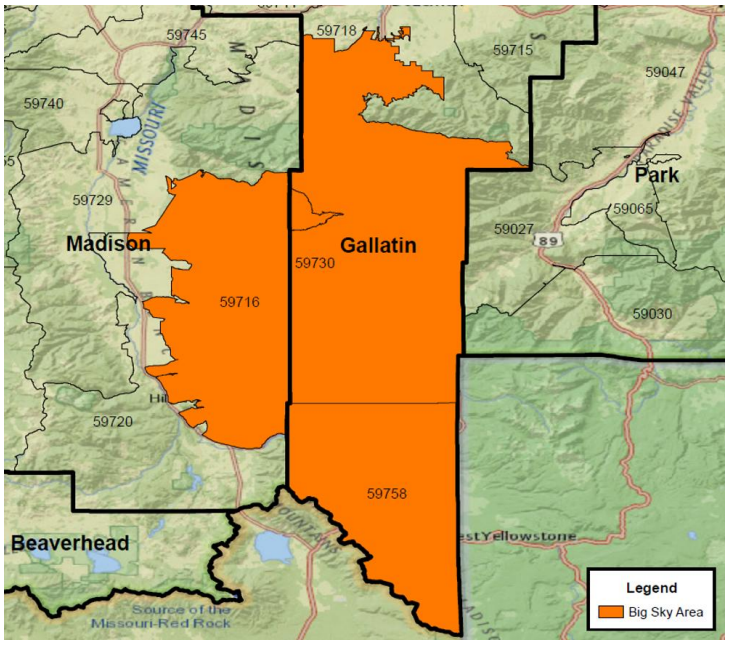
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Bozeman Health and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Big Sky Area” in this report) is defined as the 59716, 59730, and 59758 ZIP Codes. This community definition, determined based on the residence of recent patients of Bozeman Health Big Sky Medical Center, is illustrated in the adjacent map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included targeted surveys conducted by PRC via phone or through online questionnaires, as well as a community outreach component promoted by the study sponsors through a variety of communications, including QR codes and social media postings.

RANDOM-SAMPLE SURVEYS (PRC) ► For the targeted administration, PRC administered 141 surveys throughout the service area.

COMMUNITY OUTREACH SURVEYS (Bozeman Health) ► PRC also created a link to an online version of the survey, and Bozeman Health promoted this link locally in order to drive additional participation and bolster overall samples. This yielded an additional 59 surveys to the overall sample for the Big Sky Area.

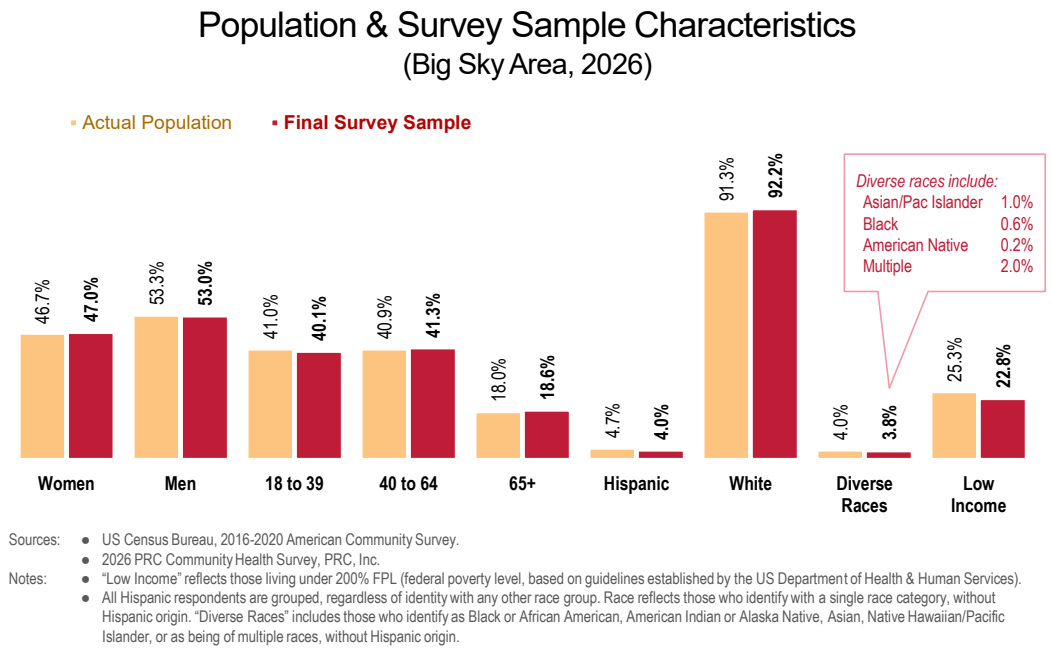
In all, 200 surveys were completed through these mechanisms. The surveys were administered from December 2025 through April 2026. Once completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Big Sky Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 200 respondents is ±6.9% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the Big Sky Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's health care needs, and these children are not represented demographically in this chart.]



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2026 PRC Community Health Survey, PRC, Inc.

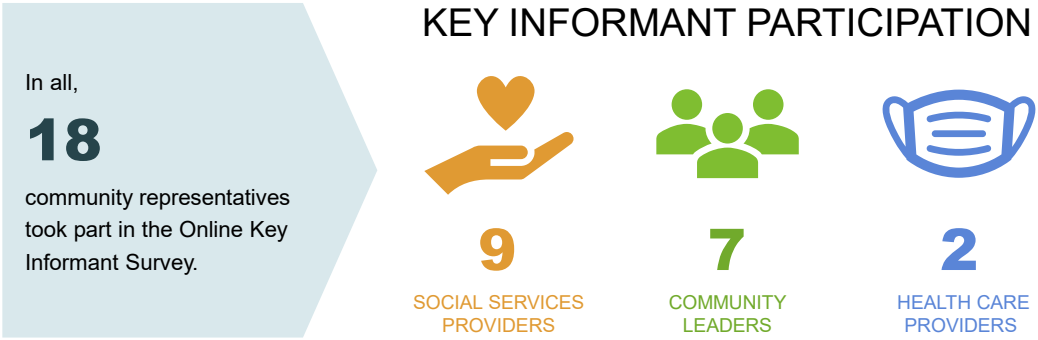
Notes:
- "Low Income" reflects those living under 200% FPL (federal poverty level, based on guidelines established by the US Department of Health & Human Services).
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Bozeman Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders in the Big Sky Area. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. While public health representatives were invited to participate, none ultimately took part in the survey.



Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the following:

- Be Well Big Sky
- Big Sky Chamber of Commerce
- Big Sky Community Food Bank
- Big Sky Community Housing Trust
- Big Sky Medical Center
- Big Sky Resort Tax Board
- Boyne Resorts
- Hebgen Basin Fire District
- Town of West Yellowstone
- Wellness in Action
- West Yellowstone Public School
- West Yellowstone Senior Center
- Yellowstone Club Foundation

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level (Gallatin County) data.

Benchmark Data

Trending

Similar surveys were administered in the Big Sky Area in 2017 and 2020 by PRC on behalf of Bozeman Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators (for Gallatin County) are also included for the purposes of trending.

Montana Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2026 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives (https://health.gov/healthypeople).

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as unhoused persons, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Bozeman Health Big Sky Medical Center made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Bozeman Health Big Sky Medical Center had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Bozeman Health Big Sky Medical Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	24
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	107
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	10
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	11
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	110

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Lack of Health Insurance ▪ Barriers to Access ○ Inconvenient Office Hours ○ Cost of Physician Visits ○ Appointment Availability ○ Difficulty Finding a Physician ▪ Routine Medical Care (Adults)
CANCER	▪ Leading Cause of Death ▪ Female Breast Cancer Incidence
DIABETES	▪ Blood Sugar Testing (Non-Diabetics)
DISABLING CONDITIONS	▪ Alzheimer’s Disease Deaths
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ High Blood Cholesterol Prevalence
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ▪ Distracted Driving
MENTAL HEALTH	▪ Suicide Deaths ▪ Difficulty Obtaining Mental Health Services ▪ *Key Informants ranked this issue as a top concern*.

— continued on the following page —

AREAS OF OPPORTUNITY (continued)	
ORAL HEALTH	▪ Lack of Dental Insurance
SUBSTANCE USE	▪ Alcohol-Induced Deaths ▪ Unintentional Drug-Induced Deaths ▪ Marijuana/THC Use ▪ Drinking & Driving ▪ *Key Informants ranked this issue as a top concern*.
TOBACCO USE	▪ Use of Vaping Products

Community Feedback on Prioritization of Health Needs

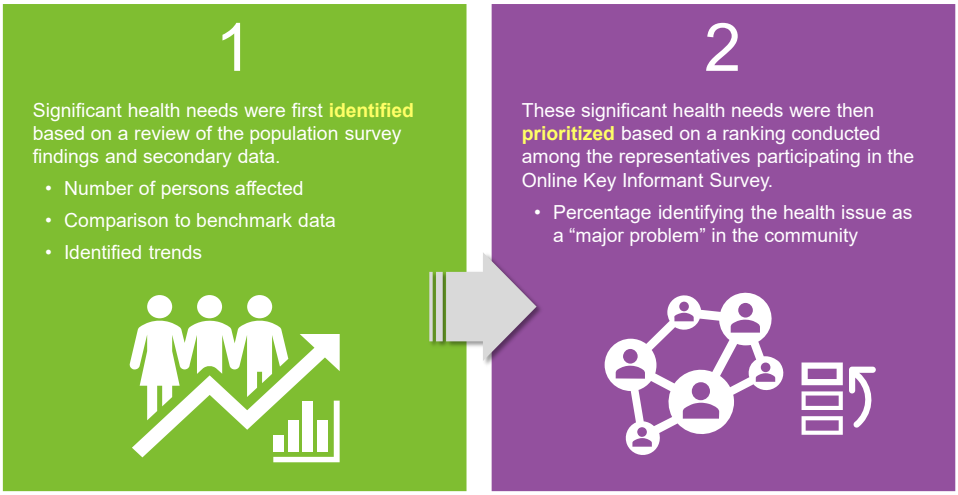
Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Substance Use
2. Mental Health
3. Access to Health Care Services
4. Cancer
5. Injury & Violence
6. Disabling Conditions
7. Tobacco Use
8. Oral Health
9. Diabetes
10. Heart Disease & Stroke

Keep in mind that the **social drivers of health** (especially affordable housing) are an important lens through which to understand and address all of these issues.

IDENTIFICATION & PRIORITIZATION OF SIGNIFICANT HEALTH NEEDS



Hospital Implementation Strategy

Bozeman Health Big Sky Medical Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2017 (or earliest available data). Note that survey data reflect the ZIP Code-defined Big Sky Area.

OTHER (SECONDARY) DATA INDICATORS:
Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade). Local secondary data reflect county-level data.

In the following tables, Big Sky Area results are shown in the larger, gray column.

The columns to the right of the Big Sky Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the Big Sky Area compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DRIVERS OF HEALTH	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
Population in Poverty (Percent)	**9.5** [County-Level Data]	11.5	12.5	8.0	
Children in Poverty (Percent)	**6.4** [County-Level Data]	12.7	16.1	8.0	
No High School Diploma (Age 25+, Percent)	**2.8** [County-Level Data]	5.4	10.4		
Unemployment Rate (Age 16+, Percent)	**2.9** [County-Level Data]	3.7	4.1		4.0
% Unable to Pay for a $400 Emergency Expense	**11.9**		21.3		
% Worry/Stress Over Rent/Mortgage in Past Year	**23.7**		31.0		27.0
% Food Insecure	**14.9**		29.3		
% Experience of Being Unhoused	**5.8**				9.3
		better	similar	worse	

OVERALL HEALTH	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	**6.3**	18.1	21.4		7.4
		better	similar	worse	

ACCESS TO HEALTH CARE	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	**19.7**	11.8	8.5	7.6	16.8
% Difficulty Accessing Health Care in Past Year (Composite)	**53.6**		50.4		44.6
% Difficulty Finding Physician in Past Year	**18.9**		20.6		10.2
% Difficulty Getting Appointment in Past Year	**26.9**		26.6		8.6
% Cost Prevented Physician Visit in Past Year	**25.3**	12.0	16.4		6.2
% Transportation Hindered Dr Visit in Past Year	**8.2**		13.3		16.1
% Inconvenient Hrs Prevented Dr Visit in Past Year	**22.8**		21.9		14.1
% Language/Culture Prevented Care in Past Year	**0.0**		2.6		
% Cost Prevented Getting Prescription in Past Year	**10.6**		14.6		5.9
% Stretched Prescription to Save Cost in Past Year	**8.5**		17.1		9.9
Primary Care Doctors per 100,000	**121.1** [County-Level Data]	121.0	119.6		
% Have a Specific Source of Ongoing Care	**70.9**		67.9	95.1	74.3
% Routine Checkup in Past Year	**59.3**	74.5	74.0		62.9
% Two or More ER Visits in Past Year	**8.4**		14.9		5.9
% Rate Local Health Care "Fair/Poor"	**22.0**		19.7		15.8

ACCESS TO HEALTH CARE (continued)	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
% Outmigration for Health Care Services	**37.7**				
% Worried About Keeping Insurance in the Coming Year	**8.1**				
		better	similar	worse	

CANCER	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000	**114.8** [County-Level Data]	197.7	182.6		107.6
Lung Cancer Deaths per 100,000	**14.8** [County-Level Data]	37.2	38.9		
Prostate Cancer Deaths per 100,000	**19.2** [County-Level Data]	28.7	20.4		
Female Breast Cancer Deaths per 100,000	**19.4** [County-Level Data]	25.5	25.1		
Colorectal Cancer Deaths per 100,000	**11.6** [County-Level Data]	17.3	16.4		
Cancer Incidence per 100,000	**431.9** [County-Level Data]	452.7	448.6		
Female Breast Cancer Incidence per 100,000	**134.1** [County-Level Data]	137.5	69.4		
Prostate Cancer Incidence per 100,000	**132.8** [County-Level Data]	131.0	116.4		
Lung Cancer Incidence per 100,000	**30.7** [County-Level Data]	45.2	52.5		
Colorectal Cancer Incidence per 100,000	**28.5** [County-Level Data]	36.4	36.7		
% Cancer	**7.2**	14.5	10.7		
% [Women 40-74] Breast Cancer Screening	**72.7**		78.0	80.3	79.1

CANCER (continued)	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
% [Women 21-65] Cervical Cancer Screening	**70.5**		74.9	79.2	56.8
% [Age 45-75] Colorectal Cancer Screening	**83.2**		77.5	72.8	68.9
		better	similar	worse	

DIABETES	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000	**9.0** [County-Level Data]	30.0	28.8		8.0
% Diabetes/High Blood Sugar	**4.0**	8.7	15.4		4.6
% Borderline/Pre-Diabetes	**12.0**		13.2		21.5
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	**46.9**				58.9
Kidney Disease Deaths per 100,000	**4.8** [County-Level Data]	13.4	16.7		6.7
		better	similar	worse	

DISABLING CONDITIONS	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	**24.5**		39.9		25.8
% Activity Limitations	**23.9**		32.0		27.1
% High-Impact Chronic Pain	**11.7**		23.2	6.4	
Alzheimer's Disease Deaths per 100,000	**38.3** [County-Level Data]	30.5	34.7		10.4
		better	similar	worse	

HEART DISEASE & STROKE	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000	**129.0** [County-Level Data]	225.4	205.0		115.2
Stroke Deaths per 100,000	**25.9** [County-Level Data]	35.8	49.1		30.0
% Heart Disease	**7.7**	6.7	9.5		4.3
% Stroke	**3.0**	3.3	5.6		1.1
% High Blood Pressure	**36.7**	32.2	41.5	41.9	45.0
% High Cholesterol	**31.7**		36.2		20.8
% 1+ Cardiovascular Risk Factor	**76.5**		86.7		78.8
		better	similar	worse	

INFANT HEALTH & FAMILY PLANNING	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
Low Birthweight (Percent of Births)	**7.5** [County-Level Data]	7.6	8.4		
Infant Deaths per 1,000 Births	**2.9** [County-Level Data]	4.9	5.5	5.0	
Teen Births per 1,000 Females 15-19	**5.5** [County-Level Data]	15.0	15.5		
% [Age 18-49] Unable to Get Reproductive Health Care in the Past Yr	**6.8**				21.2
		better	similar	worse	

INJURY & VIOLENCE	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000	**42.2** [County-Level Data]	68.1	64.2		29.7
Motor Vehicle Crash Deaths per 100,000	**12.2** [County-Level Data]	18.3	12.8		
% Distracted Driving	**59.6**				32.0
% "Always" Use Seat Belts	**87.1**				74.5
% Unlocked Firearm In or Around the Home	**27.7**				31.1
% [Age 45+] Injured from a Fall in the Past Year	**12.6**				
		better	similar	worse	

MENTAL HEALTH	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	**25.6**		20.0		20.0
% Diagnosed Depression	**30.8**	24.7	30.7		28.6
% Diagnosed Anxiety	**29.1**		31.6		
% Symptoms of Chronic Depression	**40.1**		40.1		36.0
% Typical Day Is "Extremely/Very" Stressful	**10.7**		17.9		14.9
Suicide Deaths per 100,000	**18.5** [County-Level Data]	28.3	14.6		22.3
Mental Health Providers per 100,000	**444.7** [County-Level Data]	411.1	340.5		
% Receiving Mental Health Treatment	**26.9**		23.2		21.6
% Unable to Get Mental Health Services in Past Year	**7.4**		9.1		0.4
		better	similar	worse	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	**20.8**		25.4		
% No Leisure-Time Physical Activity	**9.8**	19.1	22.3	21.8	10.1
% Meet Physical Activity Guidelines	**36.4**	32.2	29.2	29.7	29.5
% Overweight (BMI 25+)	**57.9**	67.4	66.4		62.4
% Obese (BMI 30+)	**18.9**	31.0	37.5	36.0	22.6
% Currently Taking a GLP-1 Agonist	**10.3**				

better | similar | worse

ORAL HEALTH	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
% Lack of Dental Insurance	**41.6**		24.8	25.0	48.0
% Dental Visit in Past Year	**63.6**	64.1	63.5	45.0	67.6

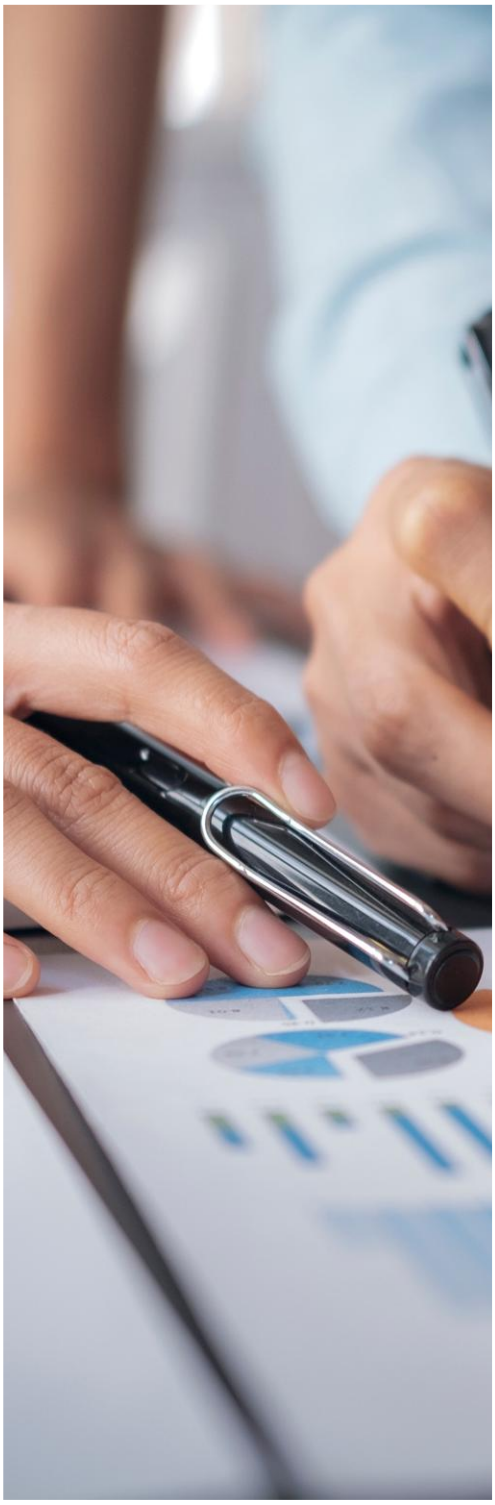
better | similar | worse

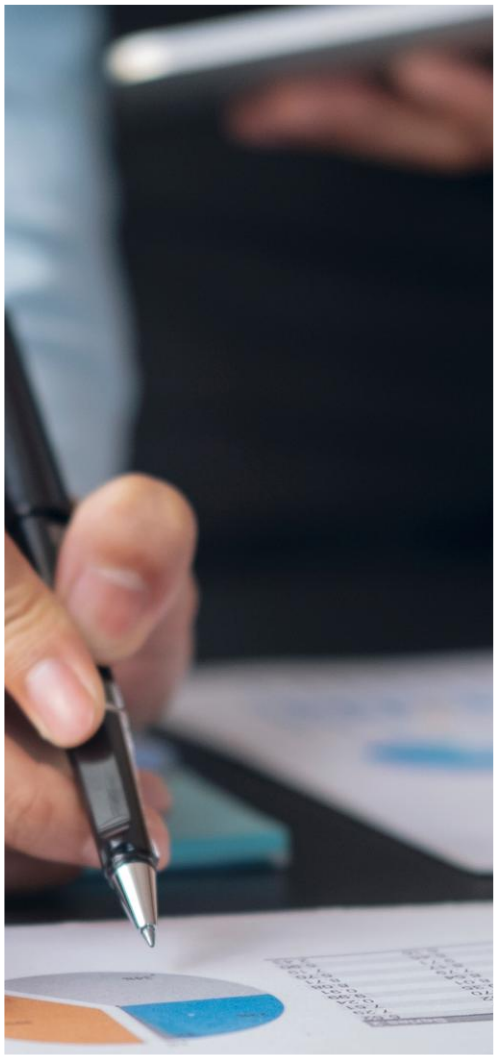
RESPIRATORY DISEASE	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000	**17.7** [County-Level Data]	59.0	43.5		30.0
Pneumonia/Influenza Deaths per 100,000	**4.8** [County-Level Data]	11.0	13.9		8.9
% [Age 18+] Flu Vaccine in Past Year	**33.5**				
% [Age 65+] Flu Vaccine in Past Year	**56.7**	58.4		70.0	66.3
% Asthma	**10.2**	12.3	17.2		7.9
% COPD (Lung Disease)	**5.6**	6.6	8.7		5.7
		better	similar	worse	

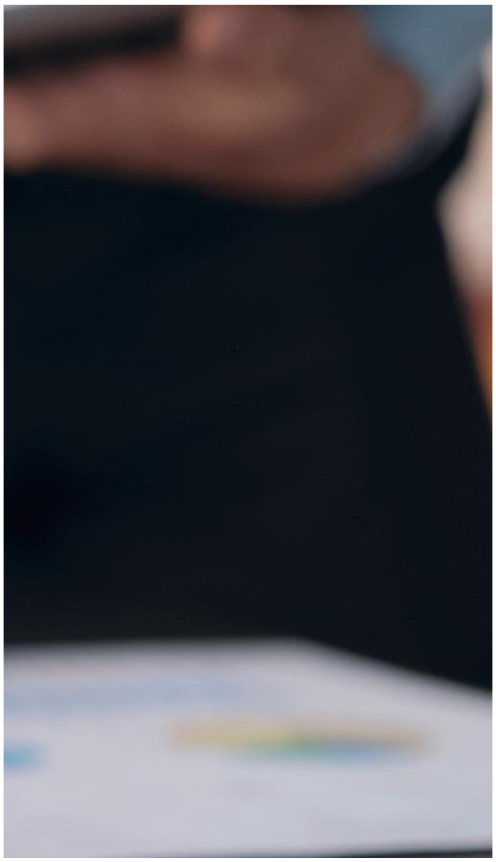
SEXUAL HEALTH	Big Sky Area	BIG SKY AREA vs. BENCHMARKS vs. MT	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	**66.3** [County-Level Data]	75.3	386.6		
Chlamydia Incidence per 100,000	**409.8** [County-Level Data]	322.7	492.2		
Gonorrhea Incidence per 100,000	**44.3** [County-Level Data]	67.7	179.0		
		better	similar	worse	

