June 30, 2014

# Yellowstone County

## Community Health Improvement Plan

## 2014-2017

*Sponsored by the Alliance-Billings Clinic, RiverStone Health and St. Vincent Healthcare*

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## Abbreviation and Terminology Glossary

ACHI: Association of Community Health Improvement

Alliance: institutional leaders of Billings Clinic, RiverStone Health & St. Vincent Healthcare

CHNA: Community Health Needs Assessment

CHIP: Community Health Improvement Plan

CHIC: Community Health Improvement Coordinator

# INTRODUCTION and BACKGROUND

## What is a Community Health Improvement Plan (CHIP)?

A Community Health Improvement Plan (CHIP) is a document that presents a long-term systematic plan to address the health problems of a community. A CHIP is based on the results of a Community Health Needs Assessment (CHNA) and a community health improvement process. Creating a successful CHIP involves participation across multiple sectors of a community and it is supplemented by community member input in addition to public health and health system partners. The outcome is a defined process through which priorities are selected, and strategies and measures are created in order to address the health issues identified.

## The Community Health Improvement Plan for Yellowstone County

The original CHIP for Yellowstone County was created in 2006 to provide a framework for increasing the health of residents in Yellowstone County. In addition to providing an action-oriented plan for the community, the CHIP also presented a summary of the results of the 2005 Yellowstone CHNA and the process for identifying the priority health issues. The original document was created to identify and list initiatives aimed toward promoting the healthy weight of Yellowstone County residents. The document was updated in 2012 following the completion of the 2010-11 CHNA and with a broader scope, addressing health-related issues beyond healthy weight. The most recent Community Health Improvement Plan has been authored in response to the 2013-14 CHNA results and a structured community process that allowed for the identification of the priorities. We anticipate this CHIP will be reviewed annually and updated as needed and will be reframed upon the completion of the next CHNA.

## Community Health Needs Assessments

In 2005, RiverStone Health and its system partners underwent an assessment of the public health system's performance in the 10 Essential Public Health Services established by the Centers for Disease Control and Prevention (CDC). The assessment was conducted using the National Public Health Performance Standards Program (NPHPSP), also established by the CDC. A key outcome of that assessment was an understanding of the need to perform a CHNA and develop a CHIP.

In 2005, the Alliance of Billings Clinic, Yellowstone City County Health Department dba RiverStone Health, and St. Vincent Healthcare sponsored the first comprehensive Yellowstone County CHNA as a follow-up to the NPHPSP assessment. The Alliance contracted Professional Research Consultants, Inc. (PRC) to perform the assessment which included focus groups with community leaders and surveys of 400 community members using the random-digit-dialing method. Additional information on methodology is described in Step 3 of the CHIP process below. This process was repeated in both 2010-11, and 2013-14 when CHNAs were once again conducted utilizing the same methodology. The results of the 2005-06, 2010-11 and 2013-14 CHNA can be accessed at www.healthybydesignyellowstone.org.

## Demographics

As the largest city in a 500 mile radius, Billings serves as a commercial and transportation hub for the state, as well as a major center for education and medical services. Billings benefits from having a diversified economy, where oil and gas, healthcare, livestock, and banking play significant roles. The city boasts three colleges (MSU-Billings, MSU-B College of Technology, and Rocky Mountain College), two major hospitals, two oil refineries, and an international airport.

Covering 2,633 square miles with an estimated population of 151,882 residents in 2012, Yellowstone County is the only county which is not designated as "rural." Billings, the county seat, is the state's largest city, with a 2012 population estimated at 106,954. Other cities and towns in Yellowstone County include: Acton, Ballantine, Broadview, Custer, Huntley, Laurel, Pompey's Pillar, Shepherd, and Worden.

The unemployment rate for Yellowstone County as of November 2013 is 3.6% compared to a statewide rate of 5%. Persons below the poverty level in Yellowstone County (per 2008-2012 data) stand at 11.9% compared with 14.8% statewide.

Montana's largest minority population is American Indian, at 6.3% of the state's population compared to 0.9% nationally. In Yellowstone County, American Indians make up 4.3 percent of the population, with slightly more Hispanic people at 4.9 percent. The *U.S. Census Bureau* projects that by 2025, Montana will have the third highest percentage of elderly in the nation, with nearly a fifth of its population estimated to be over the age of 65. 2012 Census estimates indicate 15.7% of Montanans are 65 or older and 14.7% of Yellowstone County residents are 65 and older. By contrast, persons under 18 stand at 22.1% and 23.5% respectively. The population in Yellowstone County increased by 2.6% from April 1, 2010 to July 1, 2012 compared with a statewide population increase of 1.6%.

As described in the *2012 State Public Health Assessment* Montana's population is hovering around 1 million people in an area of nearly 146,000 square miles. In this wide open space, there are only seven cities with more than 20,000 residents and 15 communities with 5,000 to 19,999 residents. Nearly all the state's communities and counties in Montana are designated as Health Professional Shortage Areas (HPSAs) with Medically Underserved Populations (MUPs).

*Sources: MT Dept. of Labor and Industry, US Census Bureau, Montana Department of Public Health and Human Services, Public Health and Safety Division, 2012 State Public Health Assessment*

## The Alliance

Yellowstone County is home to Billings, the most populous city in Montana. In addition to being an economic center, Billings is also a medical hub for the region with three primary health organizations: Billings Clinic, Yellowstone City County Health Department dba RiverStone Health, and St. Vincent Healthcare. The Alliance is an affiliated partnership consisting of the Chief Executive Officers from these three health organizations. The Alliance works collaboratively on community and regional health initiatives with the mission of identifying community health needs and then defining and implementing efficient and effective community solutions through integrated actions. Their vision states, "Together we improve the health of our community, especially those who are underserved and most vulnerable, in ways that surpass our individual capacity."

# YELLOWSTONE COUNTY COMMUNITY HEALTH IMPROVEMENT PROCESS

The **framework** utilized for the 2013-14 health improvement process was the Core Process Steps from the Association for Community Health Improvement (ACHI). This framework, which is covered in more detail throughout the next section, contains six generalized steps which were adapted to fit the needs of Yellowstone County. We have chosen to modify this model by including one additional step to "complete the circle" and acknowledge the need to revisit and refine. The steps are shown in the image below. *Source: [http://www.assesstoolkit.org/assesstoolkit/ACHI-CHAT-intro-slides-8-27-10.pdf](http://www.assesstoolkit.org/assesstoolkit/ACHI-CHAT-intro-slides-8-27-10.pdf).*


Additional detail on the steps, including a timeline graphic, is included in the CHIP process outline in the appendices.

## Step One: Establishing the Assessment Infrastructure

The first step in the ACHI framework is to establish the assessment infrastructure. This was completed by a review of previous processes by the Alliance (leadership representation of Billings Clinic, RiverStone Health and St. Vincent Healthcare) and identification of key community members to serve as the CHNA Advisory Group. The Advisory Group was then called upon to assist in finalization of the assessment make-up and content.

## Step Two: Defining the Purpose and Scope

**The Scope:** The Advisory Group chose to utilize the same scope as the 2005-06 and 2010-11CHNA by defining the target population as Yellowstone County, hence utilizing geographical area as the primary identifier.

**The Purpose:** The determined purpose of the CHNA was to identify key unmet health needs. The CHNA served as a tool to enhance Yellowstone County's ability to address three core objectives:

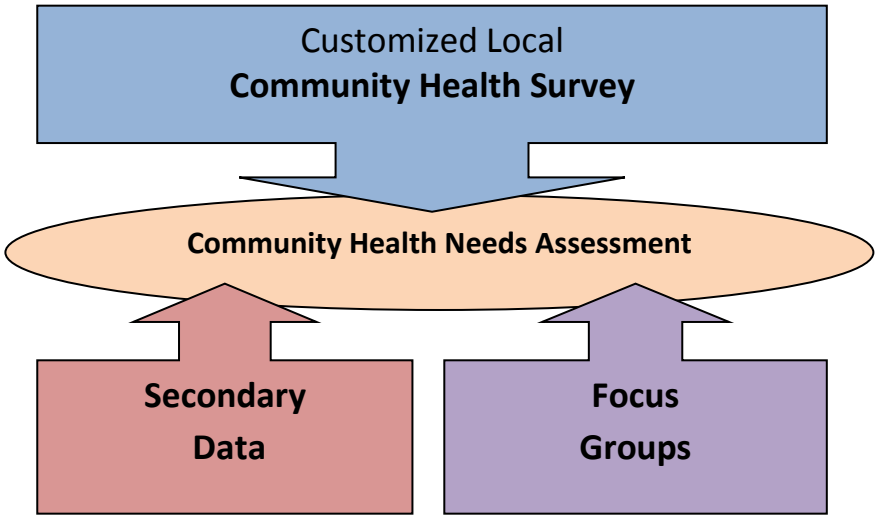
to improve residents' health status, increase their life spans, and elevate their overall quality of life; to reduce health disparities among residents; and to increase accessibility to preventative services for all community residents.

## Step Three: Collecting and Analyzing the Data

Survey Format: PRC utilized a survey instrument customized for Yellowstone County, based the 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, disease prevention, and other recognized health issues. To ensure the best representation of the population served, a telephone interview methodology was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 400 individuals aged 18 and older in Yellowstone County. For statistical purposes, the maximum rate of error associated with a sample size of 400 respondents is ± 4.9% at the 95 percent level of confidence. In addition to using proven telephone methodology and random-sampling techniques, the raw data was "weighted" to improve this representativeness even further. Once the raw data was gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity and poverty status) and a statistical application package applied weighting variables that produced a sample which more closely matches the population for these characteristics.

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.
The CHNA consisted of both quantitative data from primary research and secondary research, as well as qualitative data (demonstrated in the figure below). The quantitative data was collected through informant focus groups. The data will serve to study the objectives identified previously.




**The Focus Groups:** As part of the CHNA, five community focus groups were held in Yellowstone County to engage both providers and recipients of various community services. The focus groups included discussions with key informants in the following areas: medical and other public health personnel, legislators, employers and employees, educators, social service providers, and a south-side resident group.

Potential participants for the focus groups were selected and invited because of their ability to identify various concerns within Yellowstone County. Providers as well as recipients were engaged in discussions which focused on recognizing unmet health issues which adversely affect residents of Yellowstone County, particularly those in underserved populations, including but not limited to minorities and members of low-income households. A total of 62 individuals participated.

**CHNA Benchmarks:** *Trending* –similar surveys was administered in Yellowstone County in 2005-06 and 2010-11 by PRC on behalf of the Alliance. Trending data, as revealed by comparison to prior survey results, were provided in the CHNA where available.
*Montana Risk Factor Data and Youth Risk Data* – Statewide risk factor data were provided where available as an additional benchmark which to compare local survey findings. State-level vital statistics were also provided for comparison of secondary data indicators.
*Nationwide Risk Factor Data* – Nationwide risk factor data were provided where available as an additional benchmark and were taken from the 2008 PRC National Health Survey.
*Healthy People 2010* – This is part of the Healthy People 2010 (HP 2010) initiative, sponsored by the U.S. Department of Health and Human Services. NOTE: Healthy People 2020 goals were not available at the time of this survey although they were utilized in the community goal setting.

**Secondary Data:** Public Health, Vital Statistics & Other Data: A variety of existing (secondary) data sources was consulted to complement the research quality of the Community Health Needs Assessment. Data for Yellowstone County were obtained from the following sources:

- Centers for Disease Control & Prevention
- US Census Bureau
- Montana Board of Crime Control
- Montana Department of Public Health and Human Services
- National Center for Health Statistics
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

All results were reviewed by an internal workgroup, the Alliance, the CHNA Advisory Group, and the Healthy By Design Coalition and then released to the public via a press conference and the website, www.healthybydesignyellowstone.org on 1/21/14.

## Step Four: Selecting Priorities

In the CHNA results, a listing of "Areas of Opportunity" were identified based on the compiled data including input from the focus groups, results of the phone survey and the secondary data. This list is offered below.

- Access to Health Services
- Cancer
- Chronic Kidney Disease
- Dementias, Including Alzheimer's disease
- Heart Disease & Stroke
- Injury & Violence
- Infant Health & Family Planning
- Mental Health & Mental Disorders
- Nutrition, Physical Activity & Weight
- Respiratory Diseases
- Substance Abuse
- Tobacco Use

**Decision Process:** Following the public release of the CHNA results, a community-wide forum was convened to garner input from the community on health improvement priorities and interventions. At the community meeting, with 85 people in attendance, the CHNA results were shared and community members provided their feedback via a formal individual and group voting exercise followed by group discussions. The Community Health Improvement Coordinator, brought on staff at RiverStone Health to work on behalf of the Alliance and Healthy By Design, was responsible for facilitating this work and the additional steps in the framework.