SUBSTANCE USE	Big Sky Area	BIG SKY AREA vs. BENCHMARKS			
		vs. MT	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease Deaths per 100,000	**4.2** [County-Level Data]	23.3	15.8		
Alcohol-Induced Deaths per 100,000	**12.7** [County-Level Data]	27.7	14.5		6.7
Unintentional Drug-Induced Deaths per 100,000	**10.8** [County-Level Data]	14.7	26.8		3.6
% Excessive Drinking	**30.6**	22.5	25.1		27.3
% Drinking & Driving in Past Month	**11.4**				4.0
% Used Marijuana/THC in Past Year	**37.3**		26.4		
% Used an Illicit Drug in Past Month	**5.7**		3.9		4.4
		better	similar	worse	

TOBACCO USE	Big Sky Area	BIG SKY AREA vs. BENCHMARKS			
		vs. MT	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	**7.1**	12.2	20.5	6.1	6.5
% Use Vaping Products	**7.0**	9.5	15.3		1.6
% Use Smokeless Tobacco	**4.9**				8.1
		better	similar	worse	







DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY DESCRIPTION

Demographic Summary

The following table outlines key demographic characteristics of Gallatin County [COUNTY-LEVEL DATA]. Note that:

- A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.
- It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.
- Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.
- Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

Core Demographic Summary

		Gallatin County	MT	US
Total Population		**124,074**	1,116,875	334,922,499
% Population Change, 2010-2020		**+32.9**	+9.6	+7.1
Age	*0-17 (%)*	**18.8**	21.0	22.0
	18-64 (%)	**67.6**	58.9	60.8
	65+ (%)	**13.6**	20.1	17.2
Ethnicity	*Hispanic (%)*	**5.4**	4.6	19.3
Race	*White (%)*	**88.8**	85.0	61.0
	Black (%)	**0.5**	0.5	12.2
	Asian (%)	**1.3**	0.8	6.0
	American Indian or Alaska Native (%)	**0.6**	5.6	0.9
	Native Hawaiian/Pacific Islander (%)	**0.0**	0.1	0.2
Percent of Population Living in Areas Designated as Urban (%)		**70.1**	70.3	75.2

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Note:
- People who identify their origin as Hispanic may be of any race.
- Urban areas are identified using population density, count, and size thresholds; urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

Social Drivers of Health

ABOUT SOCIAL DRIVERS OF HEALTH

Social drivers of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social drivers of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

– Healthy People 2030

Poverty, Education & Unemployment

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to overall health. [COUNTY-LEVEL DATA]

Poverty, Education & Unemployment

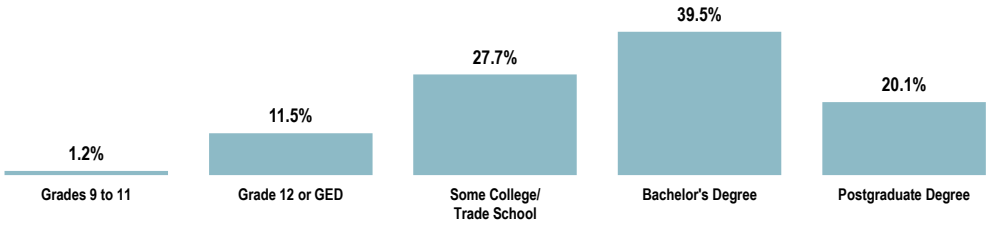
	Gallatin County	MT	US
% of Total Population Living Below 100% of the Federal Poverty Level	**9.5**	11.5	12.5
% of Children (<Age 18) Living Below 100% of the Federal Poverty Level	**6.4**	12.7	16.1
% of Population Age 25+ Without a High School Diploma	**2.8**	5.4	10.4
Unemployment Rate (December 2025)*	**2.9**	3.7	4.1

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Notes:
- *Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

PRC SURVEY ► "What is the highest grade or year of school you have completed?"

Highest Level of Education
(Big Sky Area, 2026)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: ● Asked of all respondents.

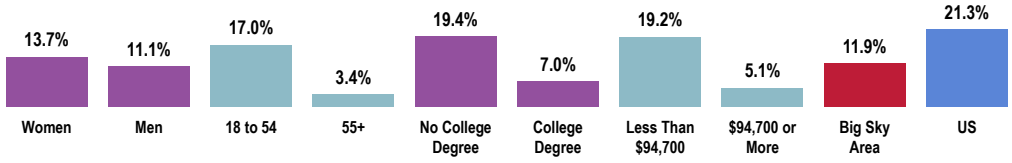
Financial Resilience

Survey findings in this report may be segmented by the key demographic characteristics of the respondents (see also the definitions that follow).

PRC SURVEY ► "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

The following details "no" responses in the Big Sky Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, level of education, and income).

Do Not Have Funds on Hand to Cover a $400 Emergency Expense
(Big Sky Area, 2026)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 50]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

INCOME & RACE/ETHNICITY

INCOME ► In this report, disparities by income are shown between two respondent sample groups: those with total annual household incomes below or equal to $94,699, and those with incomes at $94,700 or above.

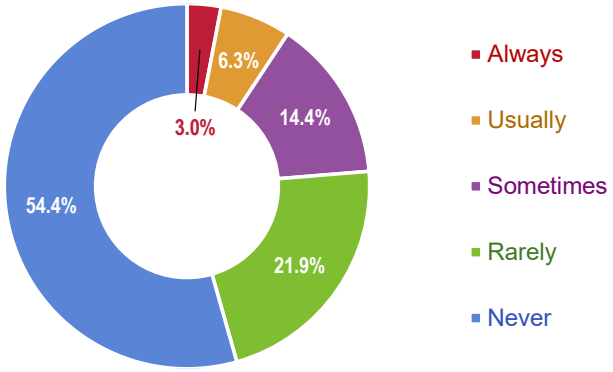
RACE & ETHNICITY ► While the survey data are representative of the full racial and ethnic makeup of the population, samples were not of sufficient size for independent analysis by race and/or ethnicity.

Housing

Housing Insecurity

PRC SURVEY ► "In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

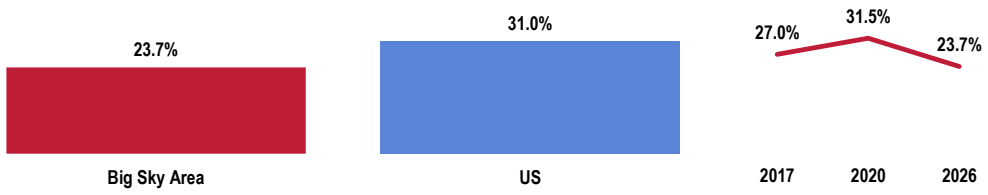
Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year
(Big Sky Area, 2026)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: ● Asked of all respondents.

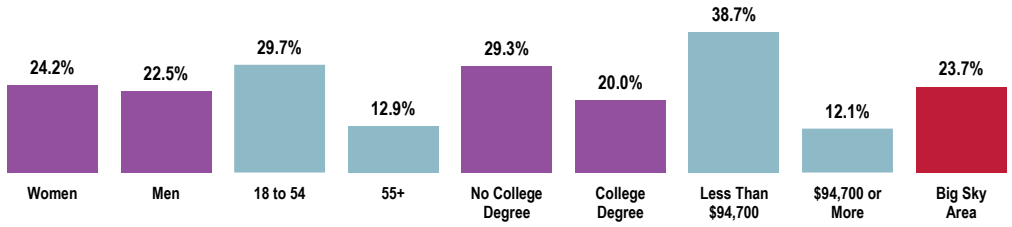
"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year

Big Sky Area



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 52]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year
(Big Sky Area, 2026)

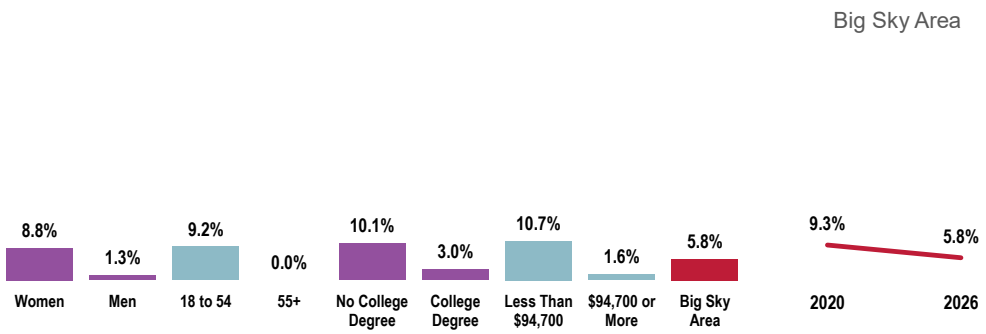


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: ● Asked of all respondents.

Experience of Being Unhoused

PRC SURVEY ► "Has there been any time in the past two years when you were living on the street, in a vehicle, in a temporary shelter, with a family member or friend temporarily, or without housing for any reason?"

Have Been Unhoused at Some Point in the Past Two Years



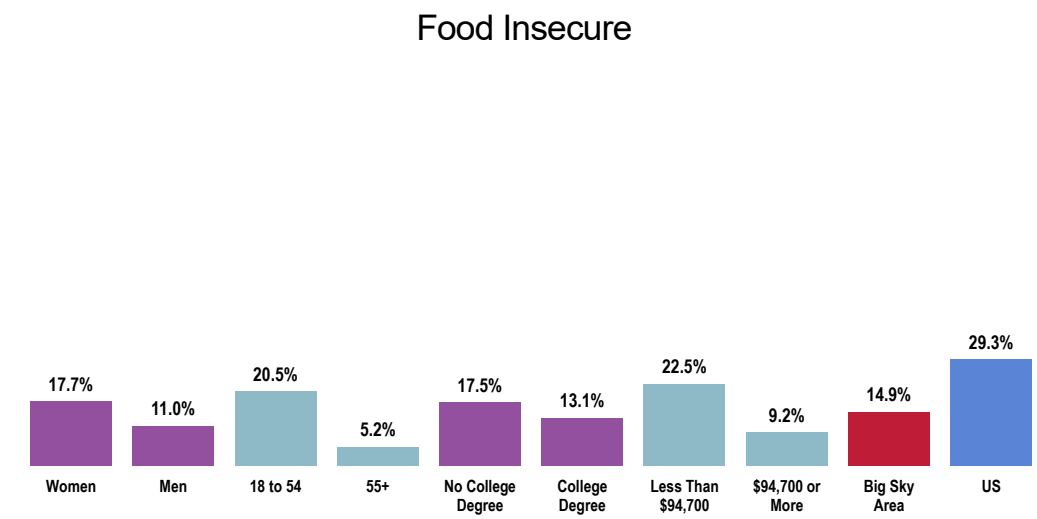
Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 313]
Notes: ● Asked of all respondents.

Food Insecurity

PRC SURVEY ► "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- 'I worried about whether our food would run out before we got money to buy more.'
- 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

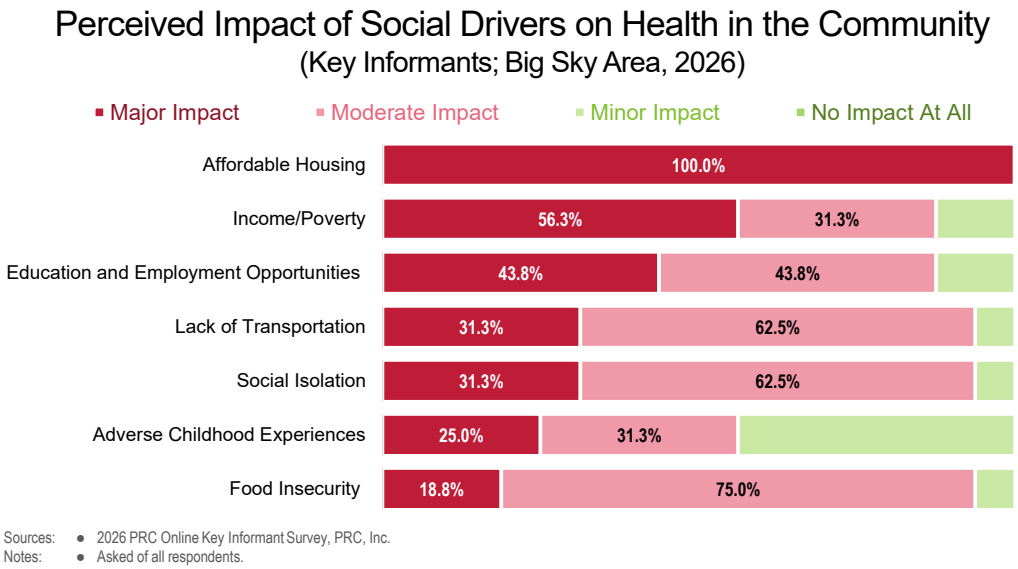


Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 98]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Key Informant Input: Social Drivers of Health

Key informants taking part in the Online Key Informant Survey acknowledge that various social drivers of health have significant impact on community health.



When asked what social driver of health is most important for community organizations to address, respondents shared the following:

Affordable Housing

> Housing affordability and access: Wages are too low to meet housing costs and other high costs of living compound that cost burden. This can be applied across all age groups and demographics. Being cost burdened is stressful and often results in reducing spending on essentials like food, prescriptions, mental health counseling, etc. — Social Services Provider
>
> Affordable housing is a major factor for instability. Without it, people feel more social isolation/less belonging and are forced to make unhealthy budget decisions to pay for housing. — Social Services Provider
>
> I think affordable housing would go a long way to address some needs. If parents didn't have to work so much to afford to live here, they could spend more time with their kids. If they saved on housing costs, they could spend more on preventative health care. If people are less worried about housing, it might lessen the mental health burdens as well. — Community Leader
>
> Housing, people are working multiple jobs on our community to try to keep a roof over their head. They end up neglecting all of their healthcare needs, family obligations and often we have latchkey kids roaming our community. Lack of affordable housing is the primary factor and causes a chain reaction of all the other social issues. — Social Services Provider

Housing Insecurity

> Housing. — Health Care Provider
>
> Housing is one of the first major concerns. — Community Leader
>
> Housing insecurity is one of the most impactful and difficult social drivers in Big Sky. It ties directly into income and finances. Housing is always at the top of everyone's mind when living in Big Sky - when will my rent increase? When will my landlord sell? What if my HOA dues go up next year? — Health Care Provider

Mental Health

> Mental Health. — Community Leader
>
> Mental Health & Wellness impacts and is impacted by many other areas (stigma, substance abuse, isolation etc.). — Social Services Provider

Cost of Living

> Financial - pay people enough to afford to live here. the cost of living has outpaced wages. — Community Leader

Access to Healthcare

> Lack of advanced medical needs beyond X-ray-PA- NP practice. Better facility. — Community Leader

Transportation

> Transportation. — Social Services Provider

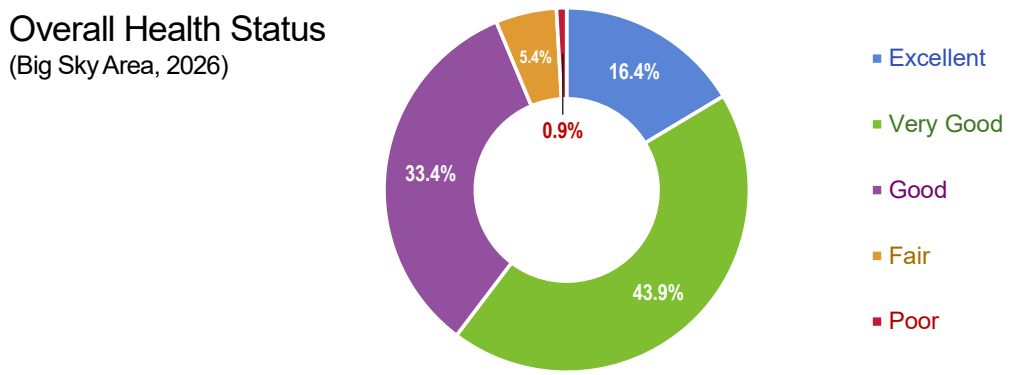
Adverse Childhood Experiences

> Adverse Childhood Experiences - many individuals move to Big Sky as seasonal workers and do not have social safety nets. Individuals often come here thinking they can escape their challenges and have complex trauma, substance challenges, and more factors that are a results of ACEs. — Social Services Provider

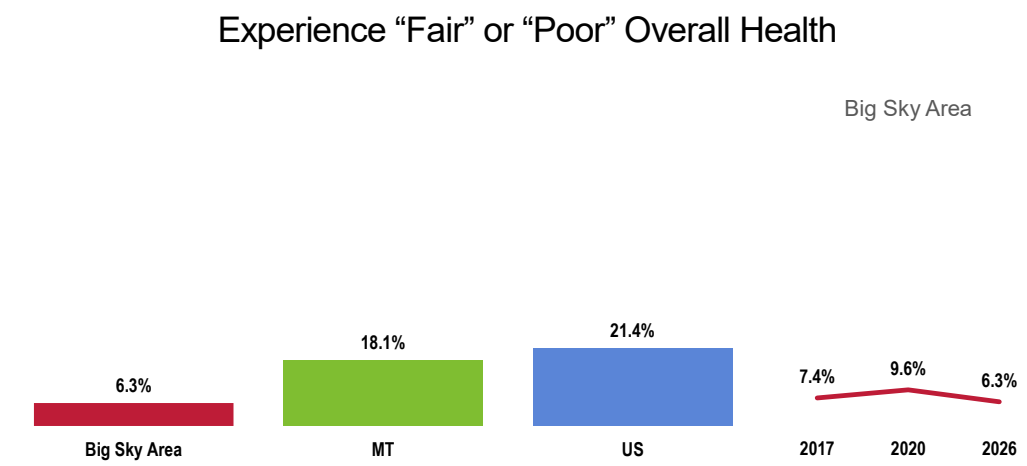
HEALTH STATUS

Overall Health

PRC SURVEY ► "Would you say that in general your health is: excellent, very good, good, fair, or poor?"

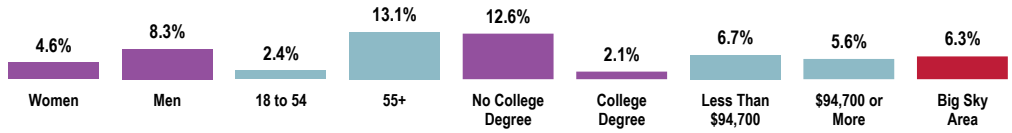


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 3]
Notes: ● Asked of all respondents.



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 3]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Big Sky Area, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 3]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

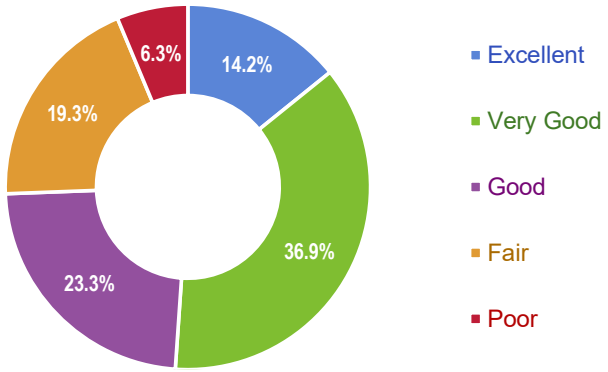
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030

Mental Health Status

PRC SURVEY ► "Now thinking about your mental health, which includes stress, anxiety, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"

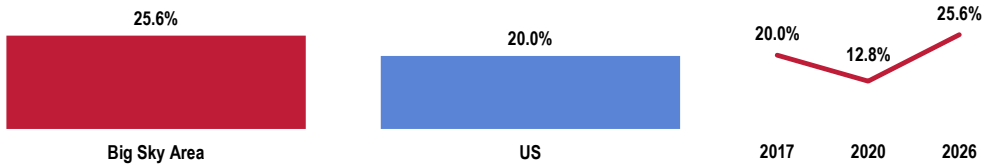
Mental Health Status
(Big Sky Area, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 74]
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

Big Sky Area



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 74]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Anxiety & Depression

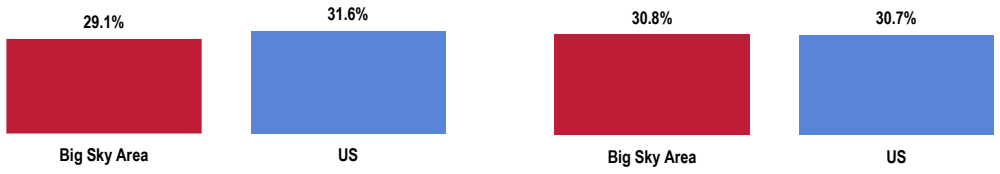
Diagnosed Anxiety & Depression

PRC SURVEY ► “Has a doctor, nurse, or other health professional ever told you that you have an anxiety disorder, including acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, posttraumatic stress disorder, or social anxiety disorder?”

PRC SURVEY ► “Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”

Have Been Diagnosed With an Anxiety Disorder

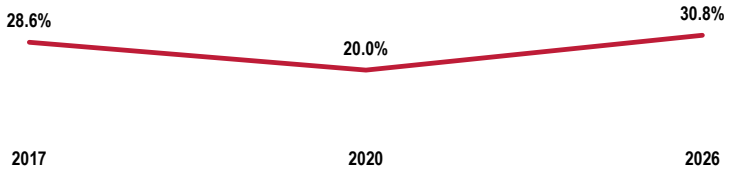
Have Been Diagnosed With a Depressive Disorder



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Items 75-76]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Anxiety disorders include acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, posttraumatic stress disorder, or social anxiety disorder.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Have Been Diagnosed With a Depressive Disorder
(Big Sky Area)



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 75]

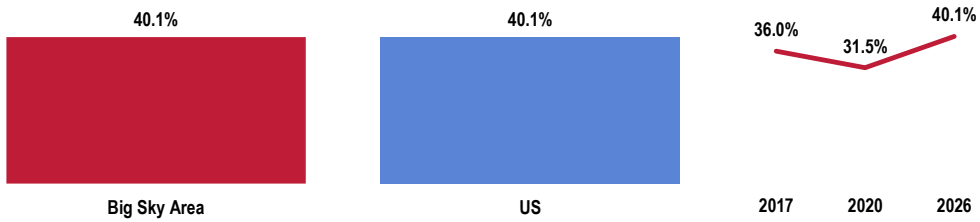
Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

PRC SURVEY ► "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"

Have Experienced Symptoms of Chronic Depression

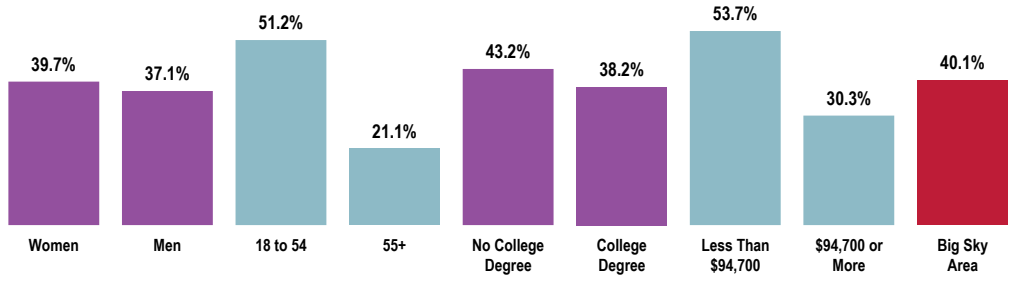
Big Sky Area



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 317]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Have Experienced Symptoms of Chronic Depression
(Big Sky Area, 2026)

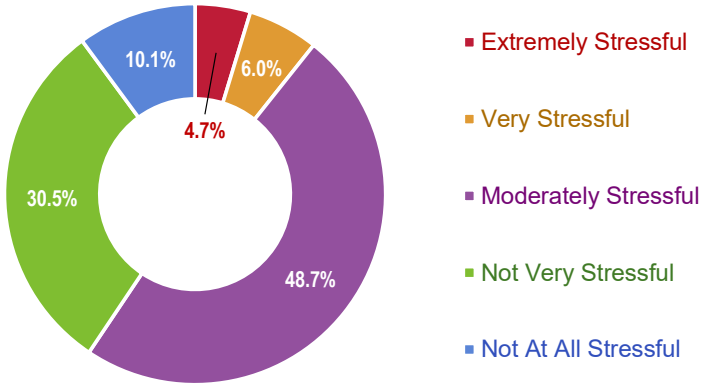


Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 317]
Notes: • Asked of all respondents.
• Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Stress

PRC SURVEY ► "Thinking about the amount of stress in your life, would you say that most days are extremely stressful, very stressful, moderately stressful, not very stressful, or not at all stressful?"

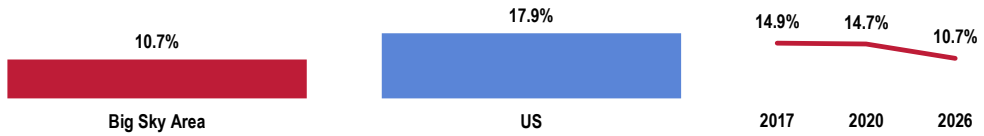
Perceived Level of Stress On a Typical Day
(Big Sky Area, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 318]
Notes: • Asked of all respondents.

Perceive Most Days as “Extremely” or “Very” Stressful

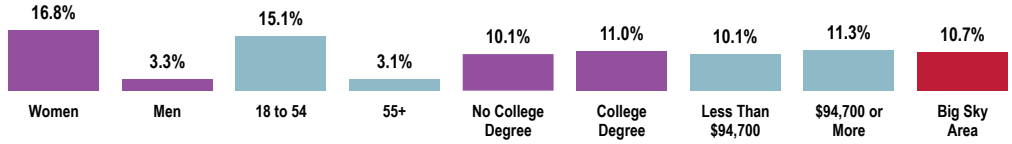
Big Sky Area



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 318]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Perceive Most Days as “Extremely” or “Very” Stressful
(Big Sky Area, 2026)



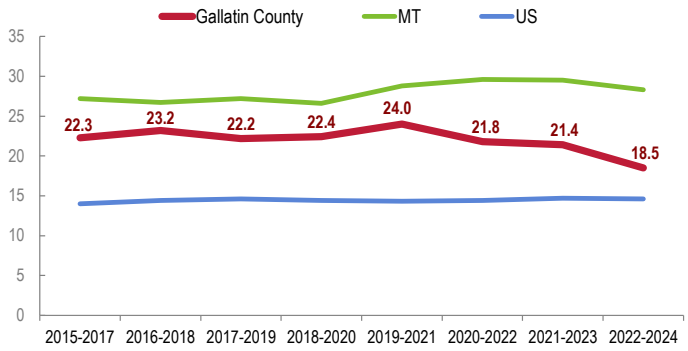
Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 318]

Notes:
- Asked of all respondents.

Suicide

The following chart outlines the most current mortality rates attributed to suicide in our population. [COUNTY-LEVEL DATA]

Suicide Mortality Trends
(Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

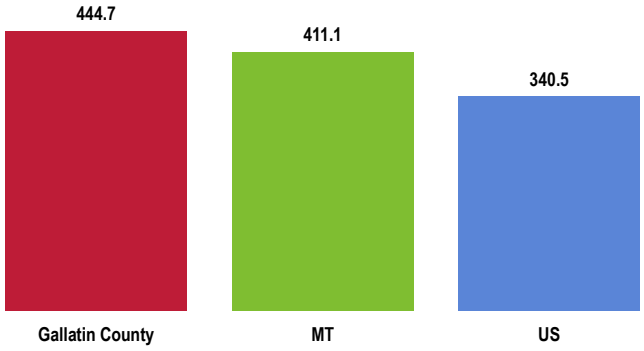
Mental Health Treatment

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) per 100,000 residents. [COUNTY-LEVEL DATA]

Note that this indicator only reflects providers practicing within the study area and residents within the study area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

Number of Mental Health Providers per 100,000 Population
(2026)

This reflects 529 mental health providers in Gallatin County.



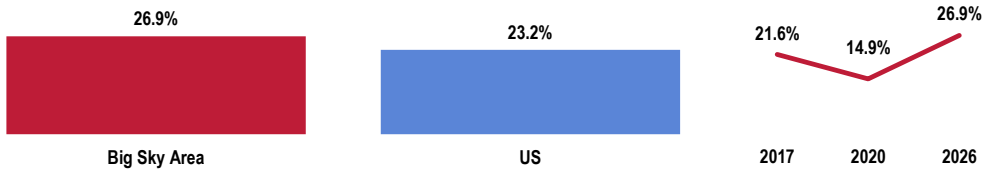
Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

PRC SURVEY ► "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

Big Sky Area

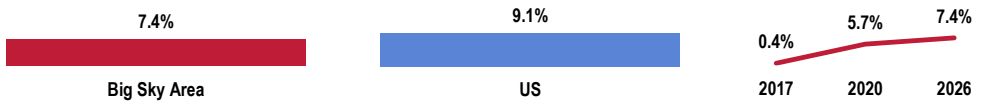


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 81]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

PRC SURVEY ► "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

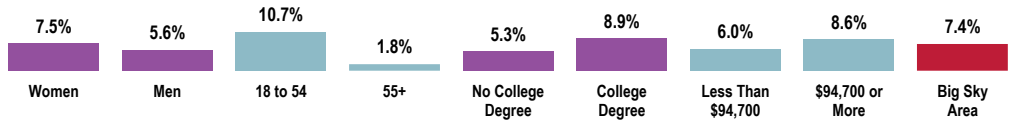
Unable to Get Mental Health Services When Needed in the Past Year

Big Sky Area



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 82]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year
(Big Sky Area, 2026)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 82]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of Mental Health as a Problem in the Community
(Key Informants; Big Sky Area, 2026)



Sources: ● 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> There are gaps along the continuum of care for people experiencing mental health issues. Some people have to either wait or leave the community to access critical care and treatment. Some people who can't afford mental health care go without. Some people find that accessing mental health care is overwhelming...it's hard to know where to start and what insurance will cover - or not. Some people don't have insurance at all, or their insurance won't cover mental healthcare. Some insurance does cover some level of care, but sessions or types of care are limited, or patient costs are high (like co-pays or deductibles). Access to providers can be difficult - there are waitlists or a lack of the type of providers needed. Sometimes it can be hard to get interventions like ketamine or other treatments that require psychiatric oversight. The social stigma around mental health is high. Education around mental health is low or spotty. Even with a diagnosis, it's hard to know how to get help.
> — Social Services Provider
>
> The availability and affordability of mental health care. The stigma that comes with mental health issues.
> — Community Leader
>
> Access and education about types of resources available and where to find them. — Community Leader
>
> Lack of resources, limited counselors, limited pediatric providers, patients with limited funds and limited access.
> — Health Care Provider

> This is a critical service that has attention, but lack of resources and current funding. — Community Leader
>
> Very limited services and still a major negative view about seeking help. We need to start a campaign for making seeking mental health help the new norm. If we can get famous people to do HIV commercials they should do mental health commercials. — Social Services Provider

Awareness/Education

> Awareness of and access to care at an affordable cost. — Social Services Provider

Denial/Stigma

> Stigma, thinking they can deal with it on their own, types of connections with community loneliness, surface-level, hard to build, drinking and drug-use, anxiety and depression, hard to make it in Big Sky. — Community Leader

Cultural/Personal Beliefs

> Work hard play hard perspective, stigma and access to services. — Community Leader

Isolation

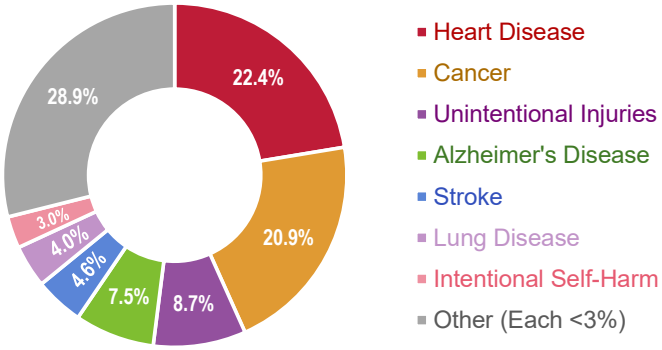
> Social isolation, life transition, anxiety, depression and stress related to relationships/families and housing. Crisis services are also not regularly available in Big Sky. — Social Services Provider

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

The following outlines leading causes of death in Gallatin County. [COUNTY-LEVEL DATA]

Leading
Causes of Death
(Gallatin County, 2022-2024)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Lung disease includes deaths classified as chronic lower respiratory disease.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

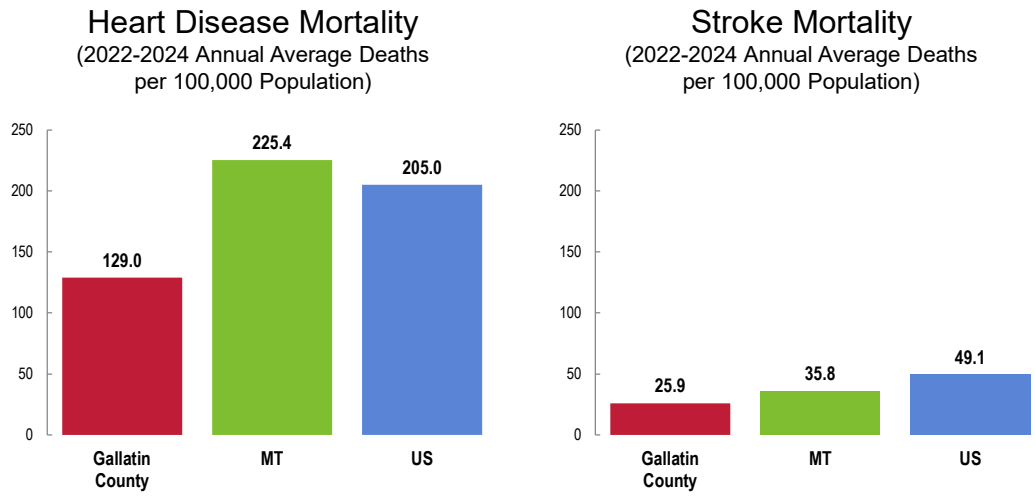
In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030

Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

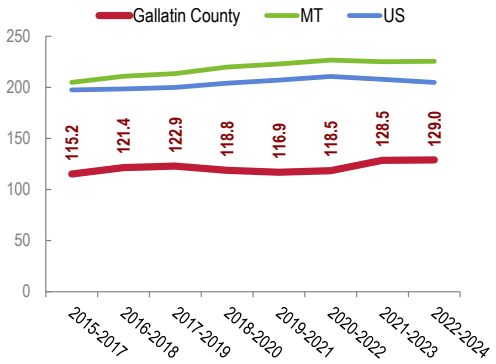
The following charts outline mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]



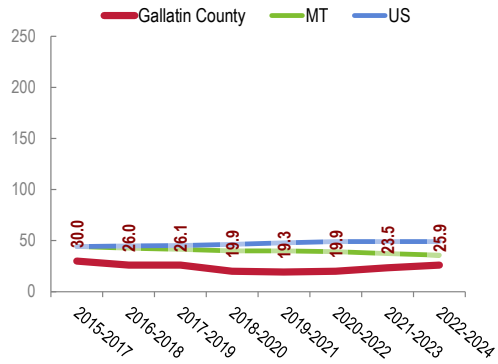
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Heart Disease Mortality Trends
(Annual Average Deaths per 100,000 Population)



Stroke Mortality Trends
(Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

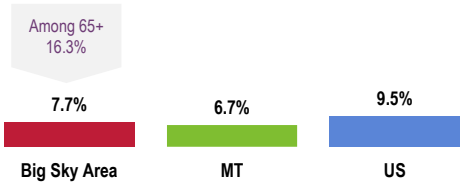
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Heart Disease & Stroke

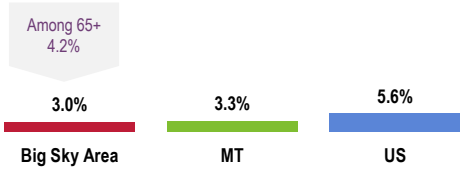
PRC SURVEY ► "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, heart failure or cardiomyopathy, or coronary heart disease?"

PRC SURVEY ► "Have you ever suffered from or been diagnosed with a stroke?"

Prevalence of Heart Disease



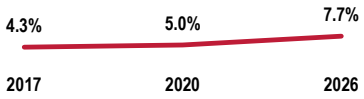
Prevalence of Stroke



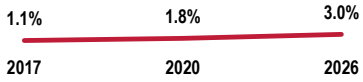
Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Items 21-22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Heart disease includes diagnoses of heart attack, angina, heart failure or cardiomyopathy, or coronary heart disease.

Prevalence of Heart Disease
(Big Sky Area)



Prevalence of Stroke
(Big Sky Area)



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Items 21-22]

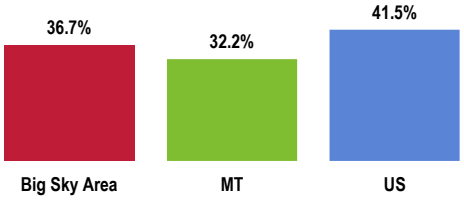
Notes:
- Asked of all respondents.
- Heart disease includes diagnoses of heart attack, angina, heart failure or cardiomyopathy, or coronary heart disease.

Blood Pressure & Cholesterol

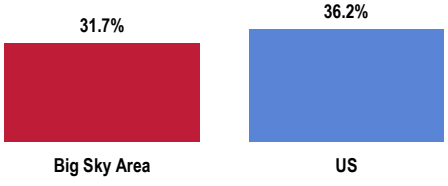
PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health professional that you had high blood pressure?"

PRC SURVEY ► "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?"

Prevalence of
High Blood Pressure
Healthy People 2030 = 41.9% or Lower



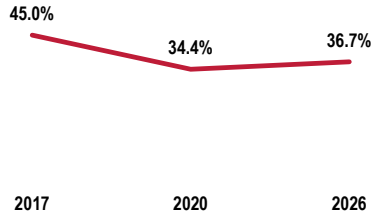
Prevalence of
High Blood Cholesterol



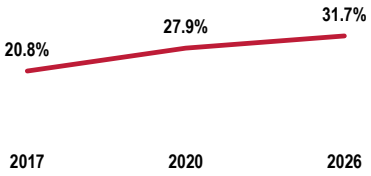
Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.

Prevalence of
High Blood Pressure
(Big Sky Area)
Healthy People 2030 = 41.9% or Lower



Prevalence of
High Blood Cholesterol
(Big Sky Area)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● US Department of Health and Human Services. Healthy People 2030.
Notes: ● Asked of all respondents.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:

Perceptions of Heart Disease & Stroke
as a Problem in the Community
(Key Informants; Big Sky Area, 2026)



Sources: ● 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Follow-Up/Support

> No support services in West Yellowstone and zero education materials. — Social Services Provider

Cancer

ABOUT CANCER

The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social drivers of health, including education, economic status, and access to health care.

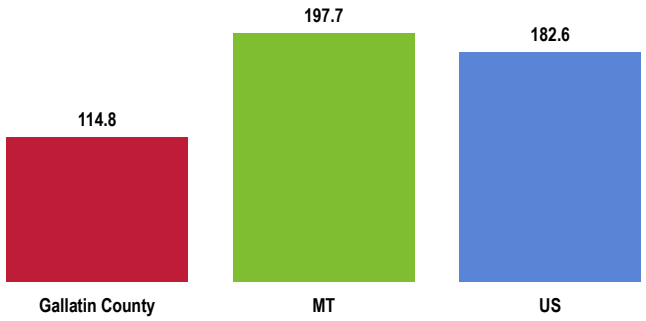
Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030

Cancer Deaths

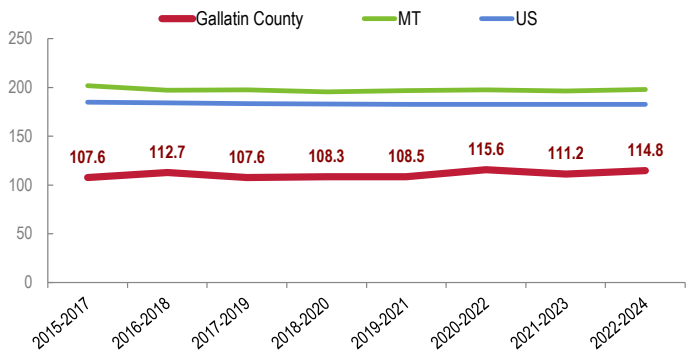
The following chart illustrates cancer mortality (all types). [COUNTY-LEVEL DATA]

Cancer Mortality
(2022-2024 Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Cancer Mortality Trends
(Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Female breast cancer and prostate cancer are the leading causes of cancer deaths. [COUNTY-LEVEL DATA]

Cancer Death Rates by Site
(2022-2024 Annual Average Deaths per 100,000 Population)

	Gallatin County	MT	US
ALL CANCERS	**114.8**	197.7	182.6
Female Breast Cancer	**19.4**	25.5	25.1
Prostate Cancer	**19.2**	28.7	20.4
Lung Cancer	**14.8**	37.2	38.9
Colorectal Cancer	**11.6**	17.3	16.4

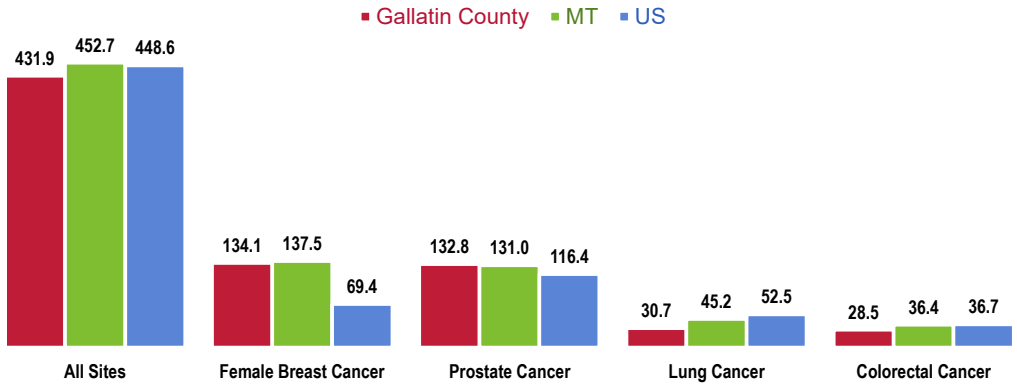
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. It is usually expressed as cases per 100,000 population per year. [COUNTY-LEVEL DATA]

Cancer Incidence Rates by Site
(2018-2022)

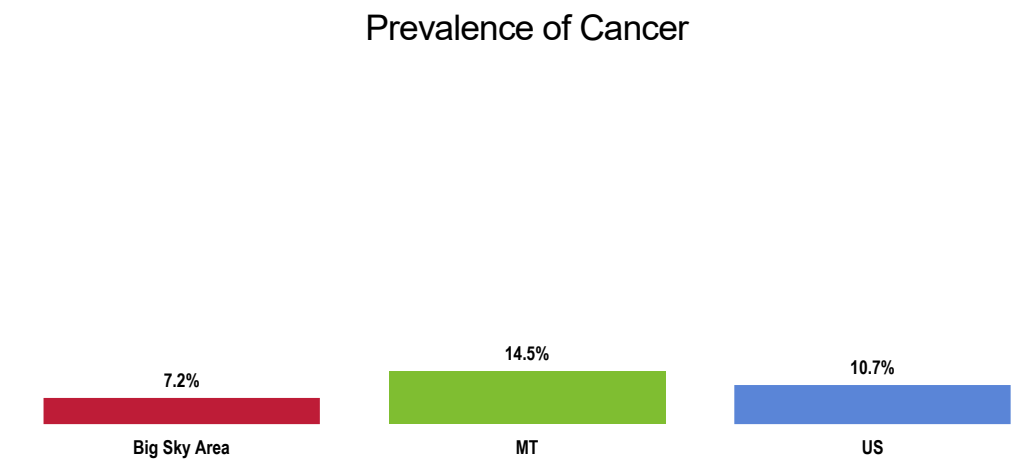


Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Prevalence of Cancer

PRC SURVEY ► "Have you ever suffered from or been diagnosed with cancer?"



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cancer Screenings

Cancer screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 40 to 74 years (Grade B recommendation). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women 75 years or older.

CERVICAL CANCER

The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years (Grade A recommendation). The USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with hrHPV testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing) in women age 40 to 65 years (Grade A recommendation). The USPSTF recommends against screening for cervical cancer in women younger than 21 years (Grade D recommendation). The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer (Grade D recommendation). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion or cervical cancer (Grade D recommendation).

COLORECTAL CANCER

The USPSTF recommends screening for colorectal cancer in all adults age 50 to 75 years (Grade A recommendation). The USPSTF recommends screening for colorectal cancer in adults age 45 to 49 years (Grade B recommendation). The USPSTF recommends that clinicians selectively offer screening for colorectal cancer in adults age 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences (Grade C recommendation).

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Breast Cancer Screening

PRC SURVEY ► "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 40 to 74 who indicate mammography within the past two years.

Cervical Cancer Screening

PRC SURVEY ► "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 65.

Colorectal Cancer Screening

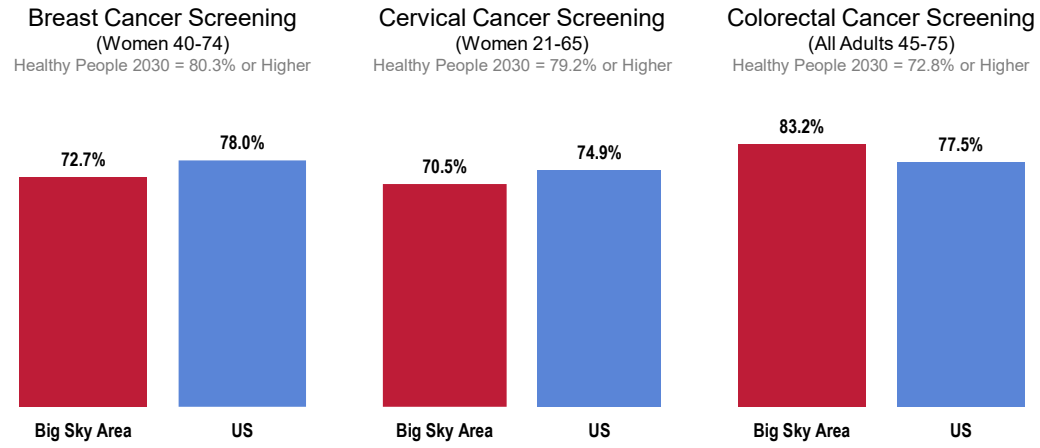
PRC SURVEY ► "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

PRC SURVEY ► "Have you ever had any other kind of test for colorectal cancer, such as a virtual colonoscopy, CT colonography, blood stool test, FIT DNA, or a Cologuard test?"

PRC SURVEY ► "Which of these tests did you have most recently?"