Criteria used in this process included:

1. Cost and Return on Investment
2. Availability of solutions
3. Impact of problem
4. Availability of resources (staff, time, money, equipment) to solve problem
5. Urgency of solving problem (air pollution, H1N1)
6. Size of problem (number of individuals affected)

*Public Health Foundation criteria commonly used to identify priority problems as identified by the National Association of County and City Health Officials, http://www.phf.org/infrasturcture/priority-matrix.pdf, accessed 2/9/10.*

The CHNA Advisory Committee was reconvened after the forum to validate the priority ranking process and results and to review the community's input. Much of the strategy development began to take shape during these meetings. Goals, objectives, and measurable outcomes were drafted, by the workgroup based on the results of the Community Forum and input from the Advisory Committee. Once the goals and objectives were drafted, expert meetings were held, which called upon community experts in each of the identified priority areas. The feedback from these experts then helped to shape the final draft of the goals and objectives, as well as give input into the strategies.


**Creation of Goals and Objectives - Assets:** During the goals and objectives creation, it was important to acknowledge the assets available to the community. The first asset identified was the Alliance itself. The Alliance brings together two healthcare organizations and the local health department to collectively work on community health issues. This asset is arguably the strongest asset identified during the development of the CHIP as this partnership allows for the following:

- The pooling of information
- Increased amount of available resources, human and financial
- Better understanding of community needs and assets
- Engagement in new issues without having sole responsibility or management of them
- Development of widespread public support for issues
- Minimal duplication of services and effort

An additional asset is the pre-existing Healthy By Design Initiative. The Healthy By Design Initiative began in 2005 following the first CHNA. The initiative was designed to work on physical activity and nutrition policy, systems, and environmental changes in Yellowstone County. The mission of Healthy By Design is to create a community that is healthy by design, (i.e. to intentionally influence the environment in which people live, learn, work and play) so that positive health effects are enhanced and negative health effects are mitigated). Creation of the Healthy By Design Coalition brought together a valuable network of human assets including professionals with expertise in health, infrastructure, engineering and planning; the largest medical center in a 500-mile radius; and a strong network of non-profits and community action groups. Healthy By Design has a proven track record of successful collaboration and is well known and respected in the community. Going forward, the framework of Healthy By Design will be utilized to engage the community in the chosen community priority areas.

These and additional assets are named under each identified priority below, with the understanding that this is not a comprehensive list. The Community Health Needs Assessment also contains an organizational listing that will be referenced at the workgroup level.

## Community Priorities

Following CHNA opportunity identification, Community Forum voting, and CHNA Advisory Committee validation, three areas were identified as the priority community health needs:

a. Healthy Weight
b. Access to Health Services
c. Mental Health, Mental Disorders and Substance Abuse

Key CHNA results related to these three health issues are presented below in the goals, objectives and strategies section.

## Step Five: Documenting and Communicating Results

After the community goals were constructed, the next step of the ACHI six-step framework is communication of results. This step, in the context of Yellowstone County, began simultaneously with steps three and four. This step included announcing the results of the Community Health Needs Assessment to key stakeholders, media and public followed by collection and communication of feedback from the community forum and expert meetings. By inviting the community to the forum and involving community experts in discussions we were ensured that the voice of the community would be incorporated in the construction of the CHIP. As strategies emerge, updates of work plans will continue to be communicated with the stakeholders and the community. This will be facilitated through Coalition meetings, posting on the Healthy By Design website www.healthbydesignyellowstone.org, and through social media on the Healthy By Design Facebook page. In order to assist in documentation of process, an appendix with notes on the steps taken throughout the CHNA/CHIP formation is included.

## Achieving the Goals

**The role of the health organizations and community connection**

The involvement of key community members and organizations is vital to achieving the goals set forth in the CHIP. To ensure success, the Alliance has taken on the role of the community facilitator and will dedicate the needed resources to provide this facilitation.

*Access to Health services and Mental Health, Mental Disorders and Substance Abuse*: Though mental health and access to health services were identified in the previous CHIP, work accomplished was minimal. Therefore, the work completed on these goals during the next three years will focus on building foundations for the work through the identification of partners, identification of policy changes required to achieve the objectives, determining future action steps required to be successful. The successful model of community engagement provided by Healthy By Design will serve as a model for establishing community involvement, as well as the facilitation of community discussion and initiatives aimed at increasing access to health services and improving mental health and substance abuse outcomes for Yellowstone County residents.

*Healthy Weight:* The work on healthy weight will be conducted by Healthy By Design; a pre-existing coalition created by the Alliance to focus on creating a community that is healthy by design (to intentionally influence the community in which we live to make the healthy choice the easy choice). More information on Healthy By Design, including recent work plans, is available on the Healthy By Design website www.healthybydesignyellowstone.org.

## Step 6: Planning for Action and Monitoring Progress

Follow-up is an essential part of ensuring that goals and objectives are met. Annual work plans will be created to ensure that a plan exists detailing the activities required to achieve objectives, the person(s) responsible for the activities, and the timeline for completion. Annual creation of the work plan will be conducted by January 1st of each year and it is the responsibility of the Alliance. The status of the work will be reviewed semi-annually at the Alliance meeting.
The CHIP will be publically accessible on all Alliance organization websites and on the Healthy By Design website: www.healthybydesignyellowstone.org. In addition, the Community Health Improvement Coordinator, in partnership with the Alliance Communication Team, will be responsible for ensuring periodic status updates through media channels, social media, and semi-annual reports. The CHIP will be reviewed annually and updated as needed and following the completion of the Yellowstone County CHNA (the next one is scheduled for 2017).

## Additional Step 7: Report, revisit and refine plan and process

This step has been added to the ACHI framework in order to remind us that this is a "living document" that needs to be reviewed and refined as needed in order to accommodate discoveries, changes and accomplishments. We also expect that this document and the accompanying work plans will inform our next CHNA and CHIP.

# Yellowstone County Goals, Objectives and Strategies

*Goals and Objectives approved by the Alliance of Billings Clinic, RiverStone Health and St. Vincent Healthcare on June 4, 2014, with additional Alliance partner and community expert discussion on strategies following*

Contributors: Community Health Needs Assessment Workgroup, Community Health Needs Assessment Advisory Group, Community Forum Participants, Content Area Expert Meeting Participants and the Alliance Members

## Overarching Goals

In response to the state of Montana's Plan to Improve the Health of Montanans' (June 2013) challenge to strengthen the public health and healthcare system, and its proposed system improvement goals, we offer the following overarching goals that we believe apply to our identified priorities and our work in Yellowstone County. Through the Alliance, existing coalitions, and future collaborative work involving sectors of the community impacting the social correlates of health (see diagram below), we will:

- strengthen partnerships and formulate effective community responses to make lasting and measurable change;
- promote effective public health policies and adequate public health funding; and
- promote the use of evidence-based interventions and practice guidelines.

## Methodology

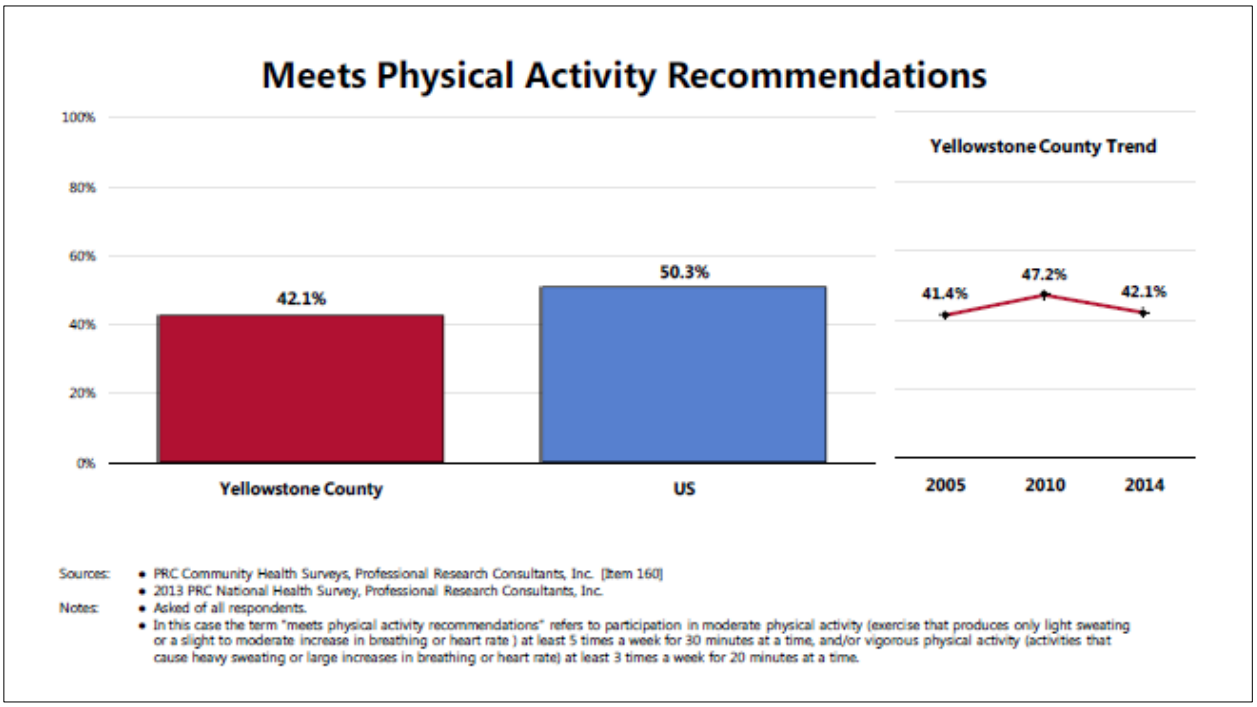
Each SMART objective target listed in the Community Health Improvement Plan is based on the Healthy People 2020 standard target of 10 percent change (%change = [(2$^{nd}$ year value-1$^{st}$ year value)/1$^{st}$ year value) x 100] unless noted otherwise. Baseline is taken from the 2014 Community Health Needs Assessment (which also includes secondary sources) unless otherwise noted.

# PRIORITY AREA: Nutrition, Physical Activity and Weight

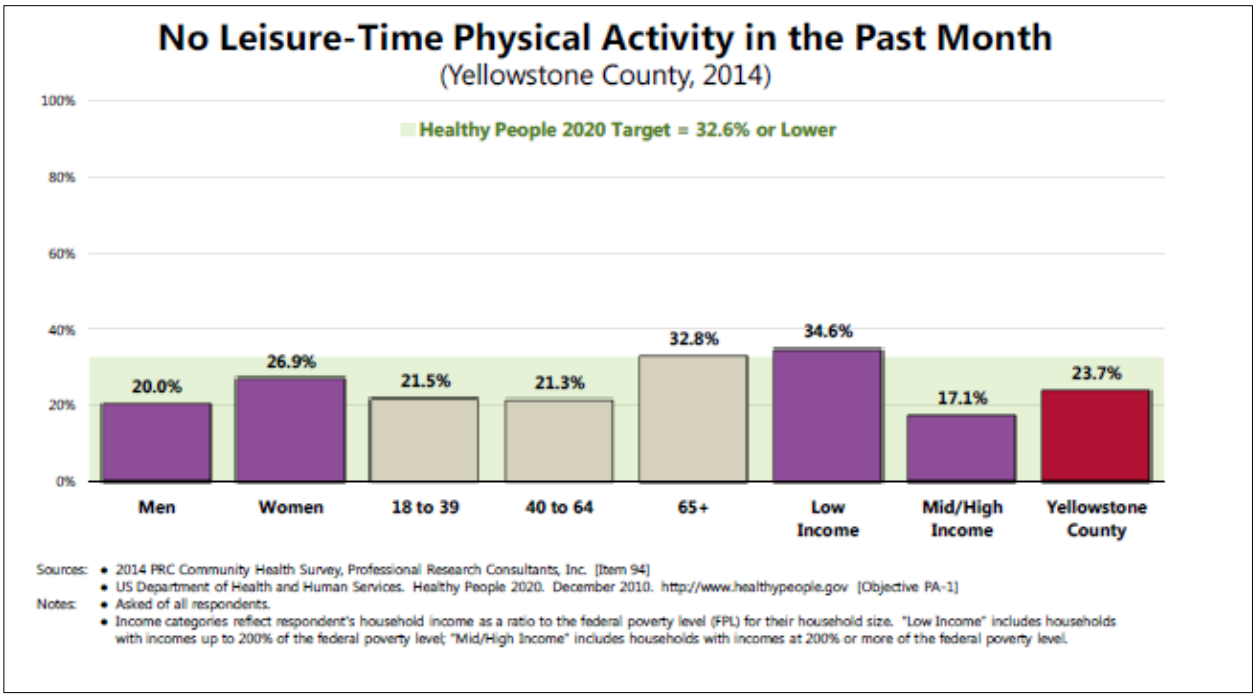
*In the area of improving healthy weight status we have interfaced with and identified the following collaborators/resources: Healthy By Design Coalition and Workgroups, School Health Advisory Council, Billings Action for Healthy Kids, Big Sky Economic Development, Bike/Ped Advocate. We anticipate engaging additional parties.*