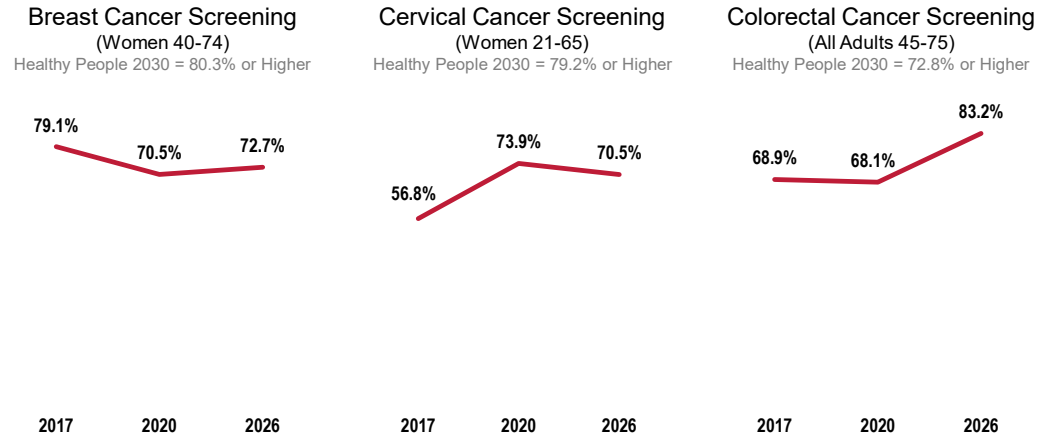
PRC SURVEY ► "About how long ago did you have this test?"

"Appropriate colorectal cancer screening" reflects individuals age 45 to 75 who received any of the following: colonoscopy/sigmoidoscopy in the past 10 years; CT colonography/virtual colonoscopy in the past five years; FIT DNA in the past three years; or fecal occult blood testing/FIT (non-DNA) in the past year.



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Each indicator is shown among the gender and/or age group specified.

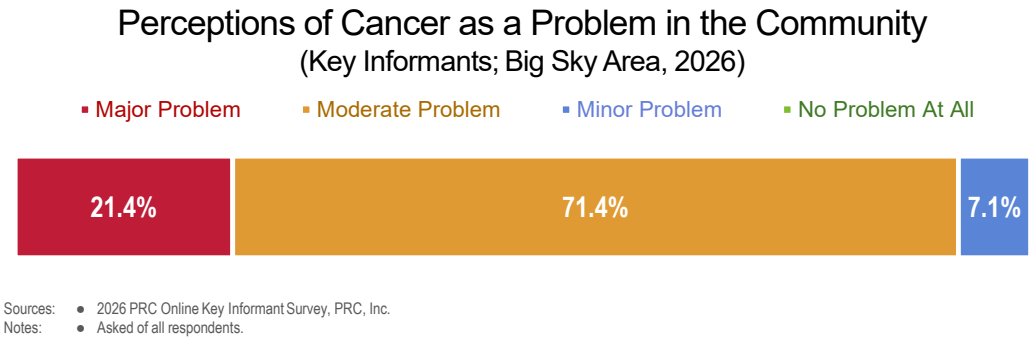


Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that trend data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.
- Note that trend data for breast cancer screening reflect the age group (50 to 74) of the previous recommendation.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:



Sources: 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> I don't know the actual numbers, but it seems like we have a high rate of cancer for our community. It might just seem like that since we generally know most people in town. — Community Leader

Access to Care/Services

> Cancer treatment is nonexistent in our community. Most people that require chemo have to travel for care or end up moving to be closer to healthcare facilities. — Social Services Provider

Prevention/Screenings

> Access to preventative cancer services is limited in Big Sky. Additionally, radon levels in Big Sky and Gallatin County are significantly elevated, as nearly 40% of home testing has results that are at or above the EPA action level of 4.0. — Community Leader

Respiratory Disease

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

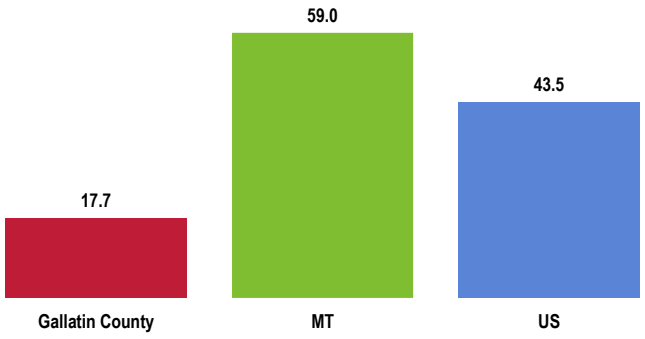
– Healthy People 2030

Respiratory Disease Deaths

Lung Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for lung disease is illustrated in the following chart. [COUNTY-LEVEL DATA]

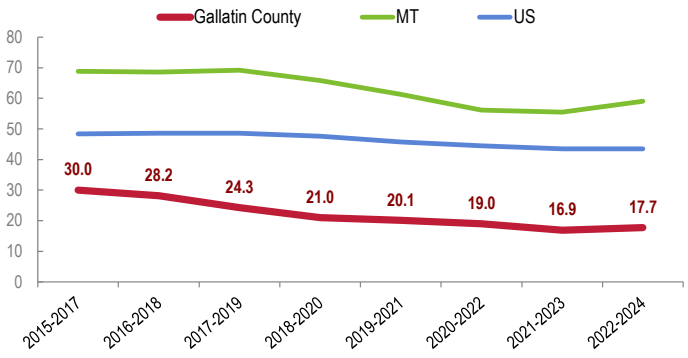
Lung Disease Mortality
(2022-2024 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Lung Disease Mortality Trends
(Annual Average Deaths per 100,000 Population)



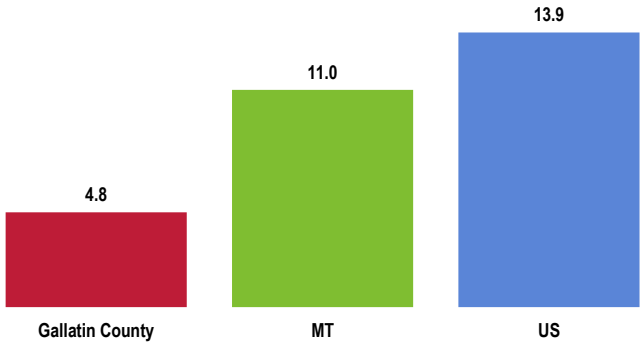
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Pneumonia/Influenza Deaths

Pneumonia and influenza mortality is illustrated here. [COUNTY-LEVEL DATA]

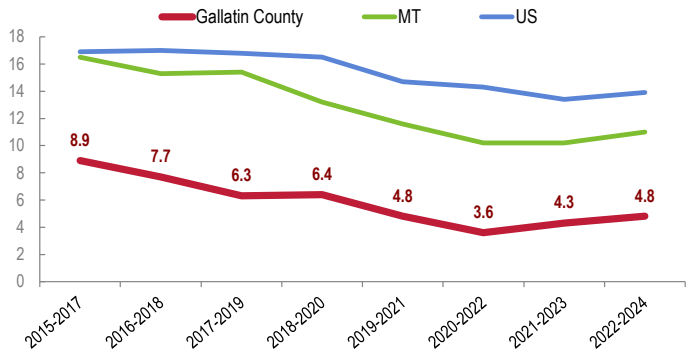
Pneumonia/Influenza Mortality
(2022-2024 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Pneumonia/Influenza Mortality Trends
(Annual Average Deaths per 100,000 Population)

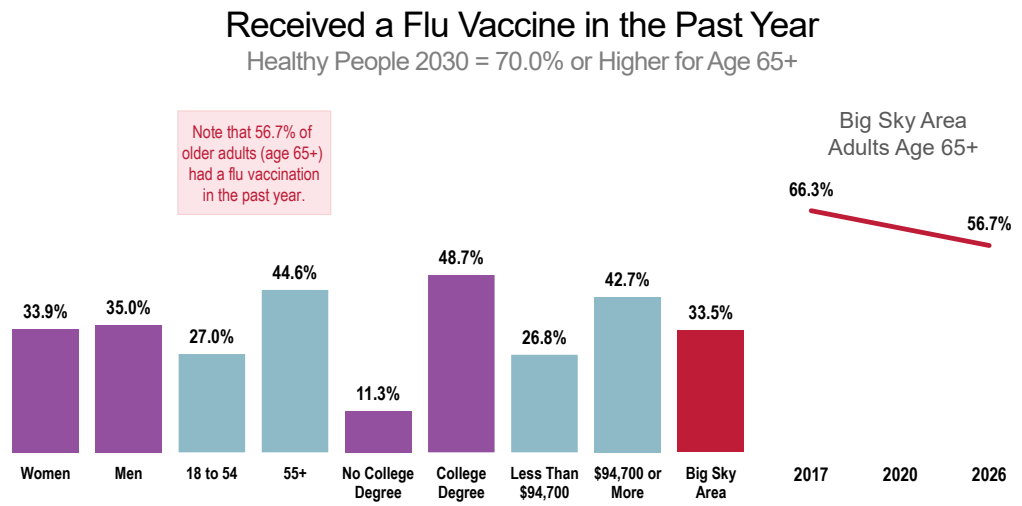


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Flu Vaccinations

PRC SURVEY ► [All ages] "During the past 12 months, have you had either a flu shot or a flu vaccine that was sprayed in your nose?"



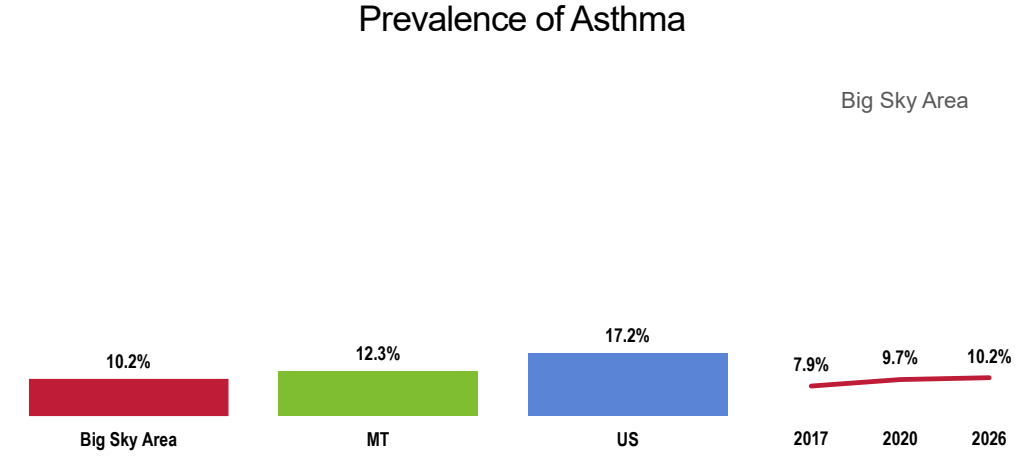
Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Items 311, 325]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.

Prevalence of Respiratory Disease

Asthma

PRC SURVEY ► "Do you currently have asthma?"



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including chronic bronchitis or emphysema?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

Big Sky Area



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:

Perceptions of Respiratory Disease as a Problem in the Community
(Key Informants; Big Sky Area, 2026)



Sources:
- 2026 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among the individual rating this issue as a "major problem," reasons related to the following:

Follow-Up/Support

> Lack of support and services. — Social Services Provider

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

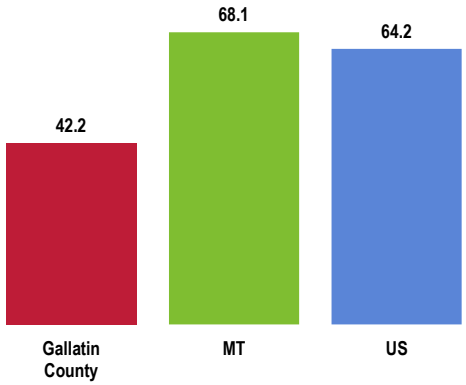
– Healthy People 2030

Unintentional Injury Deaths

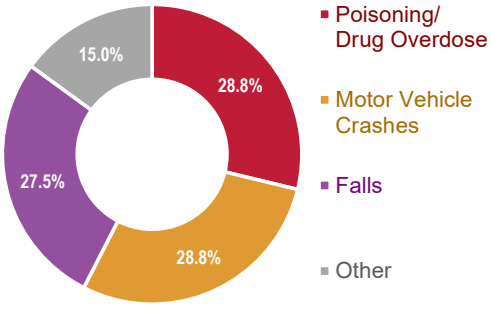
The following charts outline mortality rates for unintentional injury in the area as well as the leading causes. [COUNTY-LEVEL DATA]

RELATED ISSUE
For more information about unintentional drug-induced deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.

Unintentional Injury Mortality
(2022-2024 Annual Average Deaths per 100,000 Population)



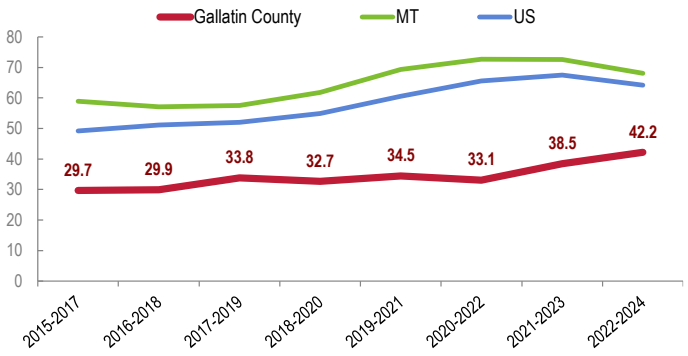
Leading Causes of Unintentional Injury Deaths
(Gallatin County, 2022-2024)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Unintentional Injury Mortality Trends

(Annual Average Deaths per 100,000 Population)



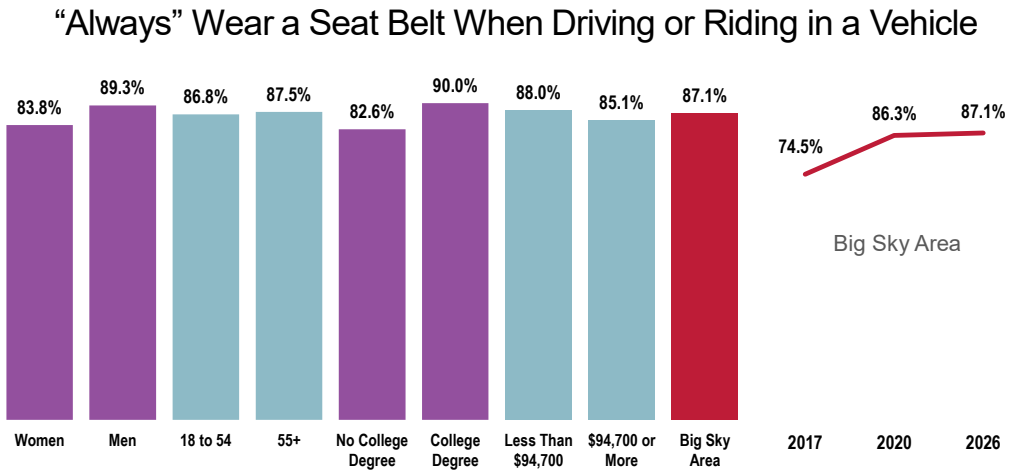
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Motor Vehicle Safety

Seat Belt Usage

PRC SURVEY ► "How often do you use seat belts when you drive or ride in a car? Would you say always, nearly always, sometimes, seldom, or never?"

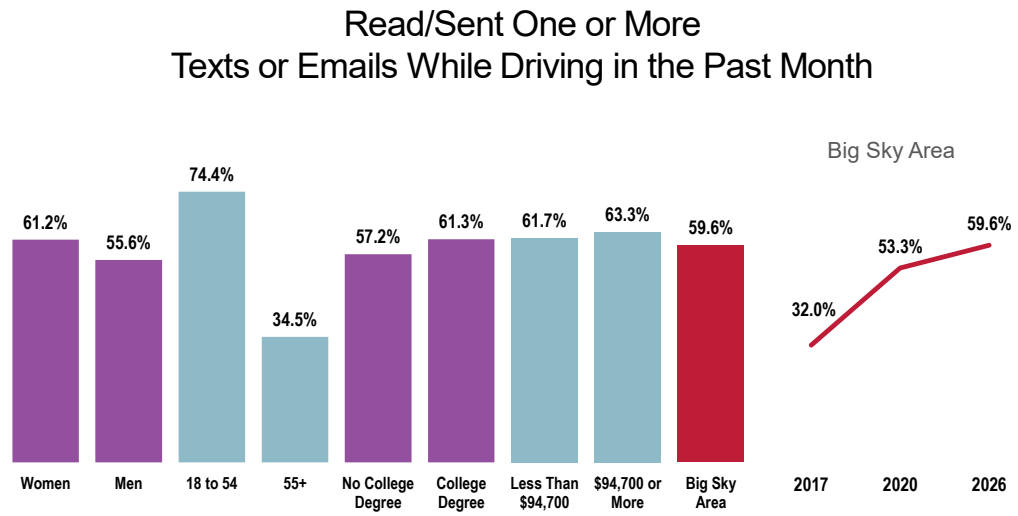


Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 307]

Notes:
- Asked of all respondents.

Distracted Driving

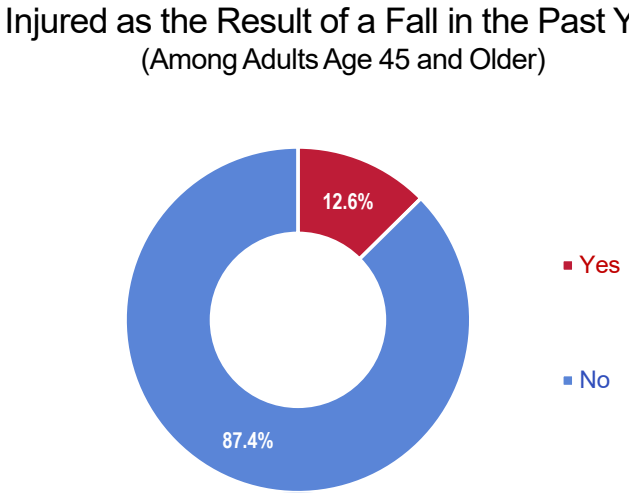
PRC SURVEY ► "In the past 30 days, how many times would you say that you sent or read text messages or e-mail while driving and the vehicle was in motion? Please consider each individual text or email you sent or read as one time."



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.

Falls

PRC SURVEY ► [Adults age 45 or older] **"In the past 12 months, were you injured as the result of a fall? For the purposes of this study, an injury means the fall caused you to limit your regular activities for at least a day or caused you to go see a doctor or other health professional."**

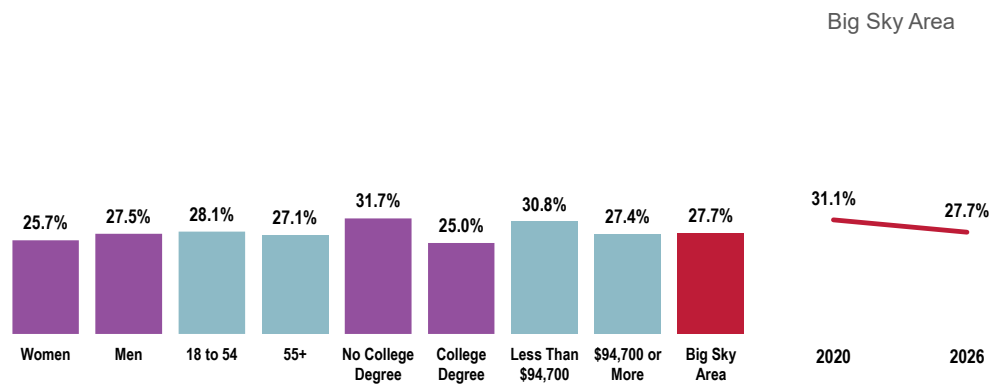


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 320]
Notes: ● Asked of all respondents age 45 and older.

Firearm Safety

PRC SURVEY ► "Are there any guns or other firearms in or around your home or vehicles that are currently unlocked, meaning that they do NOT need a key or combination to get to the gun or fire it?"

Have an Unlocked Firearm Kept In or Around the Home

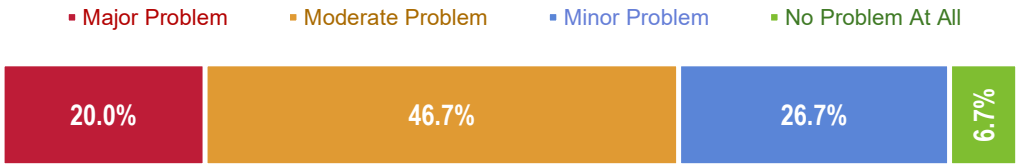


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury & Violence as a Problem in the Community
(Key Informants; Big Sky Area, 2026)



Sources: ● 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Given the active nature of residents and visitors alike, injury will always be a major component of health care in Big Sky. For other types of injury and violence, there are little if any wraparound services locally in Big Sky for victims. — Social Services Provider

Incidence/Prevalence

> Sherriff's Department statistics provided, along with demand in available services. — Community Leader

Domestic/Family Violence

> Domestic violence is a problem everywhere and in our community with zero support or resources, there is little direction on how to find help. These families end up moving away instead of getting help.
> — Social Services Provider

Diabetes

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

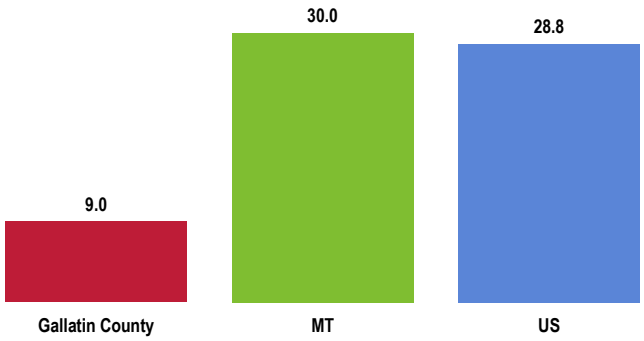
Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030

Diabetes Deaths

Diabetes mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]

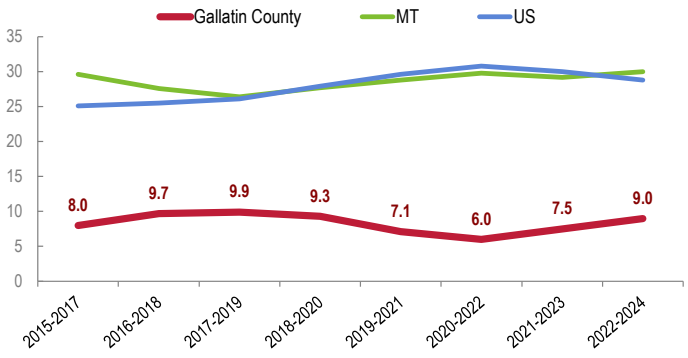
Diabetes Mortality
(2022-2024 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Diabetes Mortality Trends
(Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Diabetes

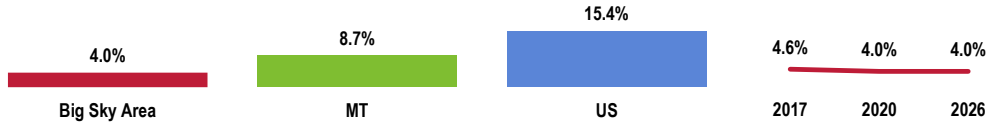
PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

PRC SURVEY ► "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

Prevalence of Diabetes

Another 12.0% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

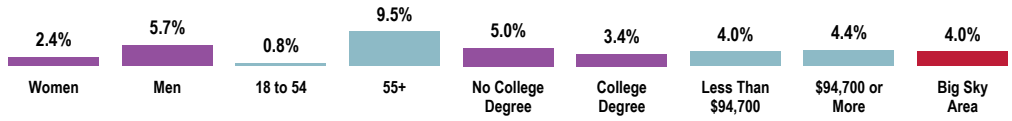
Big Sky Area



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 104]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).

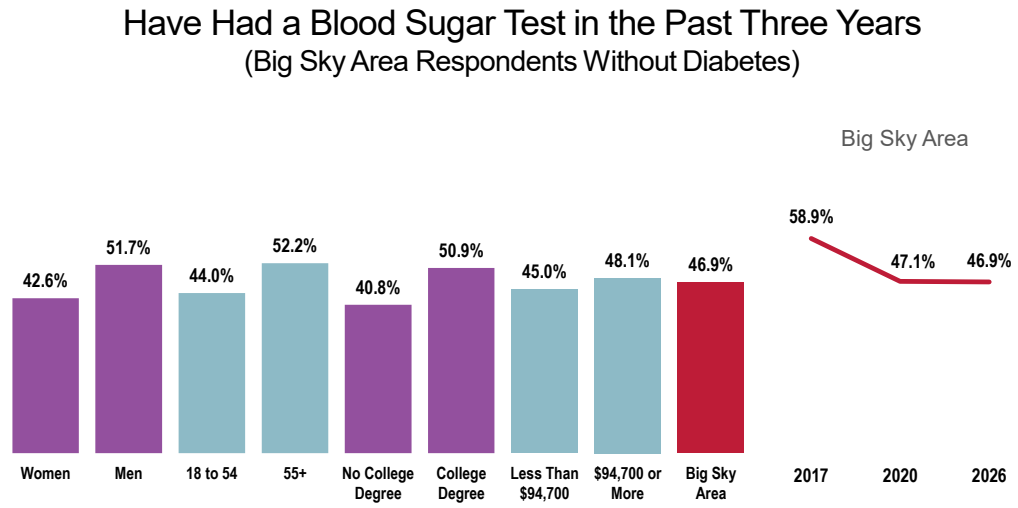
Prevalence of Diabetes
(Big Sky Area, 2026)



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 104]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

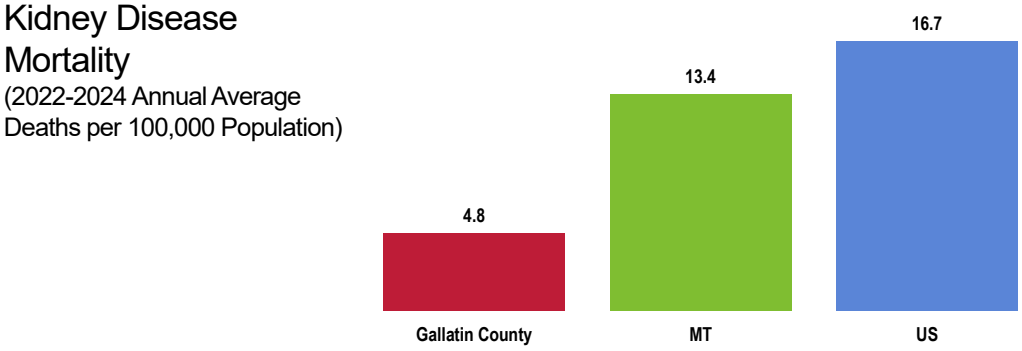
PRC SURVEY ► [Adults not diagnosed with diabetes] **"Have you had a test for high blood sugar or diabetes within the past three years?"**



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 305]
Notes: ● Asked of all respondents who have not been diagnosed with diabetes.

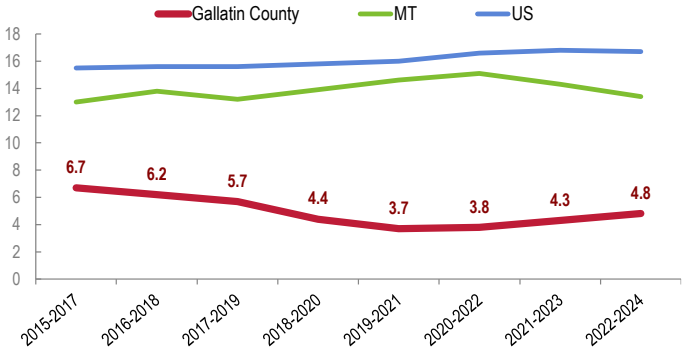
Kidney Disease

Kidney disease mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Kidney Disease Mortality Trends
(Annual Average Deaths per 100,000 Population)

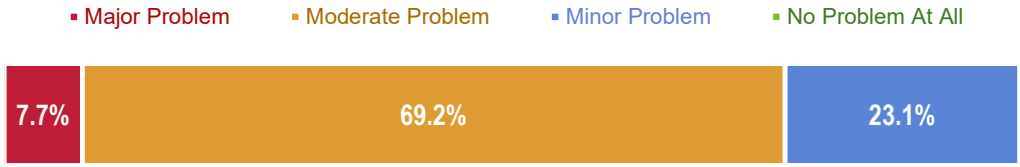


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:

Perceptions of Diabetes as a Problem in the Community
(Key Informants; Big Sky Area, 2026)



Sources: ● 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Zero resources or support. — Social Services Provider

Disabling Conditions

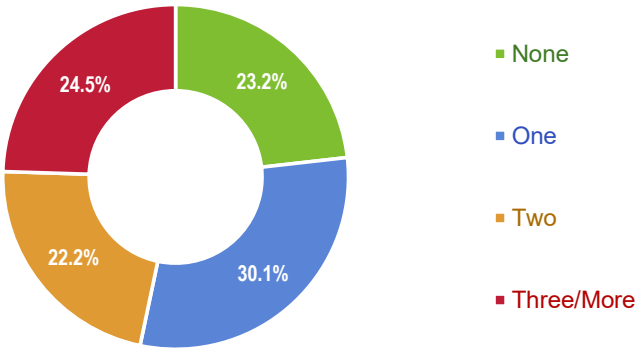
Multiple Chronic Conditions

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Stroke

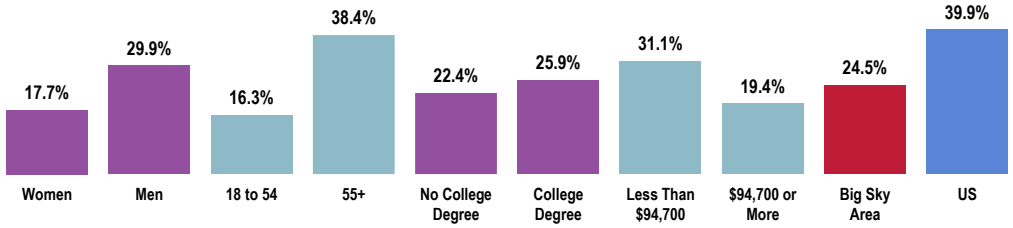
Number of Chronic Conditions
(Big Sky Area, 2026)



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 105]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

Have Three or More Chronic Conditions
(Big Sky Area, 2026)



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

Activity Limitations

ABOUT DISABILITY & HEALTH

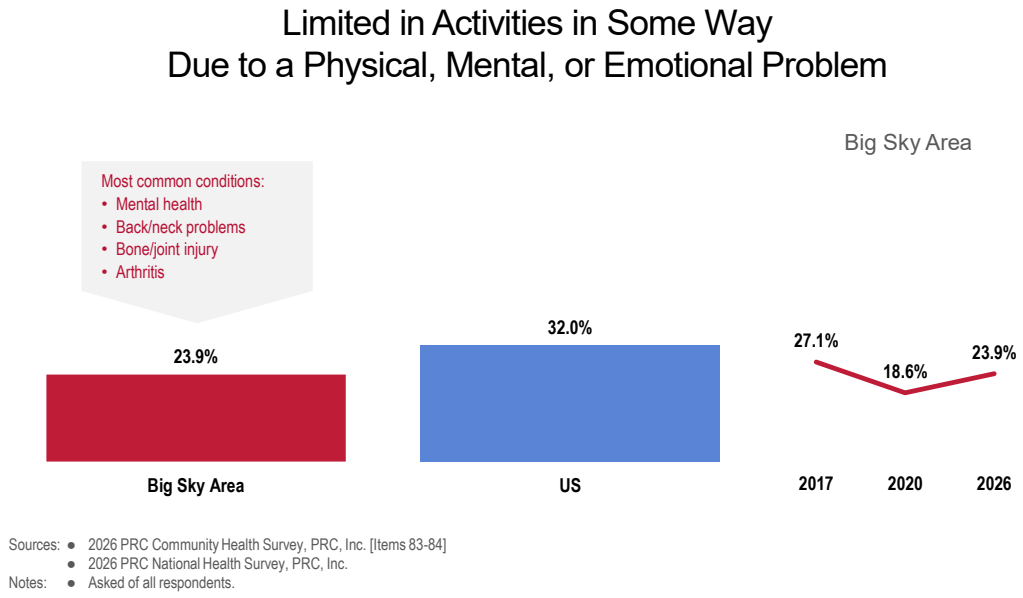
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030

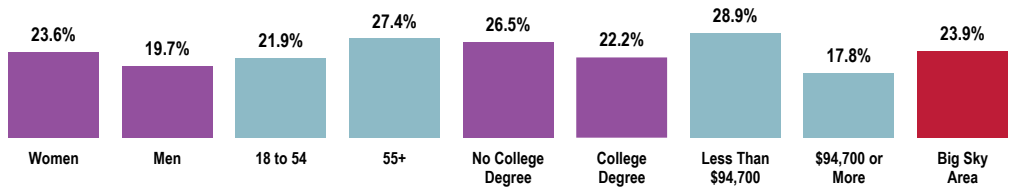
PRC SURVEY ► "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

PRC SURVEY ► [Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 83-84]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem
(Big Sky Area, 2026)



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 83]

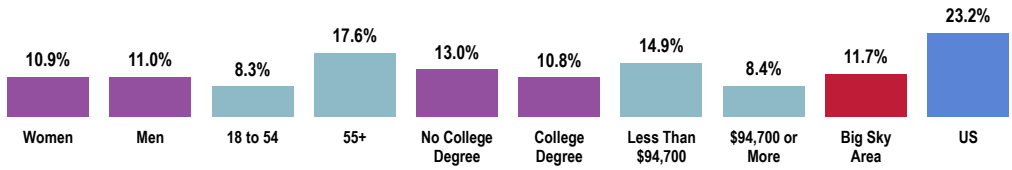
Notes:
- Asked of all respondents.

High-Impact Chronic Pain

PRC SURVEY ► "Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?"

Reported here among those responding "most days" or "every day".

Experience High-Impact Chronic Pain
(Big Sky Area, 2026)
Healthy People 2030 = 6.4% or Lower



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 31]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

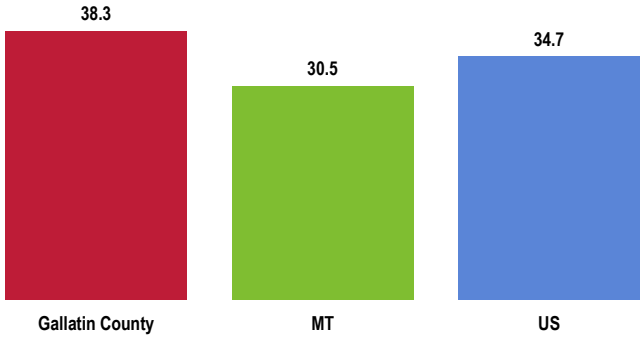
While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030

Alzheimer's Disease Deaths

Alzheimer's disease mortality is outlined in the following chart. [COUNTY-LEVEL DATA]

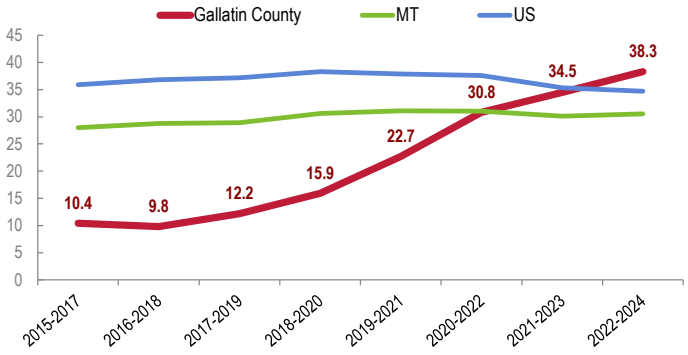
Alzheimer's Disease Mortality
(2022-2024 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Alzheimer's Disease Mortality Trends
(Annual Average Deaths per 100,000 Population)

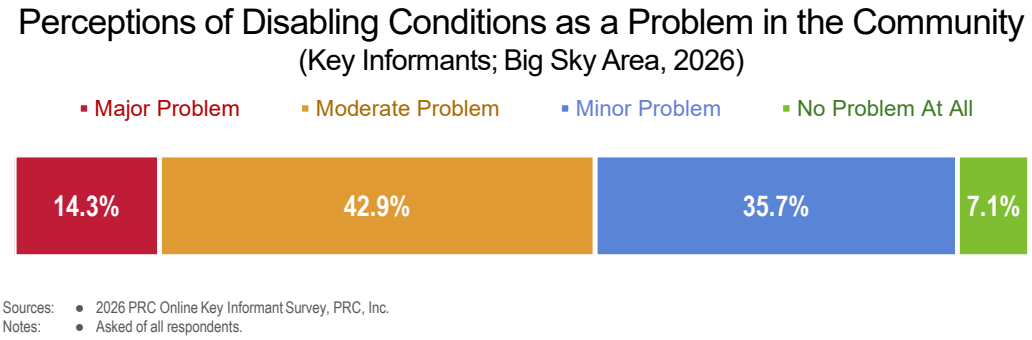


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Key Informant Input: Disabling Conditions

The following chart outlines key informants' perceptions of the severity of *Disabling Conditions* as a problem in the community:



Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Lack of In-Home Health

> In home Health and Hospice care is almost nonexistent in our community. There are over 20 agencies that service Gallatin County, but they will not drive past Big Sky. Majority of the companies that provide services are strictly self-pay which causes low-income seniors to have to choose between aging in their own home or wait until the very last minute to die in a hospital among strangers. The West Yellowstone Senior Center is now partnering with Cornerstone to help with in home health needs, but we still have not found hospice options. In my opinion and based on my personal experience working with families in my community over the last 10 years, most organization forget that Gallatin County goes past Big Sky. — Social Services Provider

Incidence/Prevalence

> The number of cases of ALS in Big Sky needs to be addressed. New cases of ALS in the United States are at 1.4-3 per 100,000 people per year. Statistically, Big Sky's population should then see one case of ALS every 9-20 years. There have been 6 cases in the last 5 years in Big Sky. This is concerning. — Community Leader

Access to Care/Services

> Specialty services are not available in Big Sky. We have a significant need for neurology services. — Community Leader

Follow-Up/Support

> There is zero support or services. — Social Services Provider

BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social drivers of health is critical for reducing these disparities.

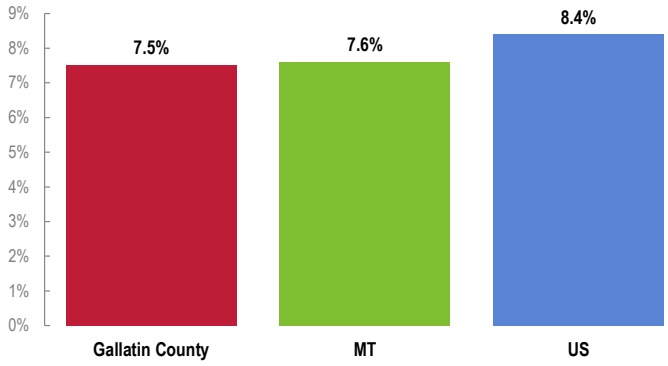
– Healthy People 2030

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. [COUNTY-LEVEL DATA]

Low-Weight Births
(Percent of Live Births, 2017-2023)

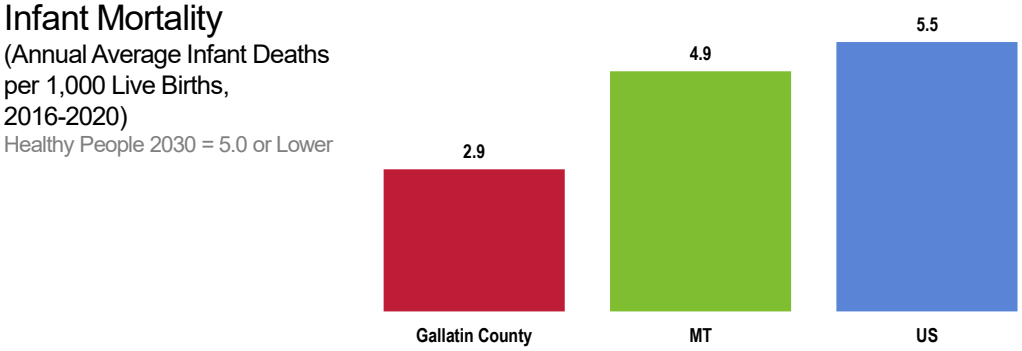


Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of total births that are low birthweight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2026.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Infant deaths include deaths of children under one year old.

Family Planning

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

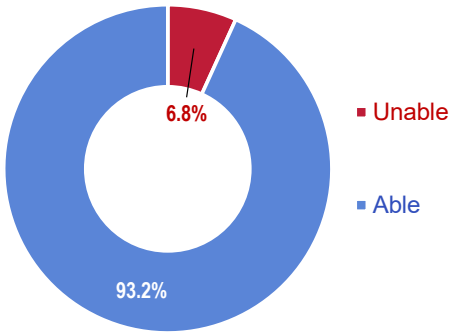
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

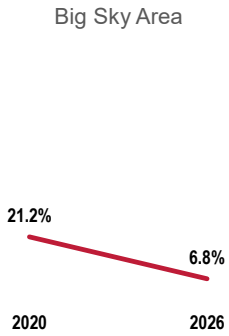
– Healthy People 2030

Reproductive Care

PRC SURVEY ► [All adults age 18 to 49] **"Was there a time in the past 12 months when you wanted health care related to reproductive health and were not able to get it?"**

Unable to Obtain Reproductive Health Care in the Past Year
(Big Sky Area Adults Age 18-49)



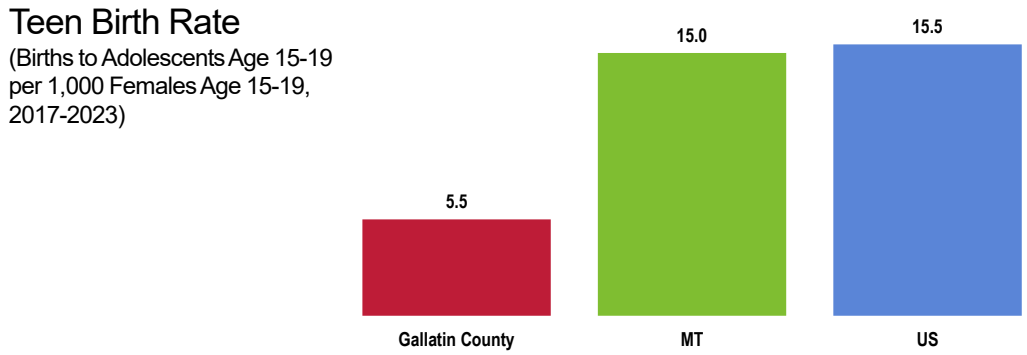


Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 316]
Notes: ● Reflects respondents age 18 to 49.

Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior. [COUNTY-LEVEL DATA]

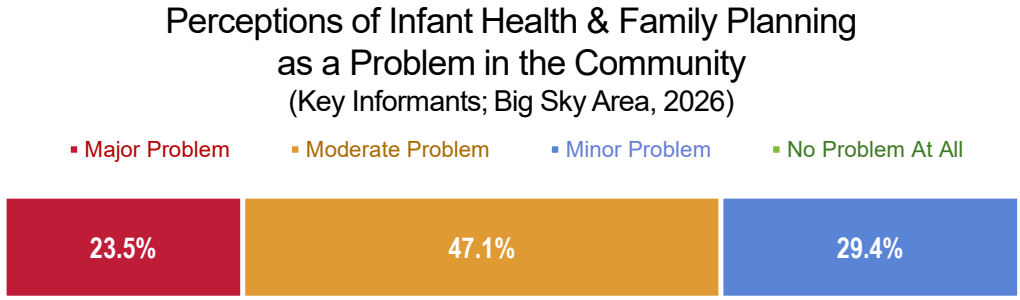


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15-19 per 1,000 female population age 15-19.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health & Family Planning* as a problem in the community:



Sources:
- 2026 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Zero services. — Social Services Provider
>
> There are families who struggle not only with services not available here, but also the funds to pay for such services. — Community Leader
>
> Outside of primary care for infants, there are few additional resources available in Big Sky and require a Bozeman trip. — Community Leader

Follow-Up/Support

> I have heard from many people that it feels isolating when they start having kids, and there's not a lot of family supports here in Big Sky. They have to go to Bozeman. I have had friends move to Bozeman to get access to these services. There are strong efforts in Big Sky to address these challenges (Morningstar, Discovery, new childcare center for example). — Community Leader

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

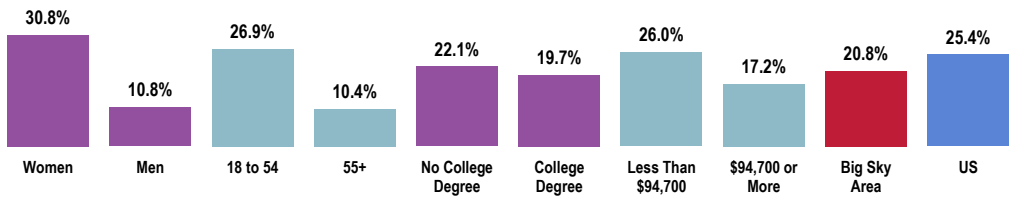
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030

Access to Fresh Produce

PRC SURVEY ► "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(Big Sky Area, 2026)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 63]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Physical Activity

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030

Leisure-Time Physical Activity

PRC SURVEY ► "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower

Big Sky Area



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 66]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

To measure physical activity frequency, duration and intensity, respondents were asked:

PRC SURVEY ► "During the past month, what type of physical activity or exercise did you spend the most time doing?"

PRC SURVEY ► "And during the past month, how many times per week or per month did you take part in this activity?"

PRC SURVEY ► "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

PRC SURVEY ► "During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles?"

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

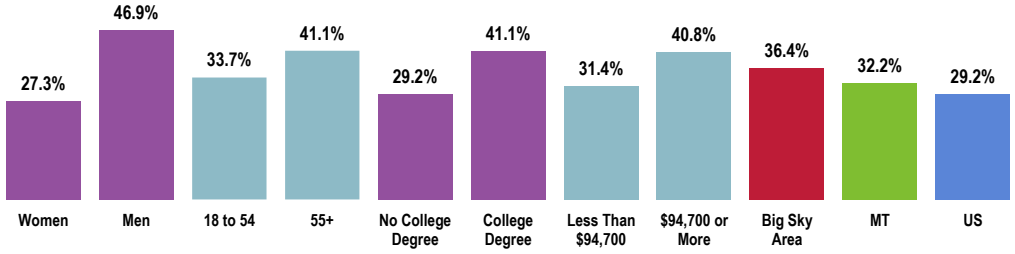
For adults, "meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activities:

- **Aerobic Activity** — For substantial health benefits, adults should do at least 150 minutes (2 hours and 30 minutes) to 300 minutes (5 hours) a week of moderate-intensity, or 75 minutes (1 hour and 15 minutes) to 150 minutes (2 hours and 30 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity. Preferably, aerobic activity should be spread throughout the week.

  Additional health benefits are gained by engaging in physical activity beyond the equivalent of 300 minutes (5 hours) of moderate-intensity physical activity a week.
- **Strengthening Activity** — Adults should also do muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on 2 or more days a week, as these activities provide additional health benefits.