The problem: Because ***weight*** is influenced by energy (calories) consumed and expended interventions to improve diet and physical activity can support changes in weight. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools. The social and physical factors affecting diet and physical activity may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity. *-Healthy People 2020, www.healthypeople.gov* **

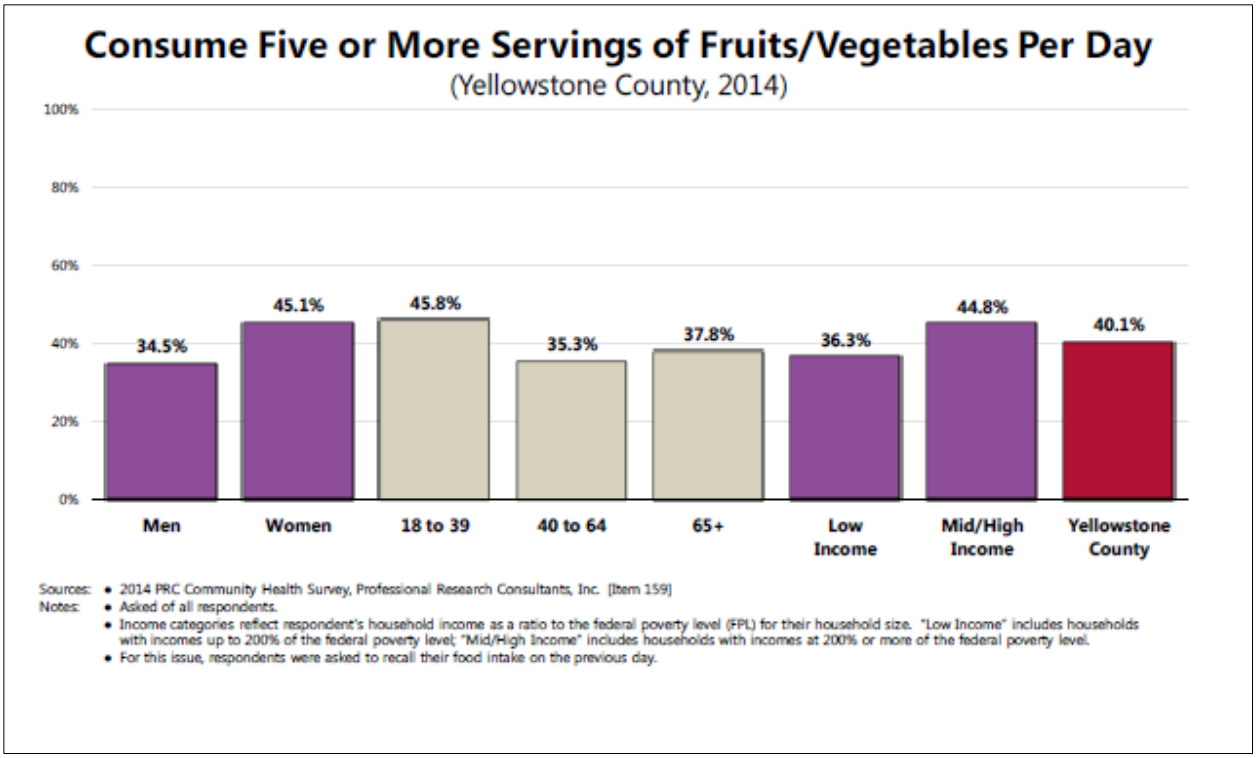
CHNA Findings: The key areas of concern noted in the 2014 Community Health Needs Assessment include: overweight/obesity prevalence and physical activity levels. Additional concerns were noted during the Community Health Forum held in February 2014 as part of the priority setting process. These include: a desire to focus on children and address modifiable behaviors and food security issues.



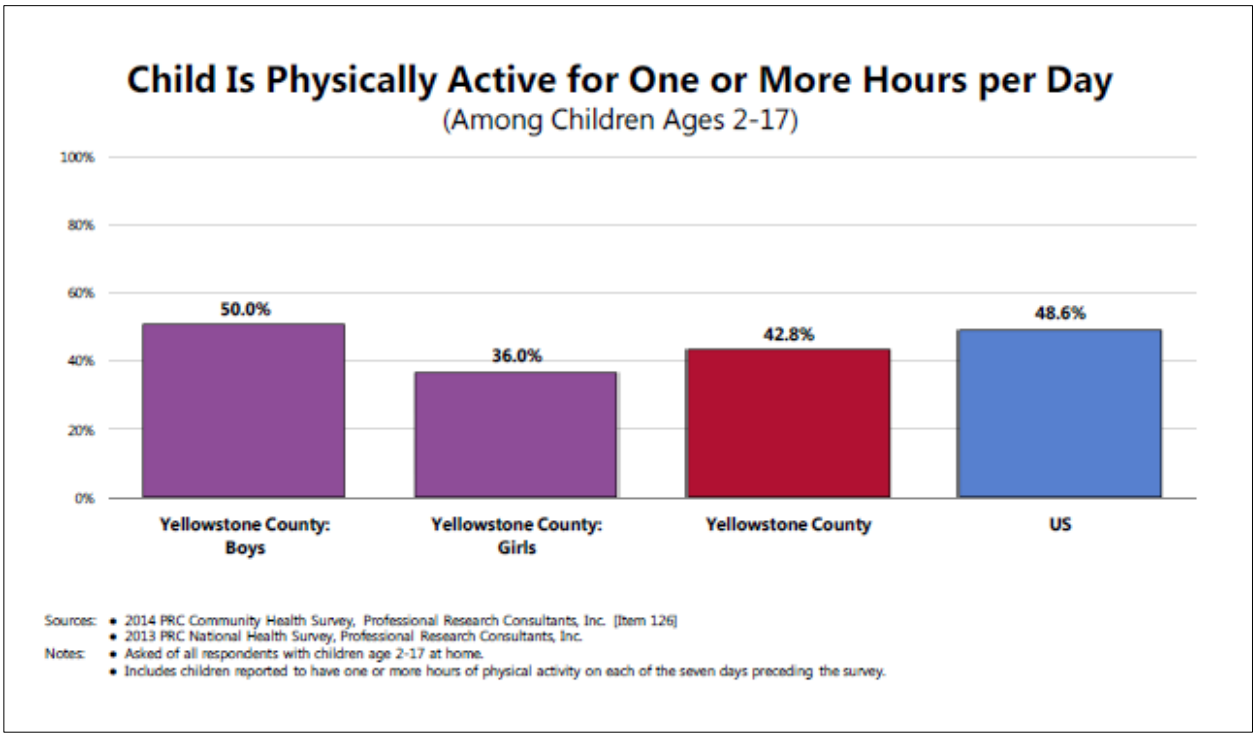

*Yellowstone County residents less likely to meet physical activity requirements include: women, seniors (65+) and residents in low-income households.*




*Yellowstone County's findings are similar to statewide (24.4%) and national findings (20.7%) and meet the Healthy People 2020 target of 32.6% or lower.*




*Yellowstone County's rate is similar to the national rate of 39.5% and has not changed significantly since 2005.*




*Though a difference is noted, it is not statistically significant. The findings are comparable to national rates.*

***Additional Healthy People 2020 information available in the Community Health Needs Assessment and on the Healthy People 2020 website*

# THE GOAL: Improve Healthy Weight Status

Healthy Weight Status Health Objectives:

1) **By 2017, the proportion of adults in Yellowstone County who have a healthy weight (Normal BMI range: 18.5-24.9) will increase from 31.9% to 35%.** (HP NWS-8) (9.7% change; 35.8% reported in 2005 CHNA 2014)

2) **By 2017, the proportion of adults in Yellowstone County reporting no leisure-time physical activity in past month will decrease from 23.7% to 21.25%.** (10.34% change; HP PA-1; leisure-time can be discussed publicly as "every day" activity

3) **By 2017, the proportion of adults in Yellowstone County who eat 5 or more servings of fruit and vegetables per day will increase from 40% to 44%.** (10% change; Related: HP NWS-14 and HP NWS-15.1 LHI)

4) **By 2017, the proportion of children in Yellowstone County who are physically active for one or more hours per day (ages 2-17) will increase from 42.8% to 47%** (9.8% change; CHNA- "each of seven days preceding the interview"; Related to HP PA-3.1-"meet current physical activity guidelines for aerobic physical activity")

Overarching Strategies:

**Public Health Policy**

- Encourage workplaces adopting Healthy By Design nutrition and physical activity guidelines and developing worksite wellness policies and healthy work environments
- Support Yellowstone County area school-based efforts to increase students' daily consumption of fruits and vegetables and increase student's physical activity levels

**Prevention and Health Promotion Efforts**

- Promote the use of the 5-2-1-0 awareness campaign
- Encourage organizations to apply for Healthy By Design recognition
- Encourage awareness of and response to gender-based physical activity disparities including increasing awareness regarding incorporation and recognition of physical activity in everyday activity
- Promote the use of active transportation where available
- Support the valuation of built environment as it relates to health and safety

**Access to Care, Particularly Clinical Preventive Services**

- Incorporate consistent recording of BMI and healthy weight discussions in Alliance partner electronic medical records

**Yellowstone County's Public Health and Healthcare System**

- Advocate access to healthy foods for low-income individuals and families (i.e. WIC, SNAP, food pantries, school-based approaches, etc.) (supported by The National Prevention Strategy)

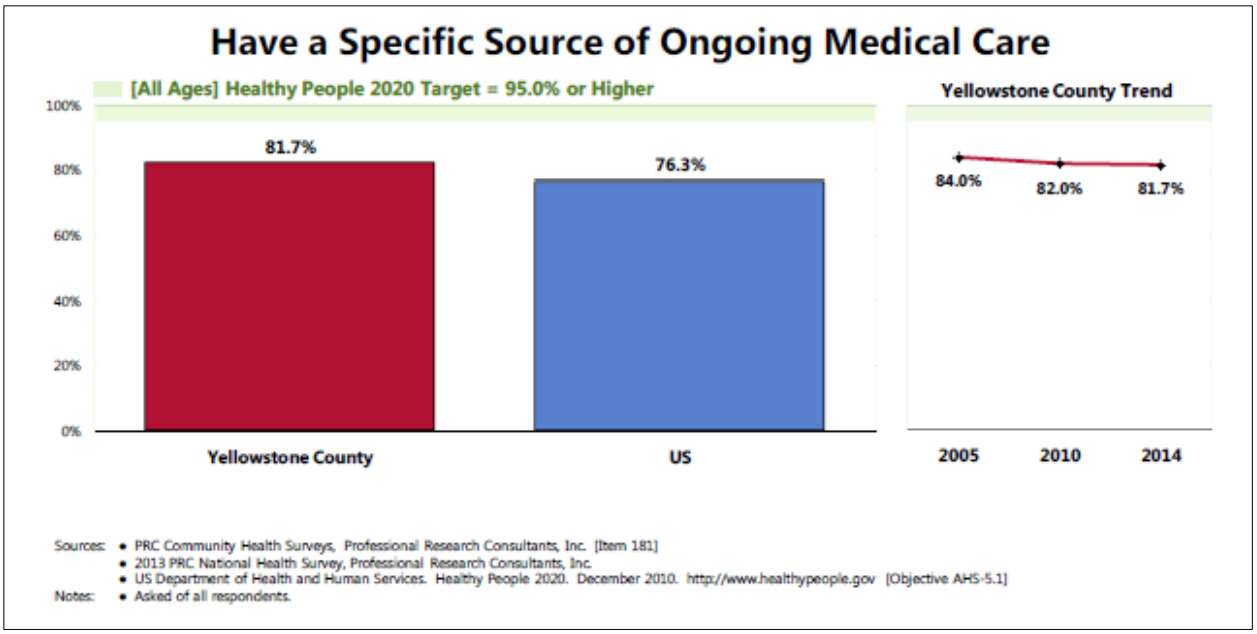
*Tactics will be developed at a work group level, executed and reported via developed work plans and will respond to the identified strategies, positively impacting the identified objectives and goals. Progress will be recorded and reported semi-annually to the Alliance.*