– 2018 Physical Activity Guidelines for Americans, US Department of Health and Human Services

Meets Physical Activity Recommendations
(Big Sky Area, 2026)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 109]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week (or an equivalent combination of moderate and vigorous-intensity activity) *and* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

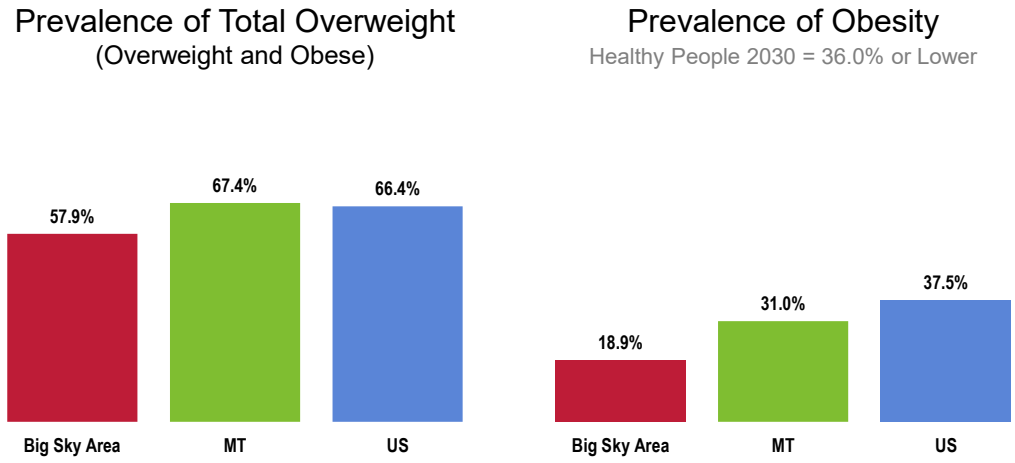
CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

PRC SURVEY ► "About how much do you weigh without shoes?"

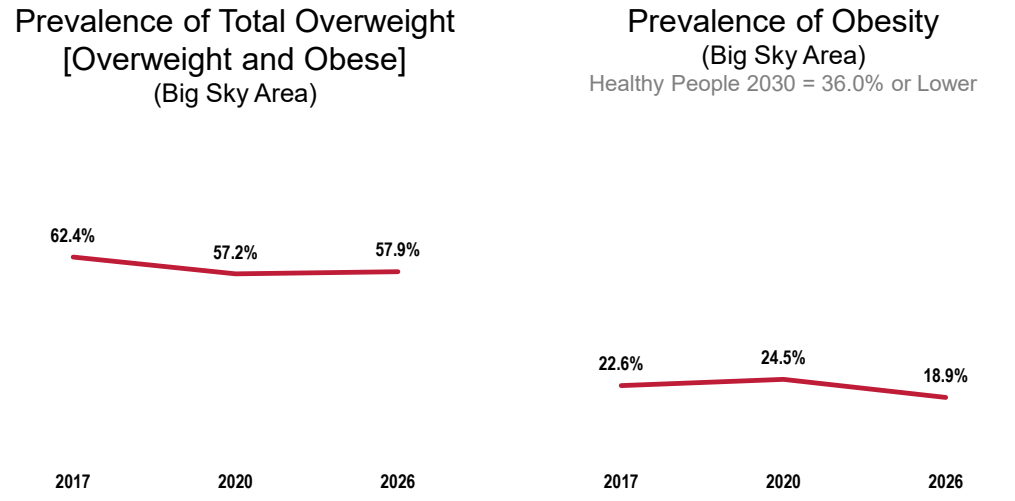
PRC SURVEY ► "About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 111]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

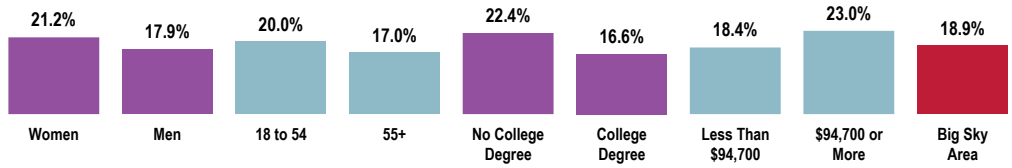
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 111]
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity
(Big Sky Area, 2026)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 111]
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

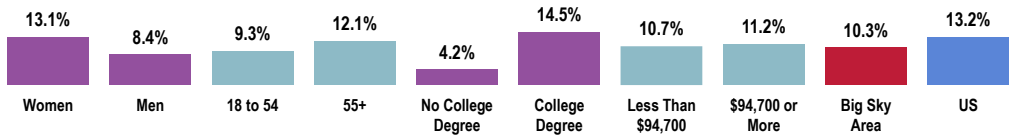
Use of GLP-1 Agonists

PRC SURVEY ► "Are you currently taking any type of GLP-1 medication?"

Respondents were told: "A class of new prescription drugs called GLP-1 agonists are being prescribed to treat diabetes, cardiovascular disease, sleep apnea, and/or for weight loss. These often involve giving yourself daily or weekly injections. Common brand names include Trulicity, Ozempic, Mounjaro, Zepbound, and Wegovy."

Currently Taking a GLP-1 Agonist Medication
(Big Sky Area, 2026)

Among Those at a Healthy Weight	6.6%
Among Those Overweight/Obese	10.8%

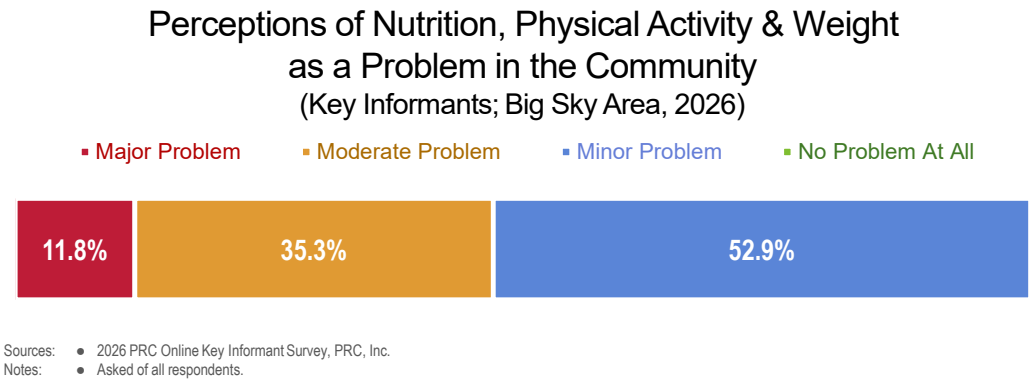


Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 28]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- GLP-1 agonists were defined for respondents as a class of drugs prescribed for weight loss or to treat diabetes, cardiovascular disease, and/or sleep apnea. These often involve daily or weekly injections. Common brand names mentioned were Trulicity, Ozempic, Mounjaro, Zepbound, and Wegovy.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:



Sources: 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> I think the nutrition problem is a battle many face, and there is a need for training on how to cook whole foods and minimize processed foods. We live in a beautiful area, and in the summer months, many have more opportunities to exercise and enjoy the outdoors, but it seems so many are working sometimes 2 jobs just to make ends meet that they have little time to exercise, which only worsens their battle with their weight. — Community Leader

Insufficient Physical Activity

> Enough activities to keep people active. — Community Leader

Substance Use

ABOUT DRUG & ALCOHOL USE

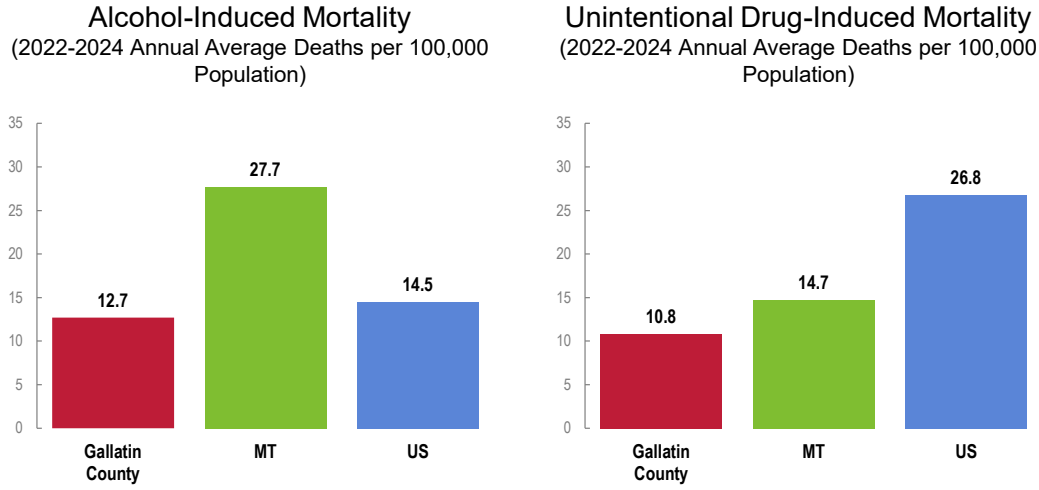
Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030

Substance-Related Deaths

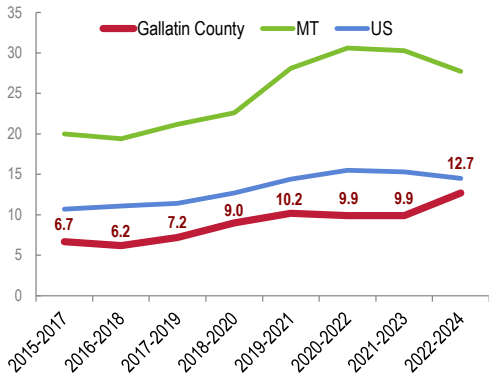
The following charts outline alcohol- and drug-induced mortality in the area. Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an underlying cause. A “drug” includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. [COUNTY-LEVEL DATA]



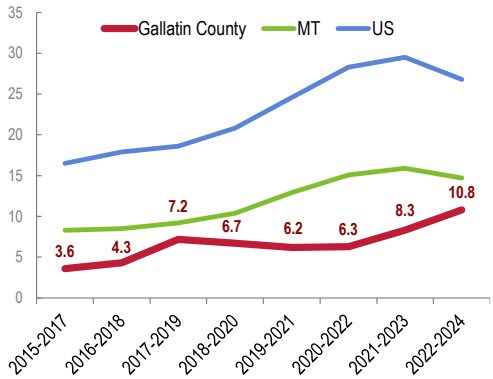
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Alcohol-Induced Mortality
(Annual Average Deaths per 100,000 Population)



Unintentional Drug-Induced Mortality
(Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2026.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Excessive Drinking

PRC SURVEY ► "During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

PRC SURVEY ► "On the day(s) when you drank, about how many drinks did you have on average?"

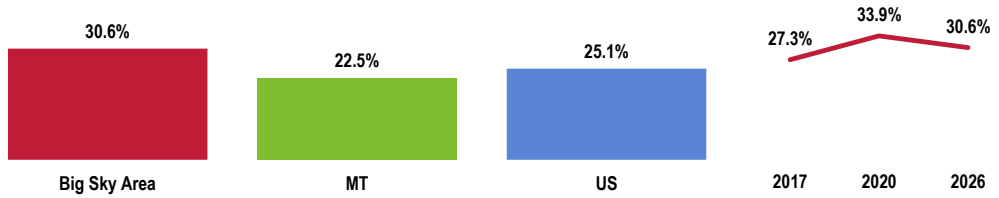
PRC SURVEY ► "Considering all types of alcoholic beverages, how many times during the past 30 days did you have five (if male)**/four** (if female) **or more drinks on an occasion?"**

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

Engage in Excessive Drinking

Big Sky Area



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 113]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.

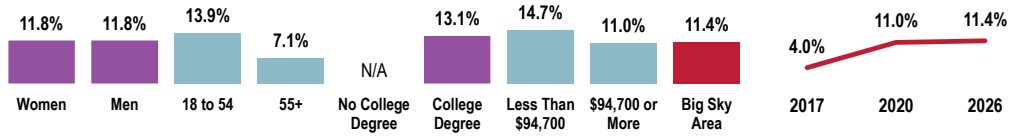
Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drinking and Driving

PRC SURVEY ► "During the past 30 days, how many times have you driven when you've had perhaps too much to drink?"

Have Driven One or More Times in the Past Month After Perhaps Having Too Much to Drink

Big Sky Area



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 310]

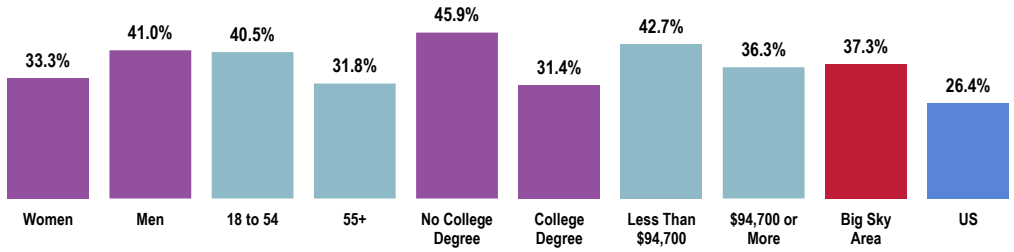
Notes:
- Asked of all respondents.
- The number of respondents with no college degree were too low to be interpreted with confidence.

Drug Use

Marijuana/THC Use

PRC SURVEY ► "During the past 12 months, have you used marijuana or products containing THC in any form? This includes use of traditional marijuana, hashish, edibles, and concentrates like hash oil, wax, or shatter. It does not include use of CBD oils."

Used Marijuana/THC in the Past Year
(Big Sky Area, 2026)



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 35]
- 2026 PRC National Health Survey, PRC, Inc.

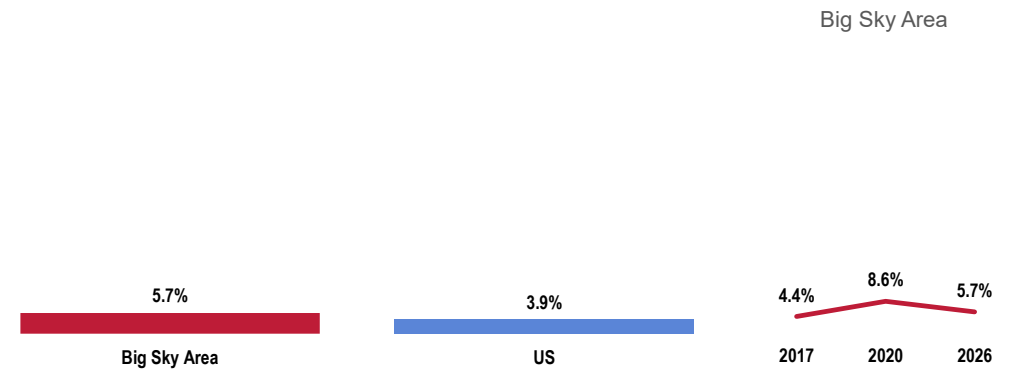
Notes:
- Asked of all respondents.
- Includes traditional marijuana, hashish, edibles, and concentrates like hash oil, wax, or shatter (does not include CBD oils).

Illicit Drug Use

PRC SURVEY ► "During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

Illicit Drug Use in the Past Month

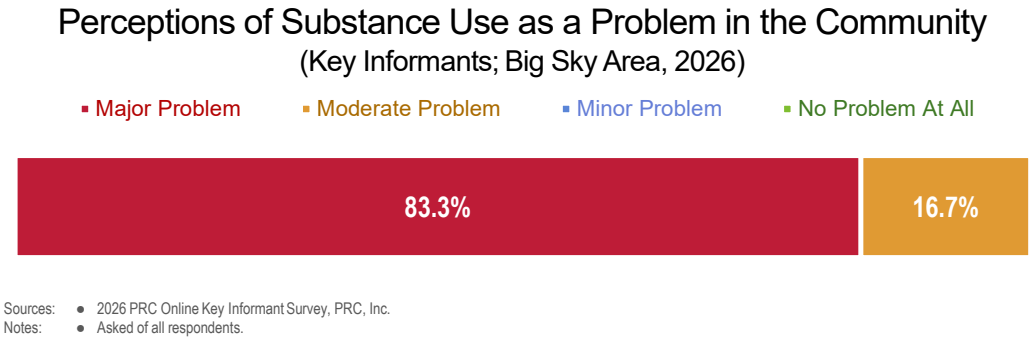


Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 39]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Substance Use

The following chart outlines key informants' perceptions of the severity of *Substance Use* as a problem in the community:



Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Must drive to Bozeman or further to access treatment. There's no access to holistic care for substance use; any treatment facility is clinical/sterile. — Community Leader
>
> Having Rimrock peer support in past years was helpful. We haven't had a peer support specialist locally in a while. — Social Services Provider
>
> There isn't any SUD treatment in Big Sky. — Health Care Provider
>
> Big Sky does not have clinical substance use treatment programming - there are several peer groups. Substance use and party culture is deeply tied to the way of life in Big Sky (like other ski towns), and it is challenging for people to change their behaviors. If someone leaves the community to access substance use treatment, there aren't a lot of follow-up support options available for them when they return. — Social Services Provider
>
> There is no substance use treatment at all in this area. — Health Care Provider
>
> Access to available providers, barriers with stigma, affordability and access when service workers are available. — Community Leader

Lack of Providers

> Lack of providers, lack of system for starting treatment and supports for ongoing treatment and support, high social use of alcohol, no inpatient treatment, no day treatment or support like clubhouse.
> — Social Services Provider

Social Norms/Community Attitude

> I think this is a tough issue. The nature of our town contributes to this. It is easy to get a job here, but there is a lot of down time and unless you are into the outdoors, sometimes there's not a lot of other things to do beside drink. I think the biggest barrier is that people have to want to quit or become sober. You cannot force people to do it. I think more counselors available would be helpful, too. — Community Leader

Geographic Isolation

> Probably the area is somewhat remote and does not have many resources to address addiction. We do have AA meetings in the community, and there is an addiction class resource through one of the churches and welcomes anyone to attend. — Community Leader

Cultural/Personal Beliefs

> Party culture and stigma, recovery beds and follow up community care are non-existent.
> — Social Services Provider

Diagnosis/Treatment

> Professional, not peer-based, treatment options. — Social Services Provider

Lack of Privacy

> Our community is so small people are reluctant to seek help. The few that we have shipped to rehab complete the program. — Social Services Provider

Lifestyle

> People who abuse substances are not generally the same people that are concerned about it. — Community Leader

Denial/Stigma

> Stigma. — Community Leader

Tobacco Use

ABOUT TOBACCO USE

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

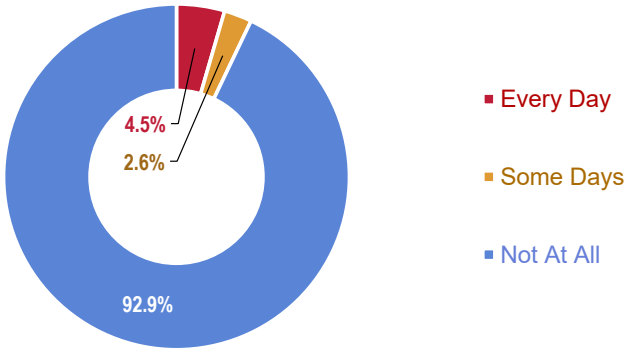
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030

Cigarette Smoking

PRC SURVEY ► "Do you currently smoke cigarettes every day, some days, or not at all?"

Prevalence of Cigarette Smoking
(Big Sky Area, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 33]
Notes: • Asked of all respondents.

"Currently Smoke Cigarettes" includes those smoking "every day" or on "some days."

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower

Big Sky Area



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 33]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

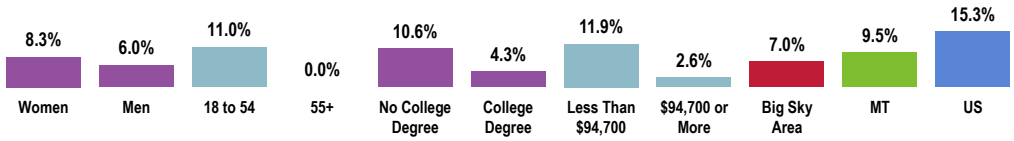
Use of Vaping Products

PRC SURVEY ► "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

"Currently Use Vaping Products" includes use "every day" or on "some days."

Currently Use Vaping Products

(Big Sky Area, 2026)



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

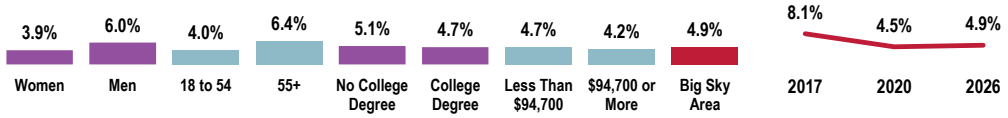
Use of Smokeless Tobacco

PRC SURVEY ▶ **"Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?"**

"Currently Use Smokeless Tobacco" includes use "every day" or on "some days."

Currently Use Smokeless Tobacco

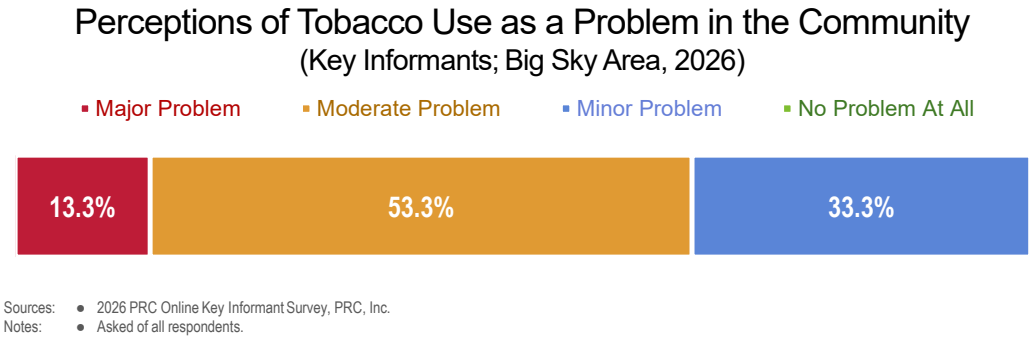
Big Sky Area



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 309]
Notes: ● Asked of all respondents.
● Includes those who use chewing tobacco, snuff, or snus products every day or on some days.

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:



Sources: 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Co-Occurrences

> I believe this is a major problem in most areas but in Big Sky specifically I believe it ties into the substance use disorders. — Health Care Provider

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

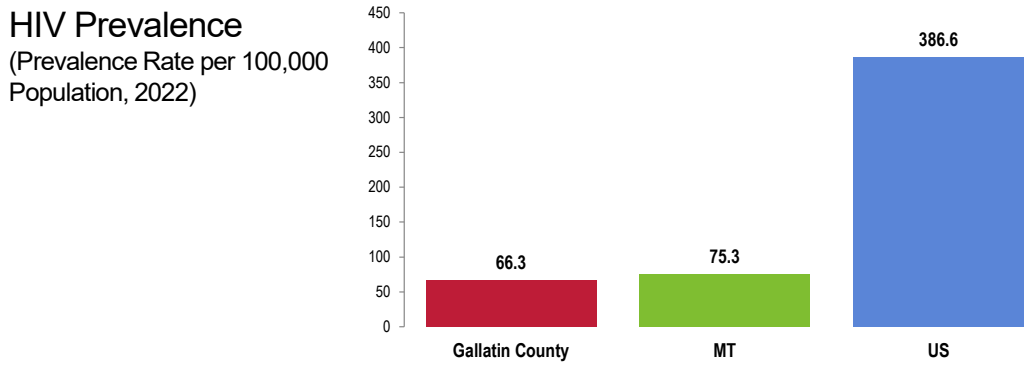
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs (sexually transmitted infections). And people who have an STI may be at higher risk of getting HIV (human immunodeficiency virus). Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030

HIV

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area. [COUNTY-LEVEL DATA]



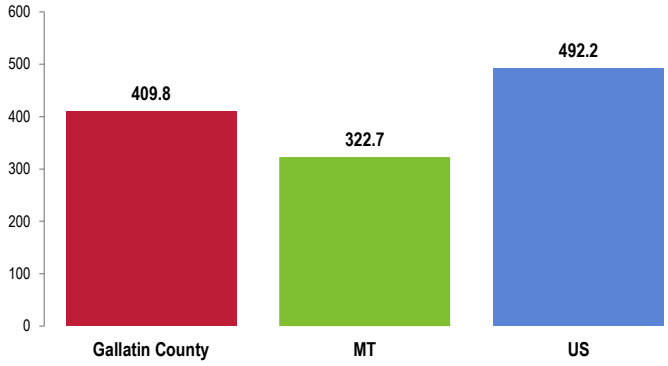
Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

Chlamydia

Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms. [COUNTY-LEVEL DATA]

Chlamydia Incidence
(Incidence Rate per 100,000 Population, 2023)

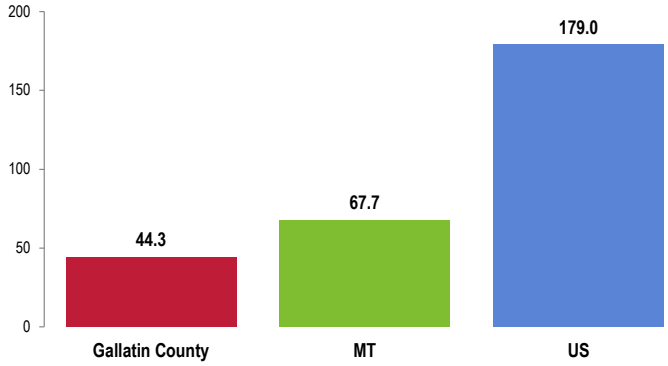


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Gonorrhea

Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men. [COUNTY-LEVEL DATA]

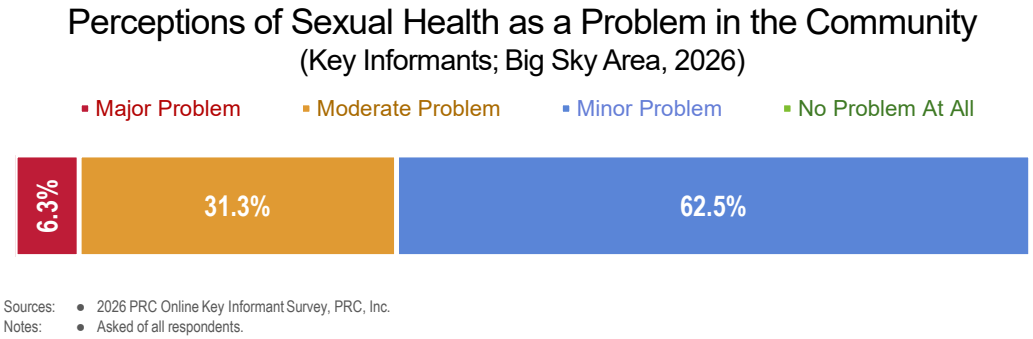
Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2023)



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Sources: 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access to care in Big Sky is limited outside of a primary care established. Bozeman is the option for this specialty, and Bridger Care specifically for the affordability. — Community Leader

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030

Lack of Health Insurance Coverage

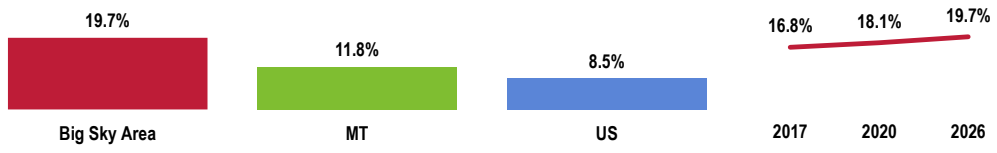
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

PRC SURVEY ► "Do you have any government-assisted health care coverage, such as Medicare, Medicaid, or VA/military benefits?"

PRC SURVEY ► "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay for health care entirely on your own?"

Lack of Health Care Insurance Coverage
(Adults 18-64)
Healthy People 2030 = 7.6% or Lower



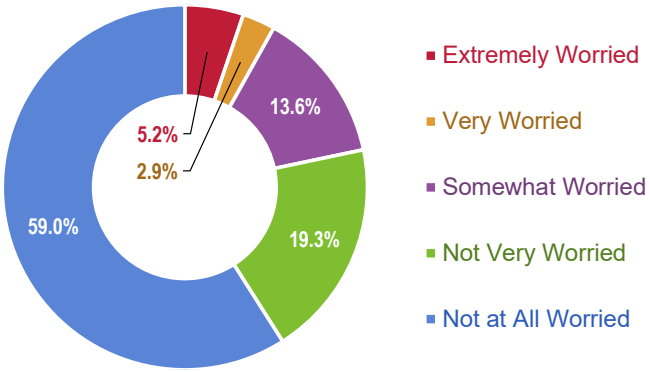
Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Reflects respondents age 18 to 64.

Loss of Coverage

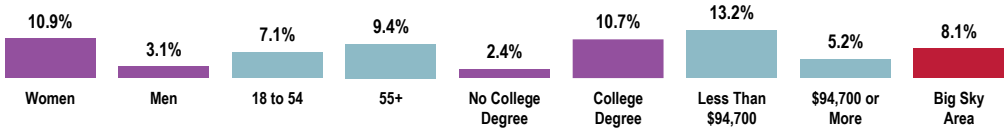
PRC SURVEY ► "How worried do you feel that you might lose health insurance coverage in the coming year because it becomes unaffordable or because you are no longer eligible for your current plan? Would you say you are: extremely worried, very worried, somewhat worried, not very worried, or not at all worried?"

Worried About Losing Health Care Insurance Coverage in the Next Year
(Big Sky Area, 2026)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 314]
Notes: • Asked of all respondents.

"Extremely" or "Very" Worried About Losing Health Care Insurance Coverage in the Next Year
(Big Sky Area Adults)



Sources: • 2026 PRC Community Health Survey, PRC, Inc. [Item 314]
Notes: • Asked of all respondents.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

PRC SURVEY ► "Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"

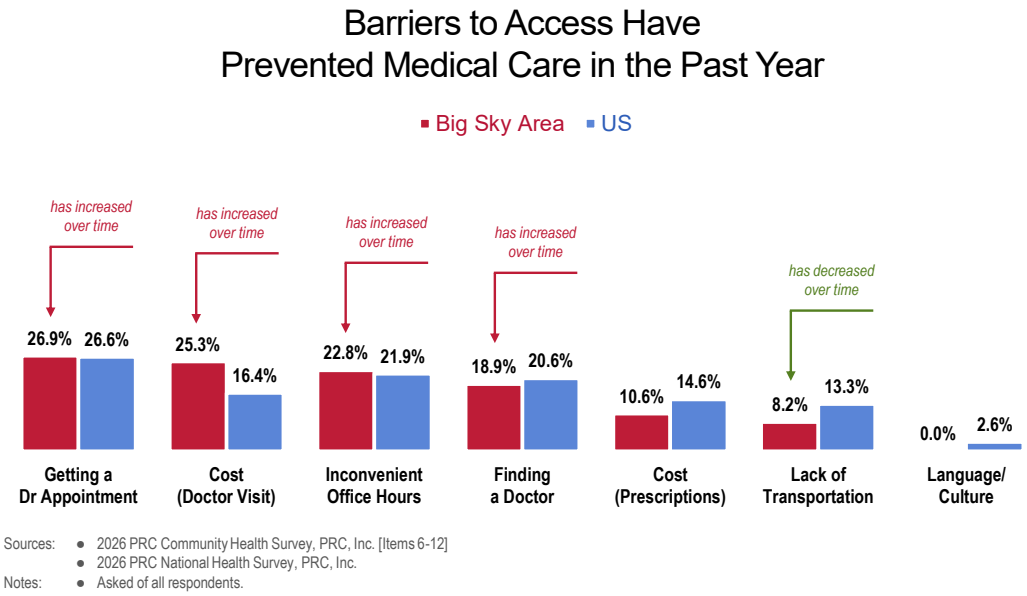
PRC SURVEY ► "Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

PRC SURVEY ► "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

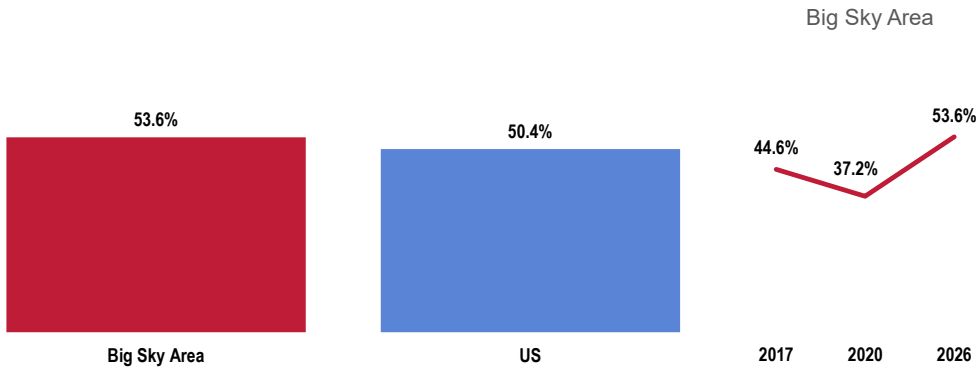


Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Items 6-12]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers), again regardless of whether they needed or sought care.

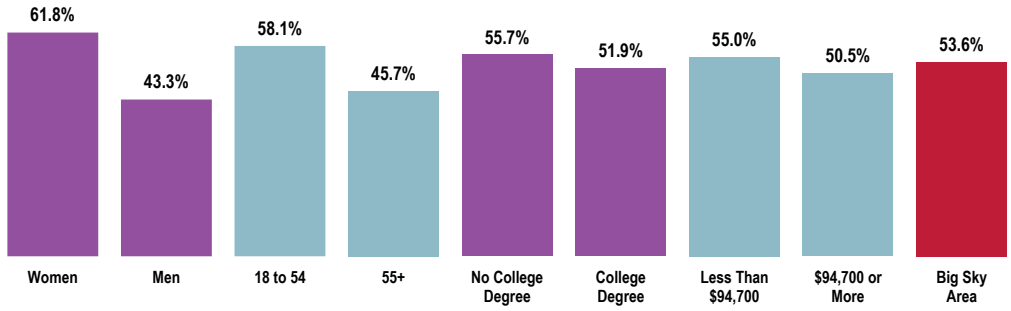
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 116]
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Big Sky Area, 2026)

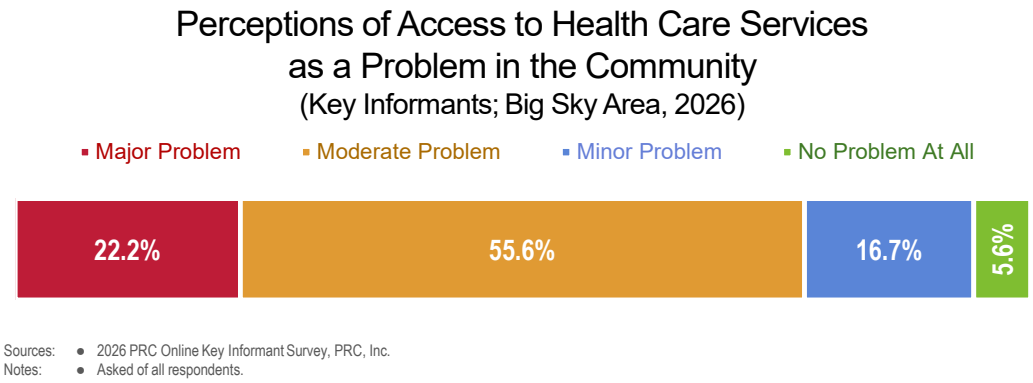


Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 116]

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:



Sources: • 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> We live 90 miles from Bozeman medical centers and 90 miles from medical centers in Idaho for those who choose to go there for medical care. This distance creates many obstacles for those choosing to travel for these services. — Community Leader
>
> West Yellowstone has a small clinic that does its best to serve the community. For most of the specialized care our community members have to drive 2 hours for referrals and appointments. Our dentist is open one day a week, OT and PT 95% go outside the community. Meatal health services are twice a month through the clinic or one day a week through social services. Low-income families struggle with telehealth as well as the senior population. — Social Services Provider

Affordable Care/Services

> Cost is a barrier - many individuals lack health insurance and are not able to afford the monthly cost of a plan. Those who do have health insurance often have a high deductible and are still responsible for many costs out of pocket before they reach their deductible. I think lower income individuals have more opportunities to access cost assistance programs while middle-income individuals/families who still struggle to afford services don't qualify for support. Appointment availability for both basic services and more specialty care services is another challenge. As the community grows, the number of providers needs to grow with it in order to keep service available. Many individuals work service jobs with irregular hours and aren't able to access care during normal business hours. Geographic location - several communities in our area are more isolated and don't have access to the same programs that are available in Bozeman. — Social Services Provider

Awareness/Education

> Despite many efforts for service providers to get the word out about local supports, many people still don't know where to go to get help. Stigma is still an issue. People think they can handle it on their own. Ability to afford counseling (especially if you want a counselor that isn't associated with a sliding fee scale program). Time in schedule - people are working multiple jobs and it requires logistics and planning to set up appointments, etc. Some people still don't have health insurance. — Community Leader

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030

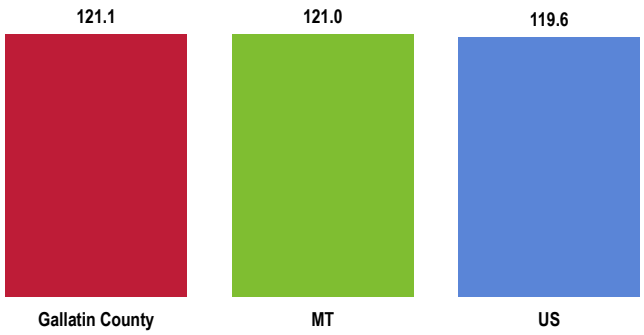
Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. [COUNTY-LEVEL DATA]

Number of Primary Care Physicians per 100,000 Population
(2026)

This reflects 144 primary care physicians in Gallatin County.

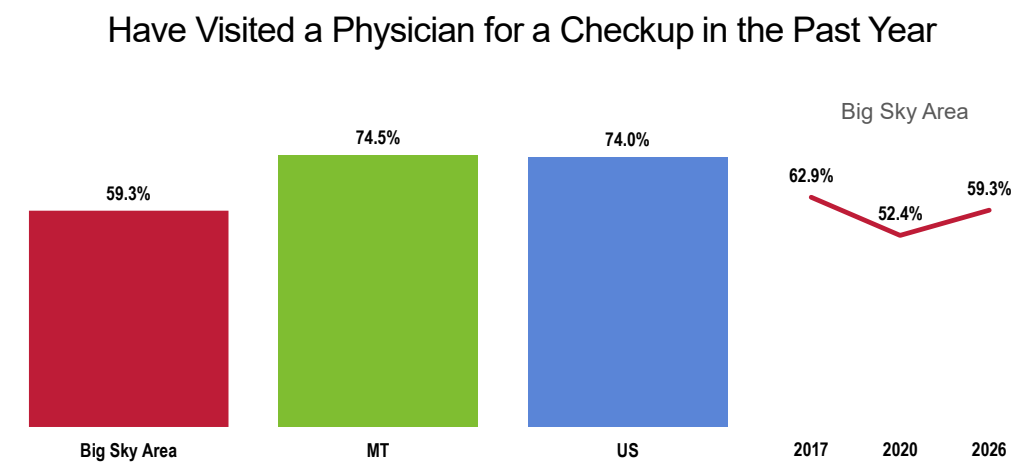


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2026 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Utilization of Primary Care Services

PRC SURVEY ► "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2024 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Emergency Room Utilization

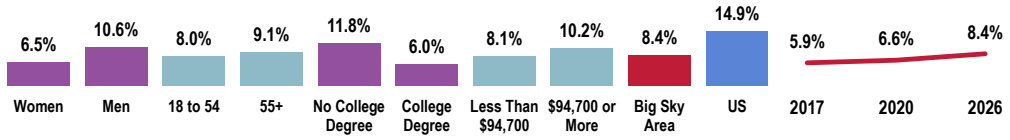
PRC SURVEY ► "In the past 12 months, how many times have you gone to a hospital emergency room about your own health? This also includes ER visits that resulted in a hospital admission."

PRC SURVEY ► [Among those who used the ER] **"What was the main reason you used the emergency room instead of going to a doctor or health professional's office or clinic?"**

Have Used a Hospital Emergency Room More Than Once in the Past Year

Big Sky Area

Used the ER because:
- Emergency situation 59.2%
- Weekend/after hours 22.4%
- Long appointment wait 6.5%
- Doctor's Recommendation 6.0%



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 19, 301]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Oral Health

ABOUT ORAL HEALTH

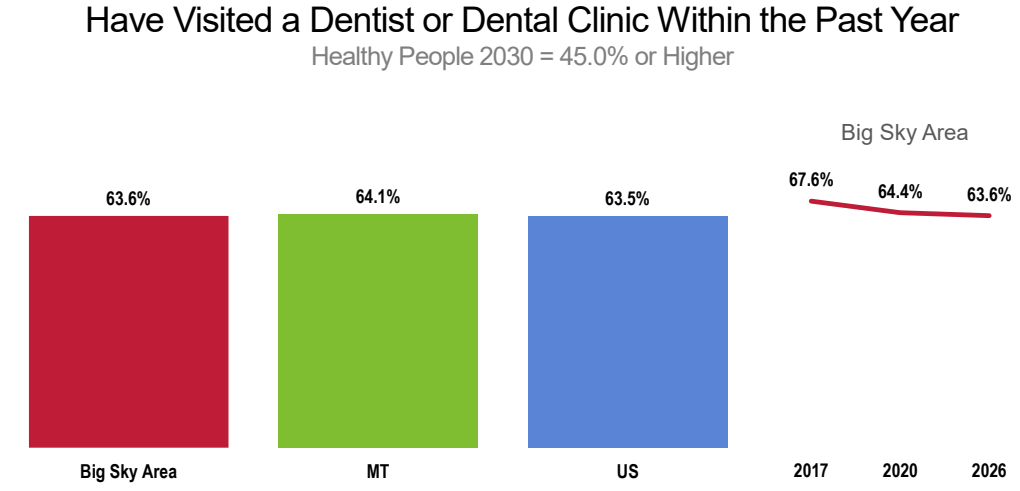
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

PRC SURVEY ► "About how long has it been since you last visited a dentist or a dental clinic for any reason?"

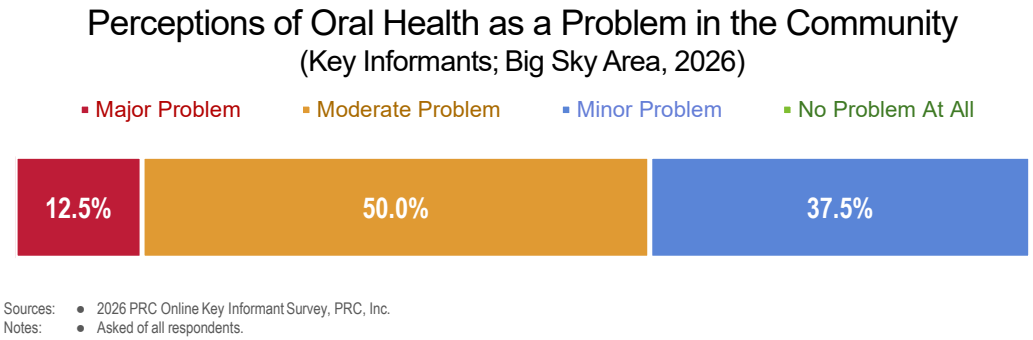


Sources:
- 2026 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 Montana data.
- 2026 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030.

Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:



Sources: 2026 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care for Uninsured/Underinsured

> Households are underinsured, especially when it comes to dental. Our access to dental care is severely limited and knowledge around oral health seems low. — Social Services Provider

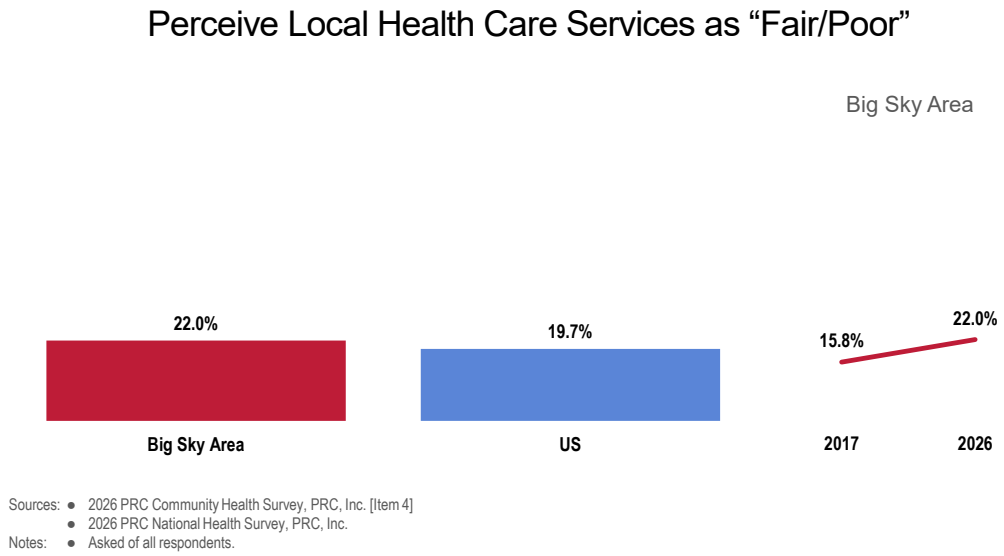
Awareness/Education

> We have one dentist that does not advertise anything about the importance of good oral health. — Social Services Provider

LOCAL RESOURCES

Perceptions of Local Health Care Services

PRC SURVEY ► "How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"



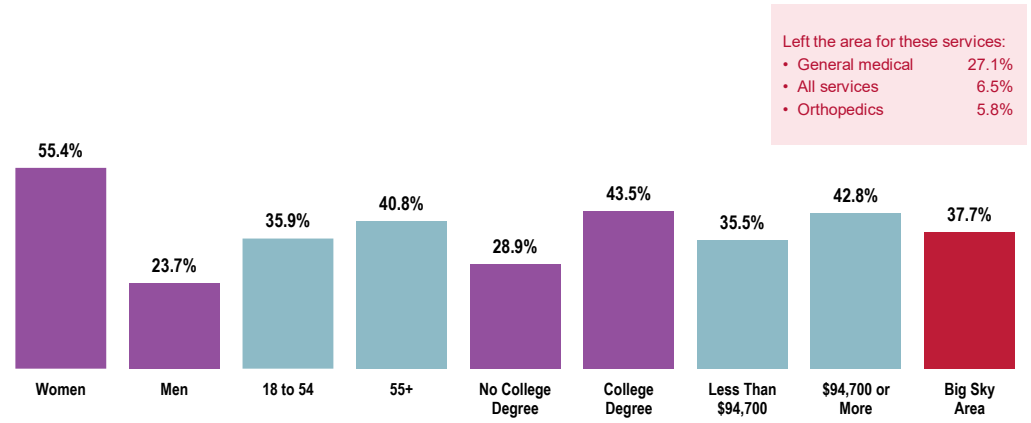
Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 4]
● 2026 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Outmigration for Care

PRC SURVEY ► "During the past 12 months, have you or has any member of your household left the local area to receive health care services?"