# PRIORITYAREA: Access to Health Services

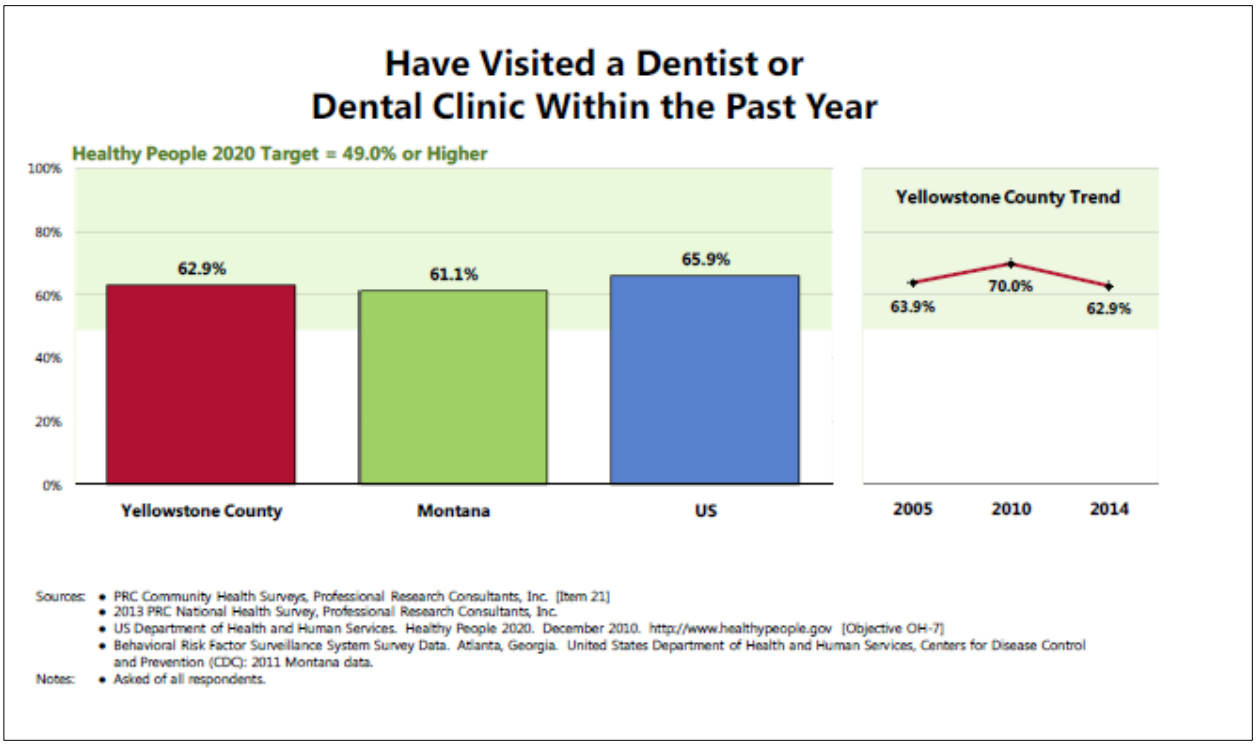
*In the area of access to health services we have interfaced with and identified the following collaborators/resources: United Way of Yellowstone County and Best Beginnings Council, and legislators. We anticipate engaging additional parties.*

**Problem:** ***Access*** to comprehensive, quality health services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Access to health services impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy. Access to health services allows the timely use of personal health services to achieve the best health outcomes. Three distinct steps are required to achieve access: 1) Gaining entry into the healthcare system. 2) Accessing a healthcare location where needed services are provided. 3) Finding a healthcare provider with whom the patient can communicate and trust. *-Healthy People 2020, www.healthypeople.gov*

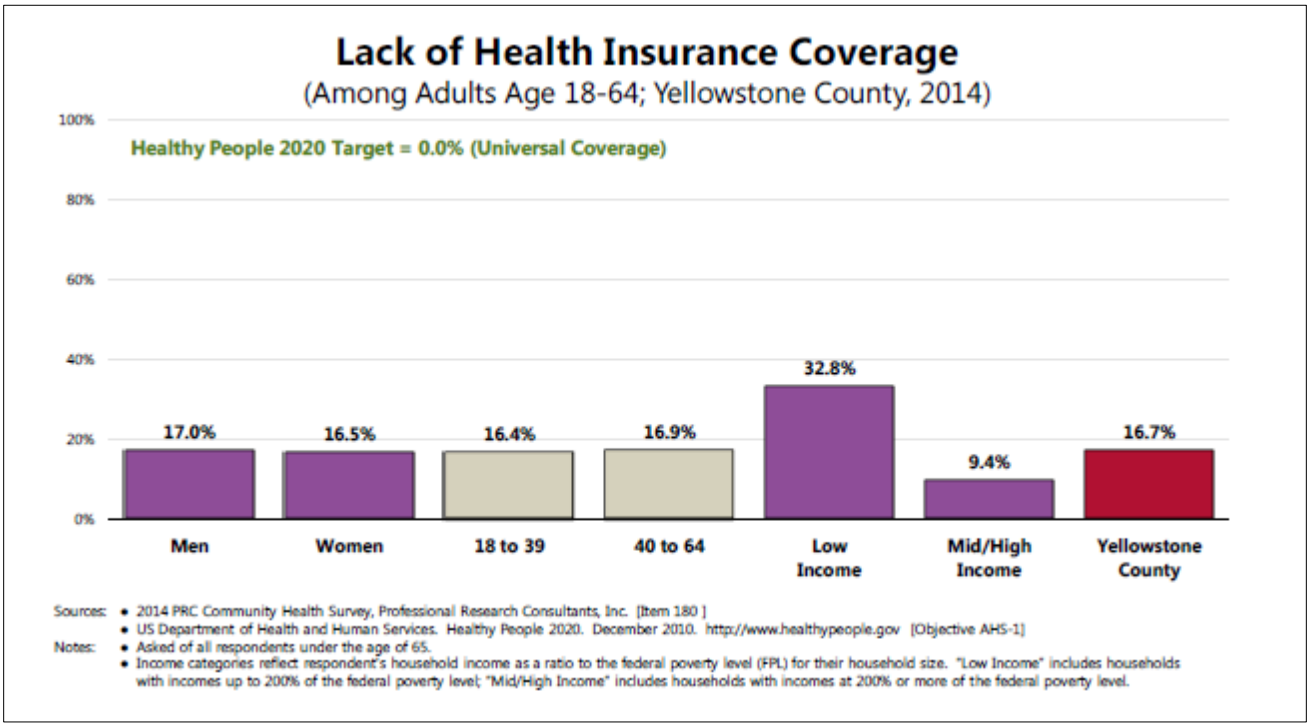
CHNA Findings: The key areas of concern noted in the 2014 Community Health Needs Assessment include: lack of healthcare coverage for ages 18-64 years, barriers to accessing healthcare services, and access to dental care, especially for low-income households. Additional concerns were noted during the Community Health Forum held in February 2014 as part of the priority setting process. These include: jointly addressing access-related policy issues, promoting primary care and offering or identifying points-of-entry into care and healthcare navigation.



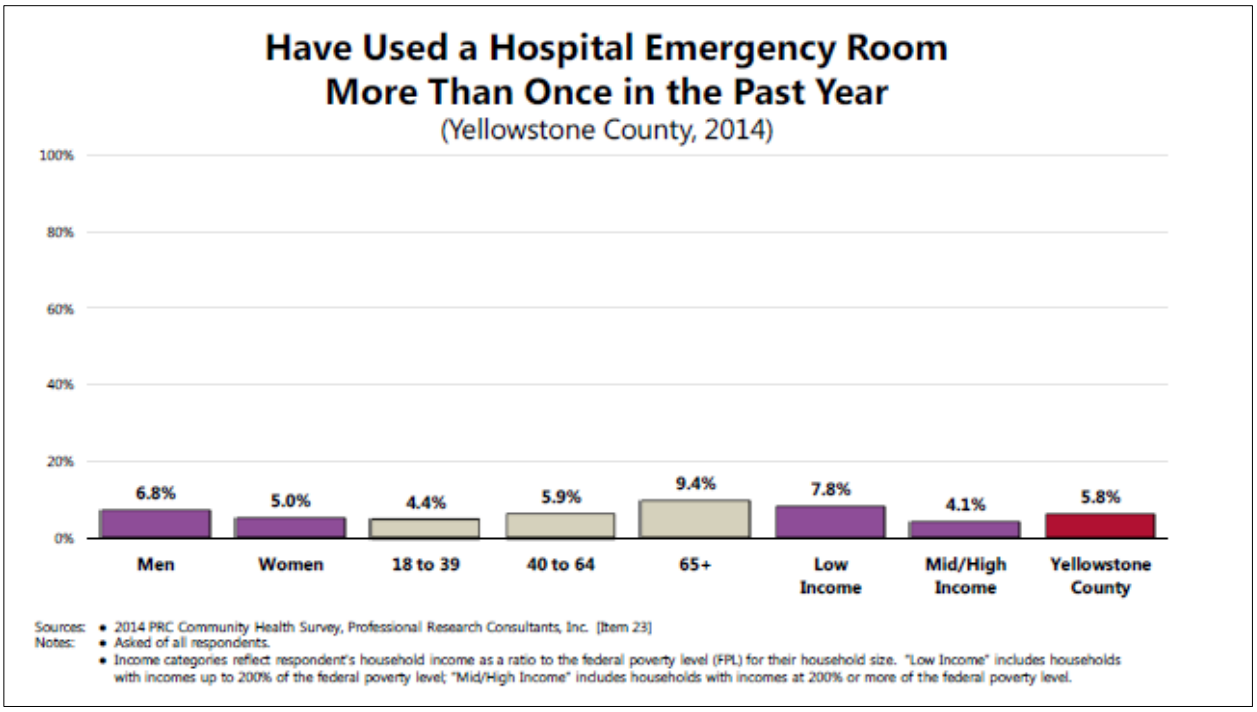

*Adults under the age of 65 are less likely to have a specific source of care, at a rate of 78.2% for Yellowstone County residents age 18-64.*




*The lowest utilizers are those who do not have dental insurance and those in low income households.*




*Among Yellowstone County adults, rates of uninsured are lower than Montana's rate (24.1% uninsured) and slightly higher than the US rate (15.1%). The findings for Yellowstone County are statistically similar to the 2005 findings.*




*2013-14 findings are lower than national findings (8.9%) and statistically similar to the 2005 findings. There is no statistical difference in ER use when viewed by demographic characteristics.*

***Additional Healthy People 2020 information available in the Community Health Needs Assessment and on the Healthy People 2020 website*

# THE GOAL: Improve Access to Health Services

Access to Care Objectives:

1) **By 2017, the proportion of adults in Yellowstone County who have a specific source of ongoing care will increase from 81.7% to 85%.** (HP AHS-5) (4.03% change); Question: Is there a particular place that you usually go if you are sick or need advice about your health? If Yes, what kind of place is it: A Hospital-Based Clinic, A Clinic That is NOT Part of a Hospital, An Urgent Care/Walk-In Clinic, A Doctor's Office, A Hospital Emergency Room, Military or Other VA Healthcare, or Some Other Place. For the next assessment, we will be redefining "on-going care".

2) **By 2017, the proportion of adults in Yellowstone County who have visited a dentist or dental clinic in the past year will increase from 62.9% to 69%** (HP AHS 6.3) (9.69% change; addressing key area of concern)

3) **By 2017, the proportion of adults in Yellowstone County who are without health insurance will decrease from 16.7% to 15%** (HP AHS 1.1; 10.18% change; addressing key area of concern)

4) **By 2017, decrease proportion of adults in Yellowstone County who have used the ED more than once in past year from 5.8% to 5.2%.** (10.34% change; CHNA 2014: 5.8%, 7.8% among low income households; 8.6% in CHNA '10)

Access to Health Services Overarching Strategies:

**Public Health Policy**

- Advocate for Medicaid Expansion
- Advocate for access to healthcare and dental service programs that assist those with financial need (e.g. Medicaid, Healthy Montana Kids, Medication Assistance Program, Community Health Access Partnership) through the development and advocacy of an Alliance legislative agenda

**Prevention and Health Promotion Efforts**

- Develop a collaborative strategy to educate residents of Yellowstone County about what health insurance means and how to use it effectively (continuum of "covered to care")

**Access to Care, Particularly Clinical Preventive Services**

- Explore avenues of asset mapping along the continuum of care that provides residents of Yellowstone County access to resources and services.
- Encourage patient centeredness when making decisions related to location and hours of services.

**Yellowstone County's Public Health and Healthcare System**

- Promote the Montana Family Medicine Residency, Internal Medicine Residency and Dental Residency programs and consider the development of other residencies that may offer pathways to appropriate workforce development
- Promote health insurance acquisition via the Health Insurance Marketplace or other avenues at each Alliance institution.
- Examine emergency department utilization across organizations and respond accordingly. Develop recommendations as appropriate. Identify high users and strategies to increase health outcomes and reduce costs.
- Support full implementation and evaluation of the Patient Centered Medical Home model in each Alliance member institution.

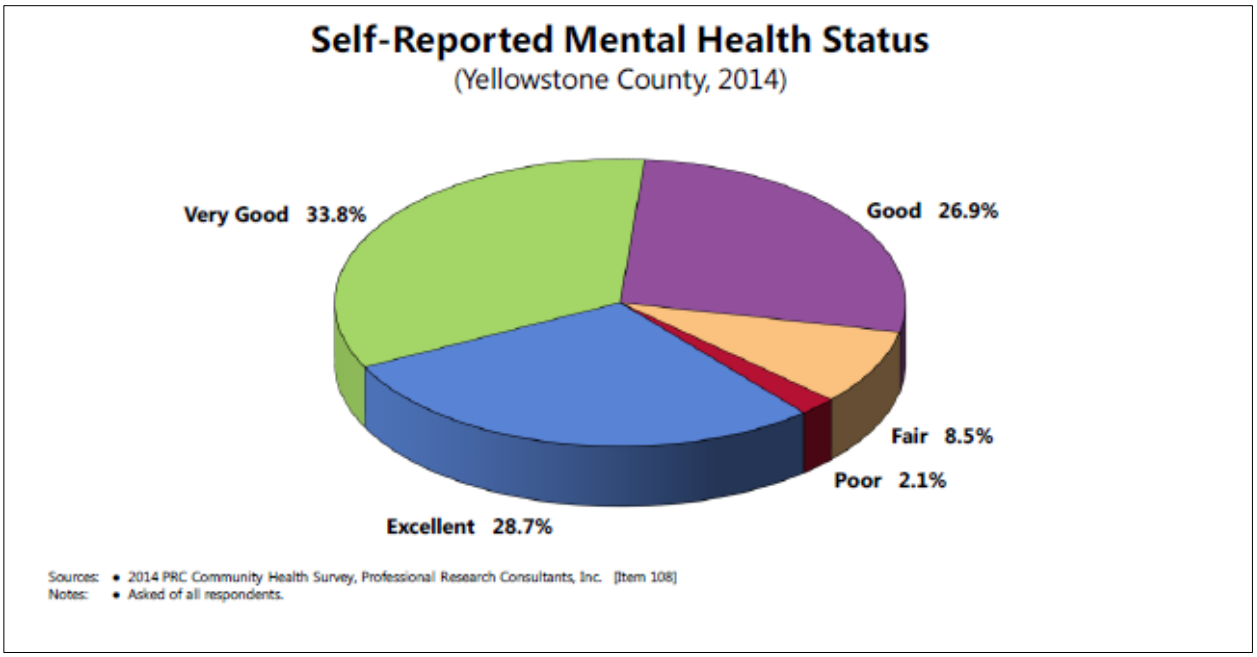
*Tactics will be developed at a work group level, executed and reported via developed work plans and will respond to the identified strategies, positively impacting the identified objectives and goals. Progress will be recorded and reported semi-annually to the Alliance.*

# PRIORITY AREAS: Mental Health & Mental Disorders and Substance Abuse

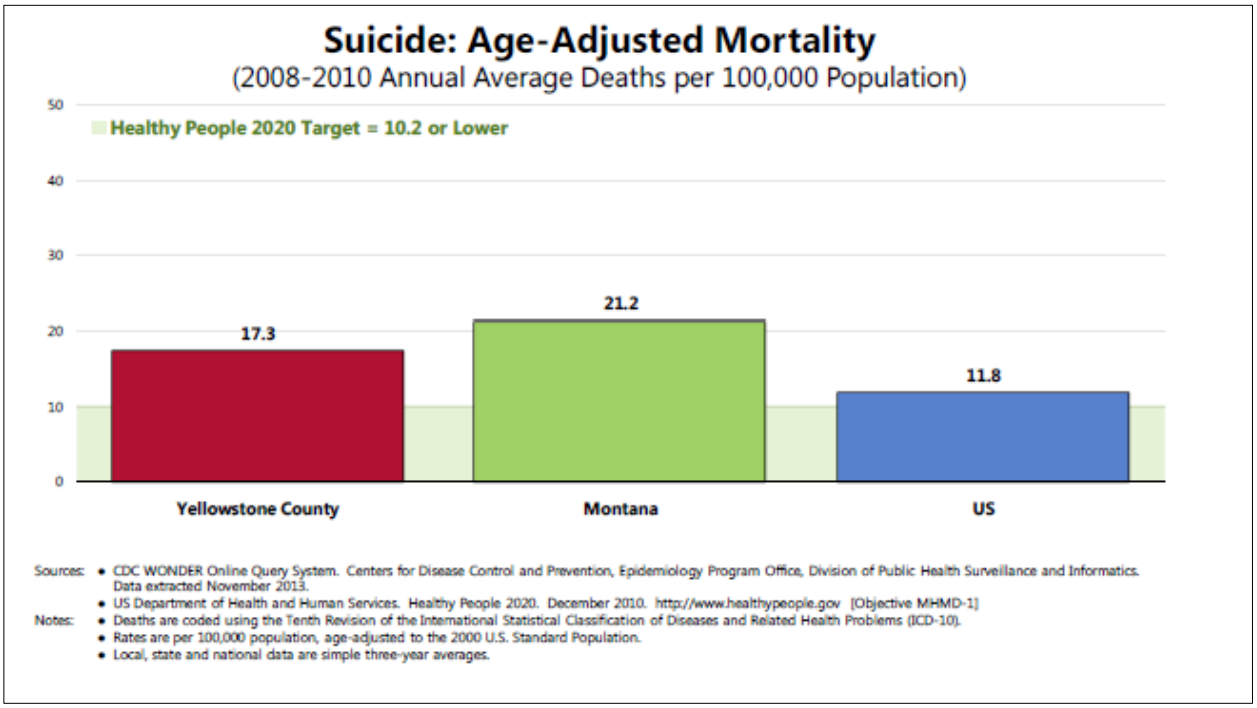
*In the areas of mental health and substance abuse we have interfaced with and identified the following collaborators/resources: Chronic Pain Task Force, Substance Abuse Prevention Partnership [via United Way], Best Beginnings, Mental Health Center, Crisis Center, Rimrock Foundation and Suicide Prevention Coalition of Yellowstone Valley. Let's Talk Billings, and reformation of the Tobacco Free Coalition. We anticipate engaging additional parties.*

Problem: ***Mental Health*** plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders contribute to a host of problems that may include disability, pain, or death. The resulting disease burden of mental illness is among the greatest of all diseases with an estimated 13 million American adults (approximately 1 in 17) having a seriously debilitating mental illness. The leading cause of disability in the United States and Canada, mental illness accounts for 25 percent of years of life lost to disability and premature mortality. Moreover, suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year. Additionally, most recent reports indicate Montana and Wyoming are tied for first in the nation for the number of suicides. Mental health and physical health are closely connected. *-Healthy People 2020, www.healthypeople.gov ** and additional public health sources*

CHNA Findings: **Mental Health:** The key areas of concern noted in the 2014 Community Health Needs Assessment include: suicides, access to mental health treatment and resources for mental health treatment. Additional concerns were noted during the Community Health Forum held in February 2014 as part of the priority setting process. These include: coordination of services, lack of services, developing common strategies, communication, access, stigma associated with mental health problems, and youth resources.



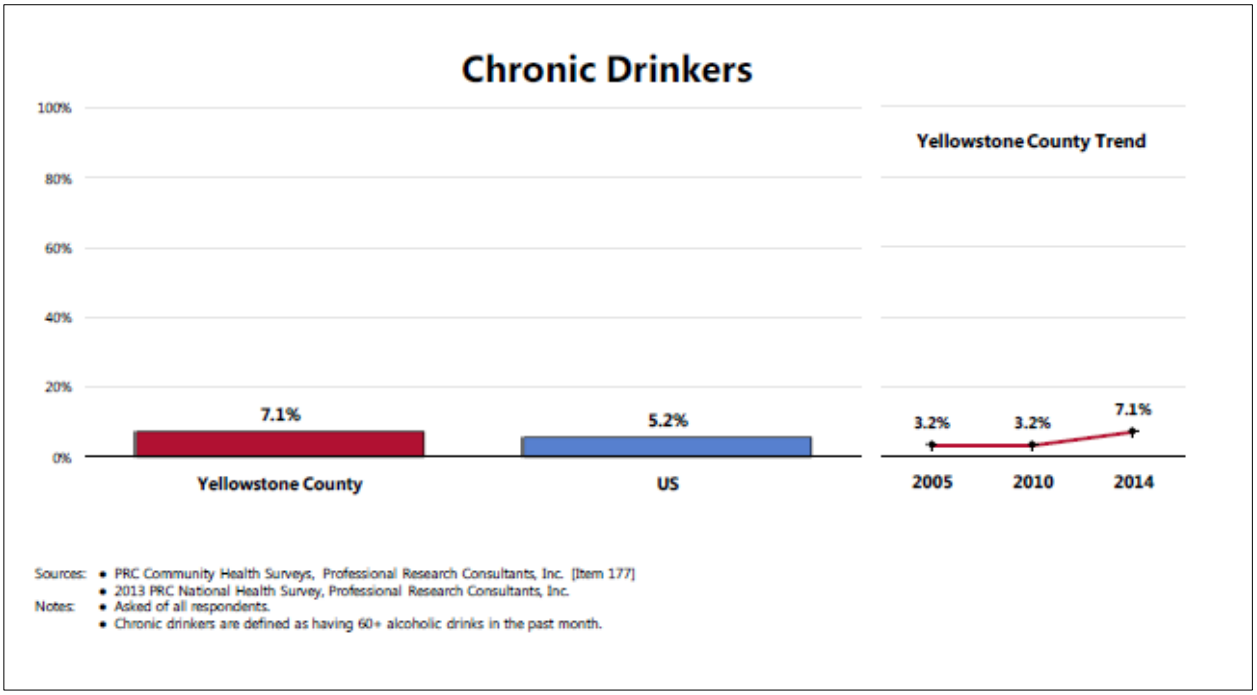

*A total of 62.5 % of Yellowstone County adults rate their overall mental health as "excellent" or "very good". With a rate of 10.6%, Yellowstone County reported similar "fair/poor" responses to national ratings.*




*A total of 9.7% of Yellowstone County residents have considered suicide at some point in their lives. The county suicide rate has fluctuated over time, showing no clear trend. Across Montana and the US overall, suicide rates have increased over time.*

Problem: ***Substances:*** Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values; people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice. In 2005, an estimated 22 million Americans struggled with a drug or alcohol use problem. Almost 95 percent of people with substance use issues are unaware of their problem. Of those who do recognize their issues, 273,000 have made an unsuccessful effort to obtain treatment. These estimates highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders. Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. - *Healthy People 2020, www.healthypeople.gov* **

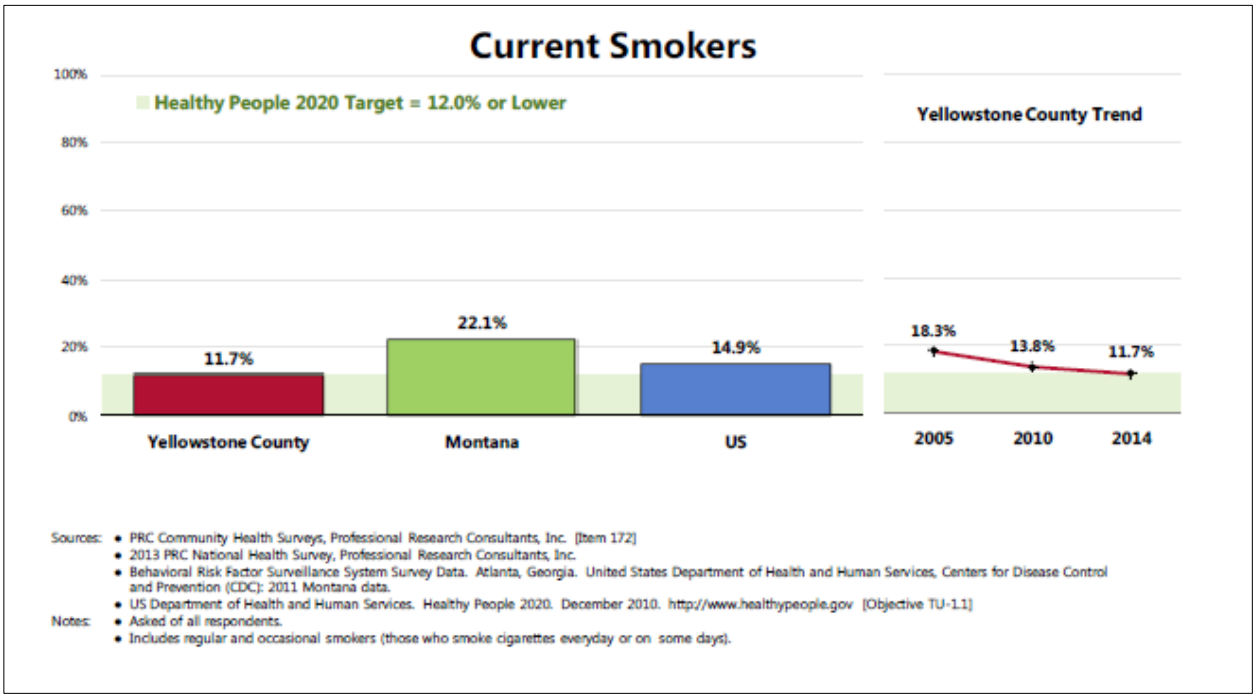
**Substance Abuse:** The key areas of concern noted in the 2014 Community Health Needs Assessment include: Cirrhosis/liver disease deaths, chronic alcohol use, drug-related deaths, and availability of substance abuse treatment. Noted during the Community Health Forum held in February 2014 was untreated patient populations and their interactions; need for preventive measure reimbursement, need to increase addiction prevention education in schools, need to educate on the environmental impact caused by those who are addicted, and consideration of policy work around Driving Under the Influence (DUIs).