PRC SURVEY ► [Among those who left the area for services in the past year] **"Would you please tell me which health care service that was?"**

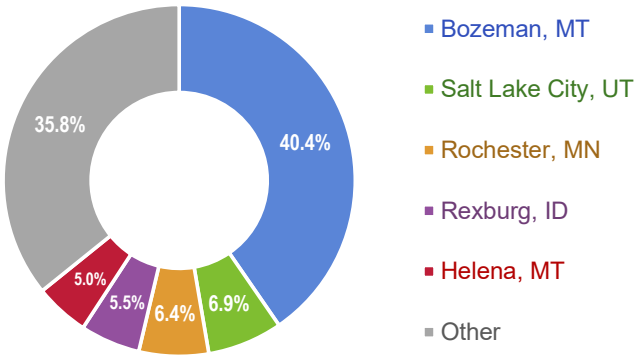
Left the Area for Health Care Services in the Past Year
(Big Sky Area, 2026)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Items 302-303]
Notes: ● Asked of all respondents.

PRC SURVEY ► [Among those who left the area for services in the past year] **"To which community did you go for these health care services?"**

Community Visited for Health Care Services
(Respondents Who Left the Area for Care, 2026)



Sources: ● 2026 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: ● Asked of all respondents who left the area for health care services in the past year.

Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Big Sky Bandage
- Big Sky Community Food Bank
- Big Sky Medical Center
- Billings Clinic
- Community First Aid
- Food Bank
- Navigator Network
- Wellness in Action

Cancer

- Community Fundraisers
- Doctors' Offices
- West Yellowstone Foundation Bus

Diabetes

- Billings Clinic

Disabling Conditions

- Doctors' Offices
- Rehab Specialist of Idaho

Infant Health & Family Planning

- Big Sky Community Food Bank
- Discovery
- Don't Know
- Gallatin Childcare Center
- Morningstar
- Morningstar Learning Center
- Roots Family Collaborative
- Wellness in Action

Injury & Violence

- Big Sky Medical Center
- Billings Clinic
- Community West Outreach
- Haven
- HRDC
- Law Enforcement
- Social Services
- Wellness in Action

Mental Health

- Arts Council of Big Sky
- BASE Community Center
- Be Well Big Sky
- Big Sky Bandage
- Big Sky Medical Center
- Big Sky OUT
- Billings Clinic
- Bozeman Health
- Bozeman Health Psychiatry
- BSMC
- Community Health Partners
- Community Support Group
- Doctors' Offices
- Food Bank
- Gallatin Behavioral Health Coalition
- Gallatin Mobile Crisis
- Health Coalition
- Help Center
- Law Enforcement
- Lighthouse Ranch
- Navigator Network
- Rimrock
- Social Services
- Telehealth
- Wellness in Action
- West Yellowstone Foundation Bus

Nutrition, Physical Activity & Weight

- Fitness Centers/Gyms
- Parks and Recreation
- School System

Oral Health

- West Yellowstone Dental

Respiratory Diseases

- Billings Clinic

Sexual Health

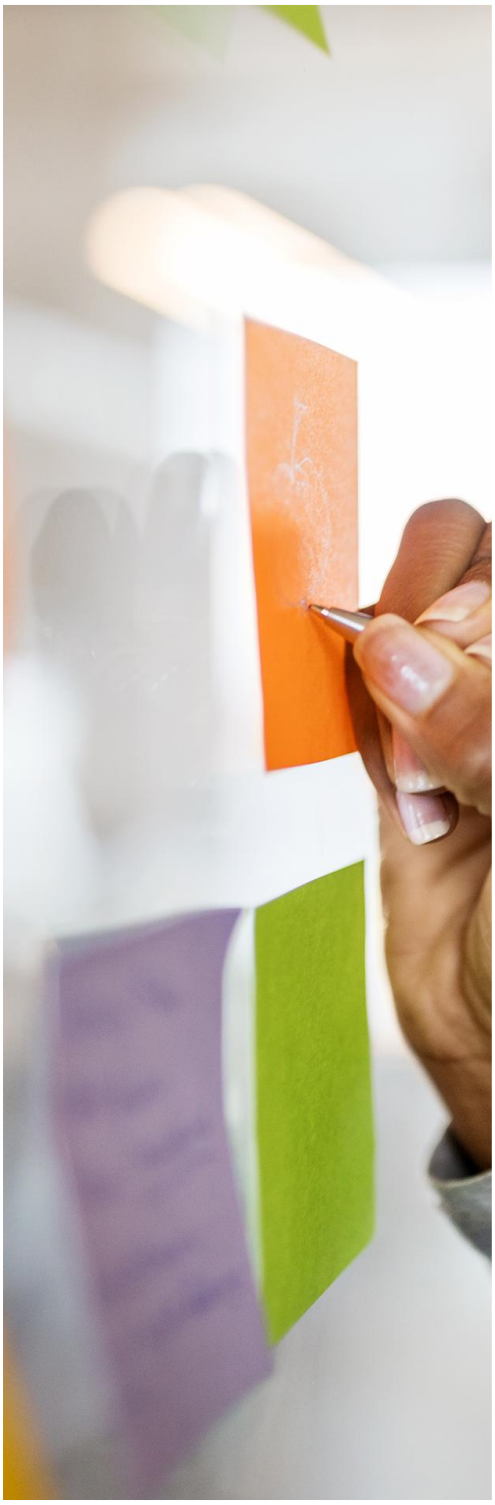
- Big Sky Medical Center
- Wellness in Action

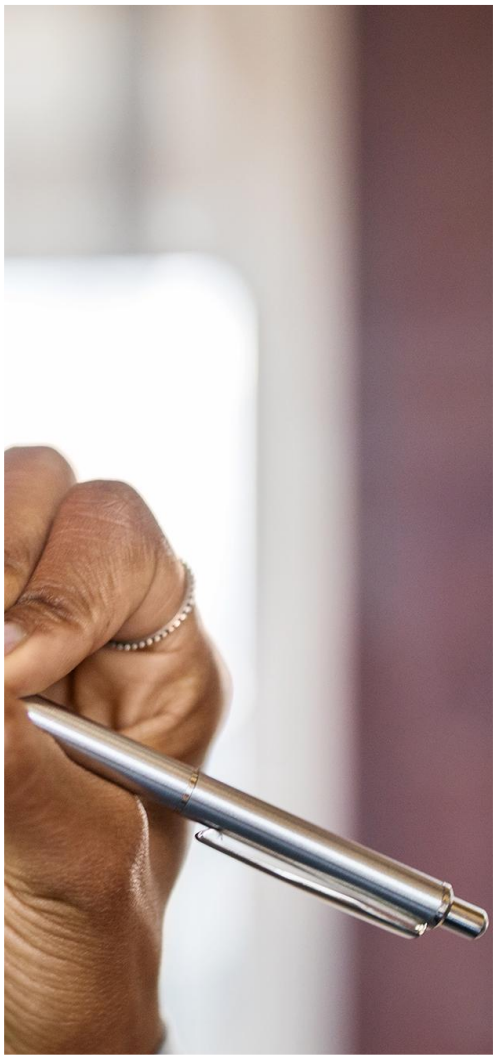
Substance Use

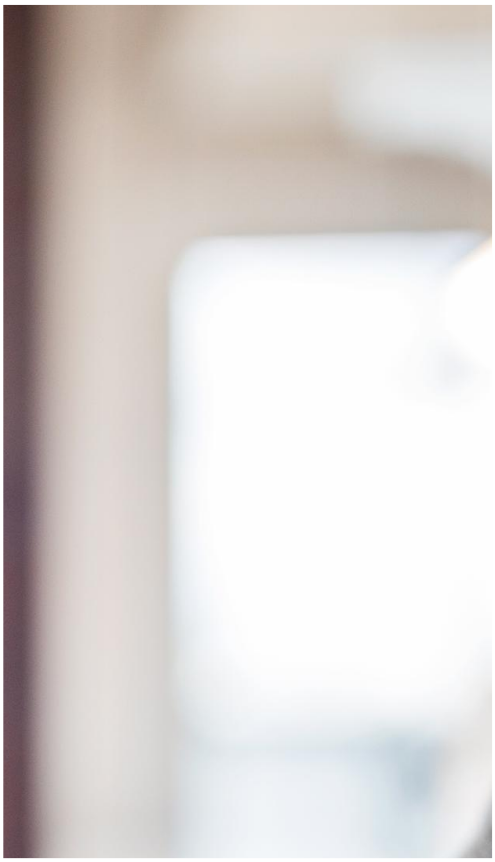
- AA/NA
- Big Sky Medical Center
- Billings Clinic
- Churches
- Community West Outreach
- Greater Impact
- Private Sector Services Addiction Treatment
- Rimrock
- School System
- Social Services
- Wellness in Action

Tobacco Use

- Big Sky Medical Center







APPENDIX

EVALUATION OF PAST ACTIVITIES

2024-2026 CHNA Progress Report

Every three years, in accordance with the requirements established by the Affordable Care Act and in alignment with our identity as a community hospital, both Bozeman Health Deaconess Regional Medical Center and Big Sky Medical Center conduct a Community Health Needs Assessment (CHNA). The CHNA identifies areas of opportunity within the health of our communities. Those opportunities then drive development of a three-year Community Health Action Plan (CHAP), which reaffirms our commitment to improving community health and outlines how Bozeman Health intends to address the identified health priorities.

The 2024-2026 CHAP health priorities are: behavioral health, access to healthcare, chronic disease prevention, and socio-economic and health measures.

Behavioral Health

Goal: Increase access to behavioral health services across the care continuum.

- **Strategy 1: Expand access to ambulatory behavioral health services within all Bozeman Health primary care sites.**
    - Expanded integrated Behavioral Health (IBH) services within our primary care sites in 2024.
    - Went live with Women's Clinic Collaborative Care IBH program, which includes a Care Manager and nurse navigators. We also have a psychiatric nurse practitioner available to support the women's clinic with perinatal/postpartum behavioral health care.
    - Increased access to outpatient psychiatric services by relocating and expanding the clinic, increased provider access with a new physician and a full-time Psychiatric Nurse Practitioner, and initiated recruiting for outpatient therapy positions.
- **Strategy 2: Enhance access to acute behavioral health services**
    - Opened inpatient psychiatric unit September 16, 2025, and coordinated a contract with Gallatin County to offer emergency detention (civil commitment) services within our organization.
    - Offered walk-in psychiatric care January through August 2025. In August, the walk-in clinic was converted to same-day acute appointments within the outpatient clinic and continues to operate as a same-day clinic currently.
- **Strategy 3: Explore outpatient alcohol and substance use disorder services with both Gallatin County and community authorities and resources**
    - Explored options to connect patients with psychiatric care options, inpatient psychiatric placement, youth inpatient psychiatric placement, and alcohol and substance use services and strengthened connections with several local, state, and regional referral services for patients.
    - Bozeman Health leaders spent more than 4,500 hours in 2024-2026 on community-based behavioral health initiatives, including Gallatin Behavioral Health Coalition and Gallatin County Local Advisory Council (LAC) meetings, activities, and initiatives as well as collaborative initiatives throughout Gallatin, Park, and surrounding counties.

- **Grants and Partnerships to support Behavioral Health goal 2024-2026:**
    - Partners in Health - $20k:
        - Big Sky Youth Empowerment - Youth Mental Health Support Program expanding access to in-house mental health counseling and therapeutic support for vulnerable teens in grades 7-12. The program provides one-on-one support for youth experiencing suicidal ideation, anxiety, depression, and other elevated mental health needs, while ensuring ethical clinical practices, parent engagement, and professional supervision.
        - Bridgercare - Behavioral Health Coordination Program: expanding access to Bridgercare's collaborative care mental health services. The Collaborative Care model provides automatic mental health screenings and allows patients to work with a Care Manager to receive comprehensive mental healthcare. This model provides affordable counseling and mental health support for low-income patients and leads to earlier detection, increased diagnosis, and increased likelihood of successful treatment.
        - Wellness in Action - Affordable Counseling Program (ACP) supporting mental and behavioral health needs across the health care continuum for those who live and work in Big Sky through reduced cost or no cost services. The ACP provides a continuum of care which includes services by licensed counselors, counselors in-training (interns), a community health worker, group therapy offerings, and education/training opportunities, available at varying discounted costs.
        - CHP/One Health – Pathways to Wellness Program: expanding Behavioral Health coordination for patients. The Behavioral Health Care Coordination program directly addresses the root causes of poor health by offering non-clinical behavioral health support within CHP's primary care model, ensuring that individuals with complex mental health and social needs can access and follow through with their treatment plans.
    - Community Collaboration – $5k:
        - Suffer Out Loud – Mental healthcare scholarships
        - Big Brothers Big Sisters of Big Sky Country – Community-based mentoring
        - Montana Mindfulness Project – Mindfulness education
        - Befrienders – Senior Engagement and support
        - Roots Family Collaborative – Peer Support Program and resource guide
        - Windhorse Equine Learning – Behavioral health programming
        - Bozeman Children's Theatre – Mental health programming
    - Partnerships:
        - Bozeman School District – Supporting employee wellness through site-based Wellness Champion Program to improve educator wellbeing. Peer-led initiatives tailored to each school increased morale, belonging, and workplace climate indicators. Programming included mental health workshops, physical wellness activities, and opportunities for social connection.
        - One Health – Integrated Behavioral Health addresses both clinical and social determinants of health, helping patients attend appointments, manage medications, access psychiatric care, and navigate housing or financial barriers. The program has improved patient engagement, reduced behavioral health crises, and strengthened coordination with community partners.
        - Wellness in Action - Expanding affordable behavioral health through sliding-scale assistance and scholarship programs that reduce cost barriers for working families and educators. Also, a Community Health Worker expanded no-cost navigation support for mental health, financial assistance, and social connection.

Access to Healthcare

Goal: Increase access to care for patients affected by health equity challenges.

- **Strategy 1: Redesign the HealthCare Connections (HCC) mobile screening program to ensure better alignment of services targeted to under-resources populations**
    - In October 2025, the HCC program was fully redesigned and relaunched to bring preventive health screenings to underserved populations across Gallatin County. Services include diabetes, cholesterol, lipid, and blood pressure screenings, vaccinations, and a touchpoint with a provider.
    - From October 2025– May 2026:
        - 190 people served
        - 293 preventative screenings
        - 130 vaccines administered
        - 423 total services
- **Strategy 2: Expand support to organizations in Big Sky working to coordinate services to benefit populations not currently engaged within the local healthcare system.**
    - We have increased our support to Wellness in Action (WIA) that not only offers behavioral health services for individuals but also provides connections to other resources via their Community Health Workers. Nearly 10% of Big Sky's full-time population accesses affordable services through WIA.
    - Big Sky Medical Center partners closely with service providers in Big Sky, including WIA, Be Well Big Sky, Big Sky School District, and the Big Sky Food Bank.
- **Strategy 3: Expand the Medical Respite program at the new HRDC shelter, Homeward Point. Collaborate on planning for the design and provision of primary care and behavioral health services at Homeward Point.**
    - In 2025, Homeward Point opened to the Gallatin community. Dedicated medical respite rooms were built into the new shelter to accommodate the program. Bozeman Health and HRDC continue planning for medical respite services at the new shelter.
    - HealthCare Connections hosts monthly clinics at Homeward Point to support the health and wellness of their customers.
- **Strategy 4: Provide leadership and coordination for new countywide Health Transportation Coalition.**
    - Bozeman Health was an active member of the Streamline Stakeholder Committee planning meeting, where we shared feedback and ideas on the community transportation needs as they relate to health care. Feedback included additional bus stop locations, times of bus service, and potential expansion ideas for Galavan services.
    - We are also part of the Transportation Advisory Committee where leaders across the valley come together to share resources and ideas on how to support transportation concerns for residents in our community.
    - In 2026, new Bozeman Health patient transportation service line was launched to support provide patient transport from Bozeman Health Deaconess Regional Medical Center and Big Sky Medical Center (BSMC) to higher-level acute care facilities, skilled nursing and assisted living facilities, critical access hospitals, behavioral health facilities, and home.

- **Strategy 5: Expand the number of recreational vehicle (RV) parking spaces on the Deaconess Regional Medical Center campus.**
    - Additional RV parking spots were opened at the end of 2025 during the Lot E expansion project. Six RV spots are now available for patients needing somewhere to park their RV during treatment at Bozeman Health.
    - Since September 2024, more than 130 patients and families have utilized the RV parking spaces to reduce the barrier of transportation and lodging.
- **Strategy 6: Expand the work of the Bozeman Health DEIB committee. Continue work on way-finding in Spanish.**
    - The DEIB committee continues to support the mission of Bozeman Health to improve community health and quality of life. Focus areas include: translation service audits, policy advisory, and employee and community education.
    - All way-finding signs on Bozeman Deaconess Regional Medical Center have been updated with Spanish translations, and we continue to audit additional signage for updates.
- **Grants and partnerships that support Access to Healthcare goal:**
    - Partners in Health - $25k:
        - Bridgercare - Removing Barriers to Healthcare for Spanish-Speaking Patients by expanding access to affordable, culturally responsive sexual and reproductive healthcare for Spanish-speaking and Limited English Proficiency (LEP) patients. Bridgercare is strengthening translation services, medical interpretation, and bilingual staffing to ensure all patients can navigate care.
        - Thrive - Spanish Speaking Parent Liaison Program: connecting parents to community resources and helping Spanish speaking families navigate new communities. Thrive's Parent Liaison Program helps schools and families work together toward the common goal of student success. Parent Liaisons (PLs) work directly in schools to support parent-teacher collaboration, connect parents to community resources, teach parenting classes, and improve parent/child engagement. PLs also help parents meet basic needs and ensure a safe, supportive home environment for children.
    - Community Collaboration - $5k:
        - World Language Initiative - Spanish for Healthcare program
        - Catalyst for Change – Community Health Workers
        - Eating Disorder Center of Montana – Housing for Patients
        - Bienvenidos a Gallatin Valley – Resource navigation
    - Partnerships:
        - Haven: Strengthening Trauma-Informed Care through healthcare coordination and medical access for survivors of domestic violence. Hospital orientations for Haven advocates, system-wide strangulation response training, and CPR certification for staff strengthened emergency response capacity.

Chronic Disease Prevention

Goal: Reduce the impact of chronic disease and cancer by promoting health lifestyles and access to low cost or free prevention activities.

- **Strategy 1: Coordinate with the Gallatin City-County Health Department and One Health to increase the provision of free early detection screening services for breast, cervical and colorectal cancer**
    - We have worked closely with the GCCHD to increase awareness of all cancer screening resources available in our service area. This includes the state programs, as well as Bozeman Health resources, such as the Mammogram Project. From 2024-May 2026, 75 mammogram vouchers were distributed to individuals in eleven towns across our service area.
- **Strategy 2: Continue supporting the Cancer Support Community in an integrative partnership to provide supportive and wrap-around services to adults and children with cancer within the Bozeman Health service area.**
    - Bozeman Health has a long history of supporting the Cancer Support Community (CSC). We continued to expand our partnership in 2024-2026, to include using Bozeman Health grant funds to support the creation of a men's retreat and the hiring of an in-house mental health provider at CSC.
    - Bozeman Health continues to support CSC events, such as the Pink Party, Stronger than Cancer barbecue, and Cruisin' on Main. These events bring awareness to the many cancer support offerings for residents in our primary and secondary service areas.
- **Strategy 3: Leverage partnerships between Bozeman Health Lifestyle Medicine, the Gallatin City-County Health Department, Bozeman Public Library, HRDC, and the Cancer Support Community to teach healthy meal preparation at multiple locations.**
    - Bozeman Health's Lifestyle Medicine provider, Dr. Joe Sofianek, partnered with local organizations across the Bozeman community to provide no-cost cooking classes. In 2024-May 2026, Dr. Sofianek hosted 20 cooking demonstrations at the Bozeman Library test kitchen as well as presentations to Highgate Assisted Living on healthy lifestyles to prevent dementia, the HRDC Food Bank, and Cancer Support Community.
        - 20 cooking classes
        - Community education classes at Highgate Assisted Living, HRDC Food Bank, and Cancer Support Community
        - 300 people participated
- **Strategy 4: Re-invigorate partnership with Gallatin Valley Land Trust to promote the TrailsRX program within all Bozeman Health Primary care settings. In addition, Bozeman Health will be a trusted resource as partner organizations explore trail creation to promote wellness initiatives in areas with diminished trail access.**
    - Conversations on reinvigorating the TrailsRX program are ongoing. Suggestions from GVLT include moving the program fully to Bozeman Health, so we are working to evaluate what implementation would look like in our primary care clinics. A TrailsRX program is planned to be reimplemented by the end of 2026.
- **Strategy 5: Provide public education through health promotion-focused signage within gateways to the Highland Glen Trail system to promote multi-modal usage of Highland Glen.**
    - We partnered with GVLT and BSF regarding joint messaging and marketing to better promote the use of Bozeman Health land to enhance a healthier lifestyle and translate how the use of the trails equates to specific chronic disease reduction and prevention. Signs were printed and hung up at the Highland Glen trailheads at the end of 2025 and continue to be used year-round.

- **Grants and partnerships that support Chronic Disease Prevention:**
    - Community Collaboration - $5k:
        - Crosscut Mountain Sports – Ski Education Program
        - Gallatin Valley YMCA – Rock Steady Boxing Program and ReCharge program
    - Partnerships:
        - Bridger Ski Foundation (BSF): Winter Trails and Mental Health - advancing chronic disease prevention and youth behavioral health by maintaining 80 kilometers of free winter trails, including Highland Glen adjacent to the hospital. BSF's Mental Health Initiative also supported 600 youth athletes through coach training, mindfulness tools, and accessible resources.
        - Gallatin Valley Land Trust (GVLT): Sunset Hills Project supported accessibility enhancements at the Sunset Hills trail system adjacent to the hospital. Improvements included widened gravel pathways for adaptive mobility devices, a reconstructed all-abilities bridge, and accessibility data collection to inform signage.

Socioeconomic and Health Measures

Goal: Bolster existing work on local affordable housing options while investigating new pathways forward to promote "Housing is Healthcare."

- **Strategy 1: Engage in the activities of the Regional Housing Coalition (RHC) to identify opportunities to support regional housing affordability efforts**
    - Bozeman Health is an active member of the RHC and financially supports the coalition to ensure that the important work continues to move forward.

- **Strategy 2: Perform a health assessment, including pre and post outcomes, of the Housing First Village permanent supportive housing to determine what additional resources may be necessary to keep this a viable health intervention for our community's most vulnerable residents.**
    - Bozeman Health and HRDC pulled preliminary data on Housing First Village outcomes in 2025. We continue to partner with HRDC to determine the best path forward for evaluating the program.
- **Strategy 3: Explore the expansion of the Care Cottage on the Hillcrest campus to house patients and family members during ongoing healthcare treatment at Deaconess Regional Medical Center.**
    - Five respite apartments are available on the Hillcrest campus to support transitional care for patients, typically between the hospital and home.

- **Grants and partnerships supporting Socioeconomic and Health Measures**
    - Partners in Health – 20k:
        - Family Promise of Gallatin Valley - Housing Continuum Program provides a comprehensive continuum of services to prevent and end family homelessness. The Housing Continuum includes prevention, diversion, emergency shelter, transitional housing, workforce housing, stabilization services, and intensive case management to address both immediate housing crises and long-term self-sufficiency.
    - Community Collaboration - $5k:
        - Bozeman Library – Summer Lunch program
        - Greater Impact – First 30 Day Fund
        - Thrive- Spanish Speaking Parent Liaison program
        - AbilityMT – Youth Independence and Life Skills program
    - Partnerships:
        - Greater Gallatin United Way – KidsLink afterschool programming provides an out-of-school-time program, helping 147 families remain employed during the school year and 40 families access summer camp care. The program provides targeted financial assistance to working families who may not qualify for public support but still struggle with Gallatin County's high cost of living.
        - HRDC - Bozeman Health partnered with the Human Resource Development Council (HRDC) to support the opening of its Path to Stability program and strengthen other community-based HRDC services. This partnership reflects a shared commitment to supporting individuals and families experiencing homelessness and connecting community members to the services they need to achieve stability and improved health.