*A significant increase in chronic drinking is denoted from 2005-06 and 2010-11 to 2013-14. Chronic drinking is more prevalent among men (10.2%) in Yellowstone County.*

Problem: ***Tobacco*** use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses, like cancer and heart disease. For every person who dies from tobacco use, 20 more people suffer with at least 1 serious tobacco-related illness. In addition, tobacco use costs the U.S. $193 billion annually in direct medical expenses and lost productivity. There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease, emphysema, and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS). Smokeless tobacco causes serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung. - *Healthy People 2020, www.healthypeople.gov ** and additional public health sources*

**Tobacco Use:** The key area of concern noted in the 2014 Community Health Needs Assessment focused on smokeless tobacco. This was not identified as one of the top areas of concern at the Community Health Forum.




*The current smoking percentage has decreased significantly since 2005-06. Smoking rates do not vary significantly by demographic characteristics.*

***Additional Healthy People 2020 information available in the Community Health Needs Assessment and on the Healthy People 2020 website*

# THE GOAL: Improve Mental Health and Reduce Substance Abuse

Mental Health Objectives:

1) **By 2017, the proportion of adults in Yellowstone County who report their mental health as being good, very good, or excellent in the past 30 days will increase from 89.4% to 94%.** (6.2% change-slightly over 2011 rate; 2011 BRFSS county baseline: "14 plus days in past 30 of 'not good' mental health" 10.8%; defined in BRFSS question as "stress, depression and other problems with emotions"; relates loosely to HP MHMD 4 "persons who experience MDE"; 2014 CHNA "overall mental health fair or poor"-10.6%)

2) **By 2017, the reported suicide rate in Yellowstone County will be reduced from 17.3 deaths per 100,000 to 16.3 per 100,000 population.** (HP MHMD-1 LHI; 5.7% change from 2008-10 rates; aligns with 2007-09 rates)

Substance Objectives:

1) **By 2017, reduce the proportion of adults in Yellowstone County who report drinking chronically from 7.1% to 6.4%.**(9.86% change; no chronic drinking HP 2020 or SHIP indicator; BRFSS: "Heavy Drinking" more than 2 per day-men; more than 1 per day-women: 4.9% in 2012; significant increase in 2014 CHNA; "chronic" defined as 60 or more drinks of alcohol in the month preceding)

2) **By 2017, pursue at least one policy focused opportunity related to chronic pain and opioid abuse that will positively impact the residents of Yellowstone County**. (related to HP SA-19; measure: execution of steps of policy campaign)

Tobacco Objectives:

1) **By 2017, reduce the proportion of adults in Yellowstone County who report smoking cigarettes from 11.7% to 10.5%.** (10.26% change; HP TU 1.1 LHI)

2) **By 2017, pursue at least one policy focused opportunity related to smoke free/tobacco free facilities, campuses, worksites, or public spaces (e.g. parks, housing) that will positively impact the residents of Yellowstone County.** (HP TU-15; measure: execution of steps of policy campaign)

Mental Health & Mental Disorders, Substance Abuse (including Tobacco) Overarching Strategies:

**Public Health Policy**

- Establish a county baseline and create community guidelines for prescribing controlled substances and discouraging nonmedical use of pain relievers in Yellowstone County. (HP 19.1; SAMHSA DSDUH report, 1/8/13 MT-4.83%; 4.6% nationally, with a range of 3.6-6.4%)
- Promote and encourage policy opportunities related to smoke free/tobacco free facilities, campuses, worksites, or public spaces (e.g. parks, housing) (HP TU-15)
- Support advocacy efforts to reduce gaps in prevention, as well as support treatment for co-occurring disorders and treatment of family units

**Prevention and Health Promotion Efforts**

- Increase capacity for trauma-informed care education, promotion, collaboration and implementation
- Support suicide prevention by increasing the number of people in the community who have received suicide prevention training.

**Access to Care, Particularly Clinical Preventive Services**

- Continue to support the Community Crisis Center
- Increase access to behavioral health specialists in primary care settings
- Explore avenues of asset mapping to provide residents of Yellowstone County access to resources and services.
- Continue promoting depression screening and referral for adolescents over the age of 12 as well as adults (Increase depression screening HP MHMD 11)

**Yellowstone County's Public Health and Healthcare System**

- Identify, support, convene, and/or engage in community-collaborative work focused on the area of mental health in order to address communication and treatment gaps. (Measure: membership and a related developed strategy)
- Examine emergency department utilization across organizations. Develop recommendation as appropriate. Identify high users and strategies to increase health outcomes and reduce costs.

*Tactics will be developed at a work group level, executed and reported via developed work plans and will respond to the identified strategies, positively impacting the identified objectives and goals. Progress will be recorded and reported semi-annually to the Alliance.*

***Additional Healthy People 2020 information available in the Community Health Needs Assessment and on the Healthy People 2020 website*

# APPENDICES

# *Appendix A: CHNA/CHIP process notes and timeline*

**CHNA/CHIP Process Outline 2013-14**

**1) Establishing the Assessment Infrastructure**

Nov. 12-Jan 13 – Alliance-appointed committee meets to discuss approach to CHNA process. Key questions include: What should be the scope? Will we do it ourselves or contract the work? Who are the potential contractors and what value will they bring to the process at what cost? Committee members included: John Felton, Barbara Schneeman, Hillary Hanson, Carol Beam & Tracy Neary from SVH, Kristianne Wilson & Jeannie Manske from BC. The result of this series of meetings was a decision to contract with PRC to complete the assessment in a similar fashion to the assessment completed in 2010. *Minutes may exist from these meetings.*

**2) Defining the Purpose and Scope**

In an effort to gather more community voice in the design of the CHNA process, about 25 community leaders were invited to be part of the CHNA Advisory Group. The HBD leadership team brainstormed the list of people to invite. The group met on 3/26 & 4/23 to review the base survey questions and offer recommendation for additions/deletions as well as recommend focus group participants. The group recommended including additional secondary data sources, specifically MT Youth Risk Behavior Survey (YRBS). *Additional details of these meetings are available in notes taken by Jeanne Manske, available in the CHNA files held by the CHIC.*

Hillary, Jeannie & Tracy coordinated these meetings and continued to lead follow-up work related to finalizing questions for the survey. Other HBD leaders, especially April & Laura contributed to this process. It was also discussed at the quarterly HBD Advisory meeting. Hillary, Jeannie & Tracy signed off on the final list of survey questions & invitation list for focus group participants. As reviewed by Heather, there is nothing specific in HBD Coalition minutes. *May be a string of e-mail correspondence from Tracy.*

**3) Collecting and Analyzing the Data**

Focus Groups- There were a total of 62 attendees in all five focus groups completed 8/15 & 8/16 (Employers – 9 attendees, Social Service Providers – 8 attendees, South Side Neighborhood Community Members - 24 attendees, Physicians and Other Health – 16 attendees, Government – 5 attendees). At the end of each focus group, we have participants list their top health concerns. We have documentation of the individuals invited to participate and sign in sheets of those actually attending the focus groups. In addition to a facilitated discussion, groups were asked to share their top five health needs. Documentation of findings will be included in the report. *Additional detail available in CHNA report.*

Telephone Survey- began in October to include 400 households in Yellowstone County. Findings will be included in the final report. Completed in November 2013.

CHNA Report, (We anticipate a formal 200+ page report, summary reports, power point presentations and access to data files for custom queries) will be provided by PRC first week of December to staff/HBDL. Due to IRS expectations of tax-exempt hospitals to "conduct" assessments and adopt implementation plans in the same tax year; results will not be posted on any websites or shared with the media until after Jan 1, 2014.

Internal Analysis

On November 22nd the CHNA workgroup (Shawn, Jeanne, Barbara, Tracy and Heather) met to discern process for previewing report (related to IRS and accreditation standards), analyzing data, previewing with additional vested groups, public announcement planning and prioritization process.

Dec. 8th -a meeting of CHNA workgroup and HBDL to preview report results and to gather initial feedback to PRC in preparation for presentation to the Alliance on Dec. 18th was conducted. CHIC provided assignments of topic areas to HBDL/CHNA workgroup staff for the Alliance meeting and for review/feedback.

Presentation with Alliance will include a 30-40 minute presentation from PRC, Q&A from Alliance based on presentation, Overview of current CHIP goals and data summary slide and review of timeline of CHNA. A

selection of several criteria considering for priority selection were also presented (Presentation determined by CHNA workgroup and CHIC)

Additional feedback from HBDL will be gathered remotely/via email in order to ensure alignment with IRS and accreditation. Feedback or any revisions will be given to PRC following the Alliance presentation of the CHNA report overview by PRC to the Alliance and compilation of HBDL feedback. (Goal-by Dec. 20th-CHIC)

Regarding CHNA report, additional work is assumed to be occurring at each Alliance organizational level to review and provide feedback to the whole via their HBDL membership.

Edits were compiled and submitted to PRC on 12-23. A follow-up phone conversation with PRC to clarify edits occurred on 12-30. Follow-up tasks are being executed by the CHIC. The schedule of edits and final reports was determined at this time. Edits were collected from HBDL on the Focus Group section until 1/7 and then sent to PRC. The Executive Summary was completed by 1-8 and the final report with edits was returned on 1-14-14.

Edits to the external website (healthforecast) were drafted by CHIC, reviewed by a HBDL member and sent to PRC. The HBD website has been prepped for the CHNA report posting and has been updated with an announcement of the Community Forum. The report and summary were provided to the webmaster in advance of 1-21.

The CHNA was posted on the Healthy By Design website and the Alliance partner websites on 1/21/14.

**4) Selecting Priorities**

Process begins with announcement and availability of results and public feedback.

Dec. 19, 2013: follow-up meeting of the CHNA workgroup to solidify logistics of press conference, community forum and key interest group communication. Finalized logistics via email.

- Jan 21st, Breakfast meeting, 7:30 am-9:00, HBD Coalition, 20-40 (guesstimate) (in Mary Alice Fortin Health Conference Center, rooms B & D, BC) *(emailed, with reminder email, to ask to rsvp BY 1-17)*
- Jan 21st Preview meeting, 11:00 am, CHNA Advisory Group, Stillwater Room, RSH *(Heather sent letter and follow up email to this group)*
- Jan 21st, 12:15-12:45 press conference in the Stillwater Room at RSH *(Barbara and Heather put together details)*
- Feb 4th, 11-1, Community Forum at the Library Community Room (reserved), will include Coalition plus list emailed, plus public messaging *(Heather sent email to HDB Coalition to save the date, sent emails to key groups and contacts to distribute, asking for an RSVP for light lunch; will send letters to previous focus group attendees, as emails are unavailable)*
- Emails and letters for the January 21st meetings were drafted by the CHIC and sent to the CHNA workgroup for review before 1/7. Both were distributed on 1/7, with a follow-up email to HBD Coalition for breakfast RSVP by 1/17.
- Meeting to flesh out agenda for preview meetings occurred 1-17-14 among CHNA workgroup.
- Meeting format-slide deck from PRC Alliance presentation was altered only slightly and presented to both the Coalition and Advisor group. Attendance was captured on a list for the Coalition and in notes for the Advisory group. Notes of general questions and comments were recorded. A few comments were collected via notecards from attendees. It is intended that the Advisory group will be reconvened following the Community Forum to further delve into priorities.

Press conference date, time and location were coordinated by CHIC with input from Alliance org Executive Assistants and CHNA workgroup. Date and time: January 21, 12:15-12:45. A media advisory and agenda were drafted by CHIC, with review by RSH Comm. Dir. and approval by the media contacts at both hospitals via CHNA workgroup representatives as of 1-2-14.

<u>Preview meetings were conducted with the following groups:</u>

- Present preview to CHNA Community Advisory Group (phone, email and press conference invite-early Jan) Group previously (2013-to assist in CHNA development) established. Gather initial impressions. Invite to community forum.
    - Occurred: January 21, 2014
    - Feedback was to have a follow-up meeting to further discuss priorities
    - Attendance tracked
    - Comments collected
    - Notes taken

- Present preview to HBD Coalition (email and press conference invite-early Jan)

Purpose will be to recognize their commitment to the work conducted to date and acknowledge long journey, where we have been, data trends and share points that reinforce what we are doing. Any surprises. Gather their initial impressions. Invite to community forum.

- Occurred: January 21, 2014
- Comments were collected.
- Attendance tracked.
- Notes taken

- Schedule and Conduct Press Conference announcing high-level results and community meeting (Community Forum-per CHNA language)
    - *It was determined by the CHNA workgroup that the United Way will be invited to participate in the press conference. RSH Communications Director communicated with United Way contact and prepped for conference. Slides were drafted by CHIC, reviewed with RSH Communications and reviewed by HBDL.*
    - *HBDL were tasked with sharing information with their marketing communications team and getting any feedback back to CHIC. CHIC sent final agenda and slides CEO's assistance on 1-17 in advance of the 1-21 press conference.*
- Schedule and conduct priority identifying meetings with following groups:
    - CHNA Community Advisory Group (Jan 21st)
    - HBD Coalition/workgroups (Jan 21st)
    - Community Forum (Feb 4th)
        - Attendee invitation list: newspaper business advertisement, newspaper calendar invitation, previous focus group invitation lists (mail), HBD Coalition, HBD email list, Facebook, CHNA advisory group, and other outreach to groups including workgroups, Best Beginnings Council, Center for Children and Families email list, colleges, RiverStone Health Population Health Staff and Clinic Board, Yellowstone Valley Suicide Coalition, Family Promise email list, Library Foundation Board, and others.
        - Logistics, RiverStone Health heavily supported logistics planning by offering CDC fellow, Dasheema Jarrett to assist and day of event volunteers. HBD Leadership and Co-Leaders led discussion groups and assisted with presenting.
        - Following research by CHIC on prioritization models, and agenda drafting, an Agenda finalizing meeting occurred with CHNA workgroup on 1/29/14.

Additional informal CHNA results meeting occurred with Big Sky Economic Development with CHIC and Tracy Neary per their request.

Results were also highlighted during two Channel 7-community station interviews. Announcement of the upcoming Community Forum was also made.

**FORUM AGENDA**

11:00 REGISTRATION (10 minutes)
11:10 WELCOME (5 minutes)
11:15 HISTORY/FRAMEWORK (5 minutes)
11:20 RESULTS Community Health Needs Assessment Summary (30 Minutes)

11:50 INDIVIDUAL RANKING (5 minutes) WORKSHEET, using NACCHO criteria
(ranking top 12 opportunities as identified by PRC)
11:55 GROUP VOTING (15 minutes)

- Individuals will find their number 1 priority and go stand by that person/sign to be counted as a vote. *Once number 1 priorities are chosen the exercise will be repeated. Meanwhile, #1 rankings will be gathered to determine top 6 choices. Once the exercise is complete…*
- *Once number 1 priorities are chosen the exercise will be repeated. Meanwhile, #1 rankings will be gathered to determine top 6 choices. Once the exercise is complete…*
    - (*Play music to keep chatter down-stop music to announce movement to next topic*) **Go.**
- *Topic Area Vote Gatherers: Luke, Claire, Shawn, Tracy, Jeanne, Barbara, Molly H., Kim P., Hannah, S., Kate H., Alyssa, Laura*

12:10 TOPIC AREA GROUPS: (30 minutes)

- *Top 6 priorities will be named; facilitators will be asked to come forward and will be assigned a priority/topic. Public will be asked to* follow a facilitator to your assigned meeting space based a topic area they feel they can contribute to. *(Note takers already assigned to a facilitator; both already assigned to a physical space.*
- *Facilitators and Note-takers: Luke, Claire, Shawn, Tracy, Jeanne, Barbara, Molly H., Kim P., Hannah, S., Kate H., Alyssa, Laura*

Transition to (5 minutes)
Transition from (5 minutes)
12:50 REPORT OUT (5 minutes)

- All folks gather in large space, standing or sitting (depending on where group was located)
- ONE key point from each group will be shared *(assigned speaker in small group)*

12:55 SUMMARY/CONCLUSION/NEXT STEPS (5 minutes)

- A summary of this Forum will be available on our website.
- We will also distribute a summary to all attendees, as well as an attendance list.

Community Forum Summary, with ranked priorities, was sent to the attendees and posted on the website. Priorities were identified

Results of Forum were presented to CHNA Advisory group on 2-26-14. This was overlaid with discussion of existing priorities and priorities identified by focus groups as part of the CHNA. Emerged priorities were validated by the group. Discussed number of priorities to consider, community assets and potential responses. (Notes and attendance taken)

With priorities in hand, work to establish objectives, brainstorm strategies and receive approval of the Community Health Improvement Plan framework was undergone.

- CHNA Workgroup Session was held 4/1/14
- Worked on priorities, Resources: CHNA Advisory Group Notes, Forum results and notes, Focus group priorities, topic area experts, best practices and models
- Content Expert Meeting to review objectives and brainstorm strategies and resources was conducted 5/2/14
- Met with CHNA Workgroup 5/15/14 to review feedback from experts and prepare goals and objectives for Alliance presentation

**Presented Priorities, Goals and Objectives to the Alliance for approval in June 4th-APPROVED**

**5) Documenting and Communicating Results**

HISTORY-per Barbara Schneeman
-'06 media advisory-first time came together-at RSH-had all media there-worked well
-'11 press release-referred back to 05 assessment-talked about community forum-didn't release until March 18; good media participation; had Karen Sanford Gall present to show broader community engagement and impact

AFTER PREVIEW "MEETINGS", BEFORE SELECTING PRIORITIES **(these happened on the same day)**

- Schedule and Conduct Press Conference Jan. 21 at noon announcing high-level results and community input meeting (Community Forum-per CHNA language)
    - *United Way was invited to participate in the press conference as an additional community partner. RSH Communications Director communicated with United Way contact and prepped for conference. Slides were drafted by CHIC, reviewed with RSH Communications and reviewed by HBDL.*
    - *HBDL were tasked with sharing information with their marketing communications team and getting any feedback back to CHIC. CHIC sent final agenda and slides CEO's assistance on 1-17 in advance of the 1-21 press conference.*
    - *Received coverage by Q2 and KURL 8, conducted correlating Channel 7 interviews and did a preview meeting with Cindy Ukin at the Gazette. Jackie Yaminacha from YPR also attended the press conference.*

Press conference notes

- Posted to websites at time of press conference
- Benefit beyond our 3 organizations; highlight at press conference that results are needed by other organizations-shared and available to everyone
- Highlight participants-show community project—list entities, groups engaged
- Community Forum announced at the press conference
- *Received coverage by Q2 and KURL 8, conducted correlating Channel 7 interviews and did a preview meeting with Cindy Ukin at the Gazette. Jackie Yaminacha from YPR also attended the press conference.*

Additional communications: Barbara S. (RSH Comm. Dir.) scheduled a preview meeting with Cindy Ukin, she, John and myself on 1-13. Resource: Mental Health journalism fellowship-Cindy Ukin; Barbara has primed the pump with Cindy on the press conference and has indicated to Cindy that information will be provided in advance.

Forum Communication

An ad placed in 40 Under 40 for the Community Forum. The CHIC put together a list of contacts to email regarding forum and shared this with the Leadership Team. Various groups and contacts were added. The invitation was distributed to various sources via email following the press conference. A flier was provided for distribution to the two hospitals and taken to such events as the Let's Talk Billings and the Suicide Coalition meeting. Attendee invitation list: previous focus group invitation lists (mail), HBD Coalition, HBD email list, Facebook, CHNA advisory group, and other outreach to groups including workgroups, Best Beginnings Council, Center for Children and Families email list, colleges, Yellowstone Valley Suicide Coalition, Family Promise email list, Library Foundation Board, and other distribution conducted by each of the Alliance organizations to staff, board and others.

The Community Forum invitation was distributed to various email groups and was posted on the Billings Gazette Calendar. This was also publicized via the Channel 7 interviews and the public coverage of the CHNA results.

A media advisor was also distributed regarding the Forum.

CHNA Results communication: presentation requests have resulted from the Forum, and other interest group inquiries. A sampling of groups requesting presentations include: Research Group Eastern Montana, RSH Community Health Center Board, MSU Physical Education Department, Young Families Early Head Start, Yellowstone Valley Suicide Coalition and others.

**6) Planning for Action and Monitoring Progress**

**CHNA Workgroup Session held 4/1. Drafted agenda sent to CHNA workgroup for review.** Resources: CHNA Advisory Group Notes, Forum results and notes, Focus group priorities, topic area experts, best practices and models

- Arrive at Goals and indicators, and possible strategies, as well as available resources
    - Present to Alliance

- May conduct another round of meetings or pull together a review team for drafted CHNA. Those engaged may include: CHNA advisory group, HBD coalition and identified "interest groups" or "topic experts" based on drafted
- Finalize strategies and indicators

**Content Area Expert Meeting held on May 2nd. Drafted agenda and presentation sent to CHNA workgroup for review.**
Resources: CHNA workgroup notes, CHNA results, HP 2020, National Prevention Strategy, State Health Improvement Plan, Yellowstone Country Community Health Improvement Plan

- Present current objectives under each proposed priority and discuss if the goal addresses the current needs and if the proposed objective will address the goal.
- Suggested revisions were noted and considered when editing the objectives and revisiting the desired percent of change.
- Individual handouts were collected and compiled in addition to group report outs
- Revised objectives were presented to CHNA workgroup for revision and further discussion

**CHNA workgroup Session held on May 15th.**
Resources: Content Area Expert meeting notes, drafted CHIP, HP 2020, National Prevention Strategy, State Health Improvement Plan, Yellowstone County Community Health Improvement Plan

- Drafted objectives were reviewed and voted on for approval.
- Additional specific objectives were added to address various areas of work
- Percent of Change was discussed and agreed upon for further exploration by CHIC
- Deadlines were discussed regarding each Alliance organization and goals were placed for rough finalization prior to Alliance meeting on June 4th

**Alliance Board meeting held on June 4th**
Resources: Yellowstone County Community Health Improvement Plan, Community Health Needs Assessment, HP 2020

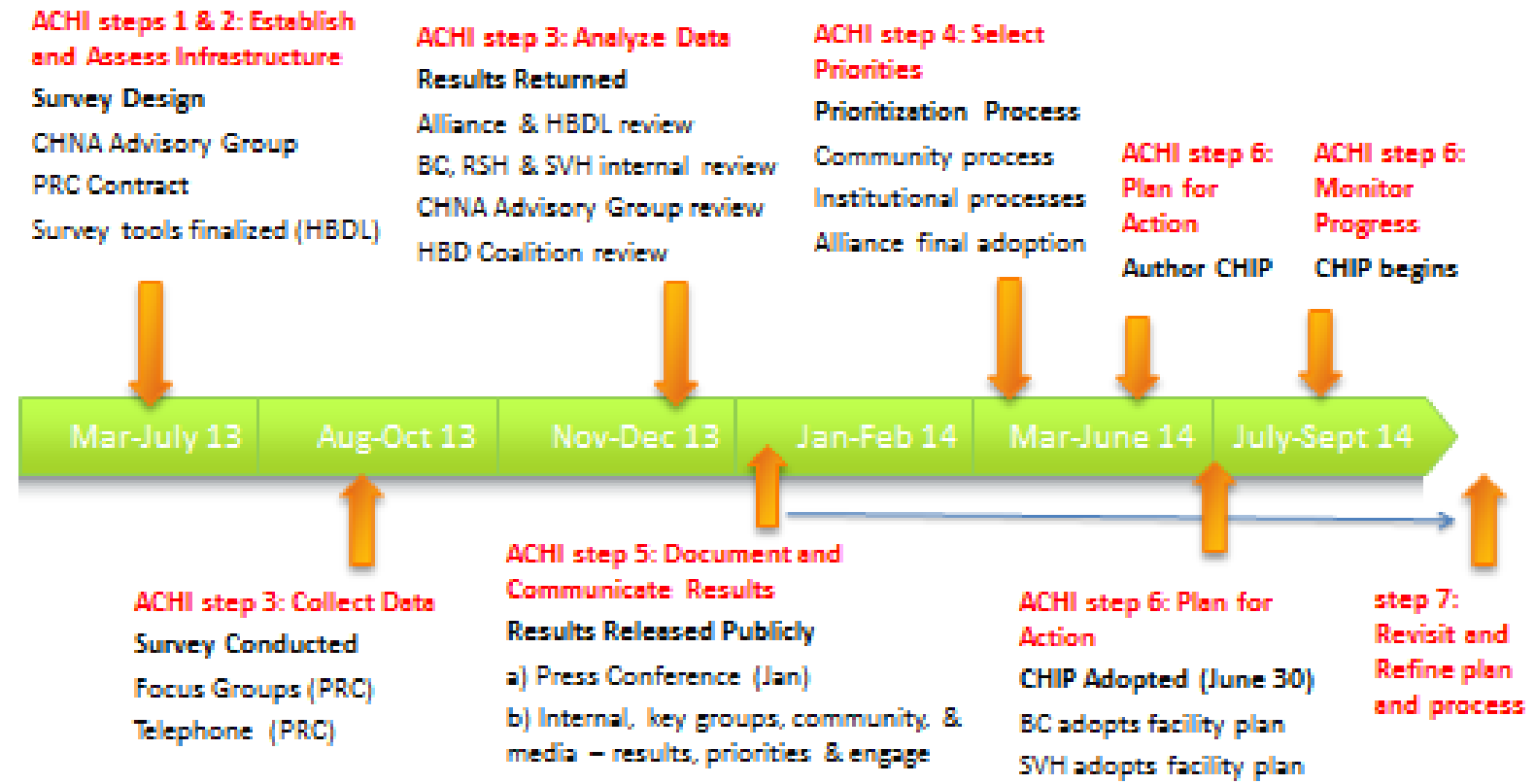
- Proposed goals and objectives were presented to the Alliance for acceptance and approval by all three organizations
- Common language discussions were held and further cleared by the CHIC through the CHNA workgroup

**CHIP Roll Out**
Approved CHIP goals and objectives were distributed to Alliance and Healthy By Design Leadership Team and hospital community benefit staff on 6/18/14. Additional content of the CHIP was distributed on 6/30/14, with the expectation that design and layout of the document for distribution continues, as does the roll out of strategies.

**7) Report, revisit and refine plan and process**

We anticipate strategies and tactics will be incorporated into the overall work of the CHIP at a workgroup level. We expect workplans will be developed and will act as goal-setting and reporting documents that will allow for annual progress assessment and refinement.

# COMMUNITY HEALTH NEEDS ASSESSMENT TIMELINE




CHNA= Community Health Needs Assessment
CHIP= Community Health Improvement Plan
ACHI=Association of Community Health Improvement
PRC= Professional Research Consultants – vendor
HBDL=Healthy By Design Leadership
(framework for CHNA-steps referenced)

# ***Appendix B:*** *Progress report from previous CHIP*

***IMPROVE ACCESS TO HEALTHCARE***

**Goal*:*** *Increase percentage of people who have a specific source of ongoing healthcare*

**Community Health Needs Assessment Results:**

2005 - 84%

2011 - 82%

**Healthy People 2020 Goal:**

95%

**Yellowstone County Goals:**

2014 - 88%

2020 - 92%

| Objectives | Strategies/Interventions | Progress (May 2013) | Updates (May 2013) | Immediate Next Steps |
|---|---|---|---|---|
| Decrease the proportion of people who cite inconvenient office hours as a barrier to medical care in the past year (CHNA 2011: 8.3%) | • Continue implementation of patient-centered medical homes | No progress on objective has been evidenced to date (next CHNA scheduled for release early 2014) | • In February 2013, RiverStone Health's community health centers in Billings, Bridger, Joliet and Worden were recognized by the National Committee for Quality Assurance as patient-centered medical homes.<br>• Billings Clinic and St. Vincent Healthcare have received ACO designation.<br>• Primary Care Medical Homes – team at Billings Clinic have been created to work together on patient needs.<br>• Scheduling changes at all three organizations have been made to offer same-day or next day access.<br>• All three organizations are working with the Montana Family Medicine Residency.<br>• Billings Clinic starting an internal medicine residency program. | • Continue work towards patient-centered medical home in each individual organization.<br>• No change to CHIP required at this time. |
| Decrease proportion of people who have utilized the ED more than once in past year (CHNA 2011: 8.6%) | • Continue implementation of patient-centered medical homes<br>• Research best practices to | No progress on objective has been evidenced to date (next CHNA scheduled for release early 2014) | • See above regarding patient-centered medical homes.<br>• Billings Clinic, RiverStone Health and St. Vincent Healthcare are working on a joint data | • Determine ED data to be utilized for analysis (Tracy Neary – lead)<br>• Determine who will |

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| | improve patient health literacy, (i.e. knowledgeable consumers)<br><br>• Increase the number of practicing primary care physicians<br><br>• Decrease the number of ED visits attributed to ambulatory care sensitive conditions | | analysis project mapping ED utilization. Right now the group is in discussion regarding what data is needed. The goal is to map the ED utilization and determine if there are specific areas of Yellowstone County that require interventions to reduce utilization.<br><br>• Additional resources requested from the Alliance to move this work forward – approved to have a Community Health Improvement Coordinator. | conduct data analysis (Tracy Neary – lead)<br><br>• No change to CHIP required at this time. |
| Continue advocacy support to maintain access to healthcare programs that assist those with financial need (e.g. Medicaid, Healthy Montana Kids, Medication Assistance Program, Community Health Assistance Program) through the development and advocacy of an Alliance legislative agenda (Fall 2012 and 2014) | • As appropriate, continue advocacy efforts with federal and state public policymakers<br><br>• Focus advocacy efforts on testimony, letters, phone calls, face-to-face meetings and activation of grassroots | 2013 Legislative Session results of bills supported by Healthcare – 12 failed and 8 passed | • In November, 2012 Billings Clinic, RiverStone Health, and St. Vincent Healthcare hosted a joint advocacy dinner to share with legislators their legislative agenda for the 2013 session.<br><br>• During the 2013 session there were multiple advocacy efforts including testimony, letters, phone calls, face-to-face meeting and activation of grassroots.<br><br>**Legislative 2013 Summary:**<br>*Policies Failing:*<br>• HB 479 – opt-out immunization registry<br>• HB 498 – Montana healthcare claims database<br><br>*Policies Enacted:*<br>• HB 28 – review of maternal deaths<br>• HB 87 – health insurance rate review<br>• SB 84 – Patient Centered Medical Home standards<br><br>**HB 2 State Budget:**<br>• Evidence-based Home Visiting ($2M)<br>• Title X ($4.6M)<br>• Health Information Technology Meaningful Use ($17M)<br>• Residency ($200,000)<br>• 10 new WWAMI placements<br><br>**Medicaid Expansion = Access to Care** (all | • Determine if there is any work to be done between legislative session on the topic of Medicaid expansion (Barbara Schneeman – lead)<br><br>• No change to CHIP required at this time. |

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| | | | failing)<br>• HB 458 – Noonan: straight expansion, asked to be tabled in favor of HB 590<br>• HB 590 – Hunter: Access Health Montana (Governor's bill), medical homes<br>• SB 393 – Kaufmann: straight expansion<br>• SB 395 – Wanzenried: reform and expansion<br>• HB 623 – Bangerter: heavily amended (twice) reform, expansion to the private insurance market<br>• HB 604 – Smith: study concluding June 2015 | |

***IMPROVE HEALTHY WEIGHT STATUS***

**Goal:** *Increase the percentage of people in Yellowstone County who have a healthy weight*

**Community Health Needs Assessment Results:**

2005 – 35.8%

2011 – 25.4%

**Healthy People 2020 Goal:**

33.9%

**Yellowstone County Goals:**

2014 – 25.4%

2020 – 33.9%

| objectives | Strategies/Interventions | Progress (May 2013) | Updates (May 2013) | Immediate Next Steps |
|---|---|---|---|---|
| Increase percentage of people that have received advice about weight by a doctor, nurse or other health professional (CHNA 2011: 15.6%) | • Increase number of primary care patients who have had their Body Mass Index (BMI) calculated<br>• Increase number of patients having healthy weight plan with BMI outside of healthy range | No progress on objective has been evidenced to date (next CHNA scheduled for release early 2014) | • The Healthy By Design Healthy Weight Workgroup has been assigned these strategies/interventions.<br>• Motivational Interviewing training was conducted for social workers, dieticians, nurses and primary care providers (over 100 people in total).<br>• RiverStone Health electronic health record updated to include Healthy Weight Plan. | • The Healthy Weight workgroup has updated their workplan to reflect the next steps needed which include: updating Healthy Weight plans, presenting at Grand Rounds, and distribution of 5-2-1-0 materials (Alyssa Auvinen and Elizabeth Ciemins – lead).<br>• No change to CHIP required at this time |

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| Decrease percentage of people with no leisure-time physical activity in past month (CHNA 2011: 22.4%) | • Increase the number of workplaces adopting Healthy By Design physical activity guidelines<br>• Increase the proportion of commuters who use active transportation (i.e. walk, bicycle and public transit) to travel to work<br>• Increase awareness of gender-based physical activity disparities<br>• Support Yellowstone County area school-based efforts to increase students' physical activity | No progress on objective has been evidenced to date (next CHNA scheduled for release early 2014) | • The Healthy By Design workgroups of Built Environment, Health Equity and Worksite Wellness have been assigned these strategies/interventions.<br>• A draft Complete Streets Benchmark report has been developed with the Built Environment Workgroup – it is currently with Alta Planning for graphic design and layout.<br>• In late May 2013 an engineer/planner from Charlotte North Carolina will be coming to Billings to meeting with City/County staff regarding complete streets implementation.<br>• Recruitment is underway for the Health Equity Workgroup/OWH physical activity course. This will include men and women and be based on the Active Living Every Day course.<br>• The Worksite Wellness Workgroup has worked with the Alliance organizations to adopt policies related to physical activity. Public launch of the policies will occur in early summer 2013. | • The public release of the Complete Streets Benchmark report (Laura Holmlund and Hillary Hanson – lead)<br>• Conduct the Health Equity gender research project in summer 2013 (April Keippel – lead).<br>• No change to CHIP required at this time. |
| Increase number of people that eat 5 or more servings of fruit and vegetables per day (CHNA 2011: 40.6%) | • Increase the number of workplaces adopting Healthy By Design nutrition guidelines<br>• Increase the number of community events applying for and achieving Healthy By Design recognition<br>• Continue advocacy efforts which support access to healthy foods for low-income individuals and families (i.e. WIC, SNAP, food pantries, etc.) (supported by The National Prevention Strategy) | No progress on objective has been evidenced to date (next CHNA scheduled for release early 2014) | • The Healthy By Design workgroups of Worksite Wellness and Health Equity have been assigned these strategies/interventions.<br>• The Worksite Wellness Workgroup has worked with the Alliance organizations to adopt policies related to nutrition (vending and catering). Public launch of the policies will occur in early summer 2013.<br>• The Recognition Workgroup has worked to simplify their application process and promote the recognition program through the Healthy By Design website. Ten events recognized to date this year (up from 7 this time last year).<br>**Legislative 2013 Summary:**<br>*Policies Failing:*<br>• HB 98 – funding for increasing school | • Continued distribution of the 5210 messaging needed – each workgroup will determine how to fit it into their workplans.<br>No change to CHIP required at this time. |

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| | Support Yellowstone County area school-based efforts to increase students' daily consumption of fruits and vegetables | | breakfast programs<br>• HB 99 – funding flexibility for TANF to support out-of-school food programs<br>• SB 315 – childhood BMI trends<br><br>*Policies Enacted:*<br>• HB 630 – MT food policy modernization act<br><br>**HB 2 State Budget:**<br>• Diabetes Prevention ($250K) | |

## *IMPROVE MENTAL HEALTH*

**Goal:** *Increase percentage of people reporting their mental health status as being good, very good or excellent*

**Community Health Needs Assessment Results:**

2005 – 89.9%

2011 – 93.1%*

(*22.5% of low income individuals reported experiencing fair or poor mental health, while only 5.8% of middle/high income individual reported the same)

**Healthy People 2020 Goal:**

No Goal

**Yellowstone County Goals:**

2014 – 89.9%

2020 - 92%

| Objectives | Strategies/Interventions | Progress (May 2013) | Updates (May 2013) | Immediate Next Steps |
|---|---|---|---|---|
| Increase the percent of depressed persons seeking help (CHNA 2011: 62.1%) | • Increase availability of mental health treatment options<br><br>• Increase utilization of behavioral health specialists in primary care settings<br><br>• Maintain 24/7 access to mental health assessment/triage | No progress on objective has been evidenced to date (next CHNA scheduled for release early 2014) | • Statewide Suicide Task Force to be developed following legislative session. The Alliance will work to have a representative on this Task Force and link the statewide work to what occurs on the local level.<br><br>• Additional resources requested from the Alliance to move this work forward – approved to have a Community Health Improvement Coordinator.<br><br>• Alliance Chronic Pain Committee established to develop community wide chronic pain prescribing policy. | • Gather a group to determine the next steps for work on these strategies/interventions (Community Health Improvement Coordinator – lead)<br><br>• Discussion regarding whether or not new goal should be added to CHIP regarding chronic pain committee. No change needed now but will be revisited with the |

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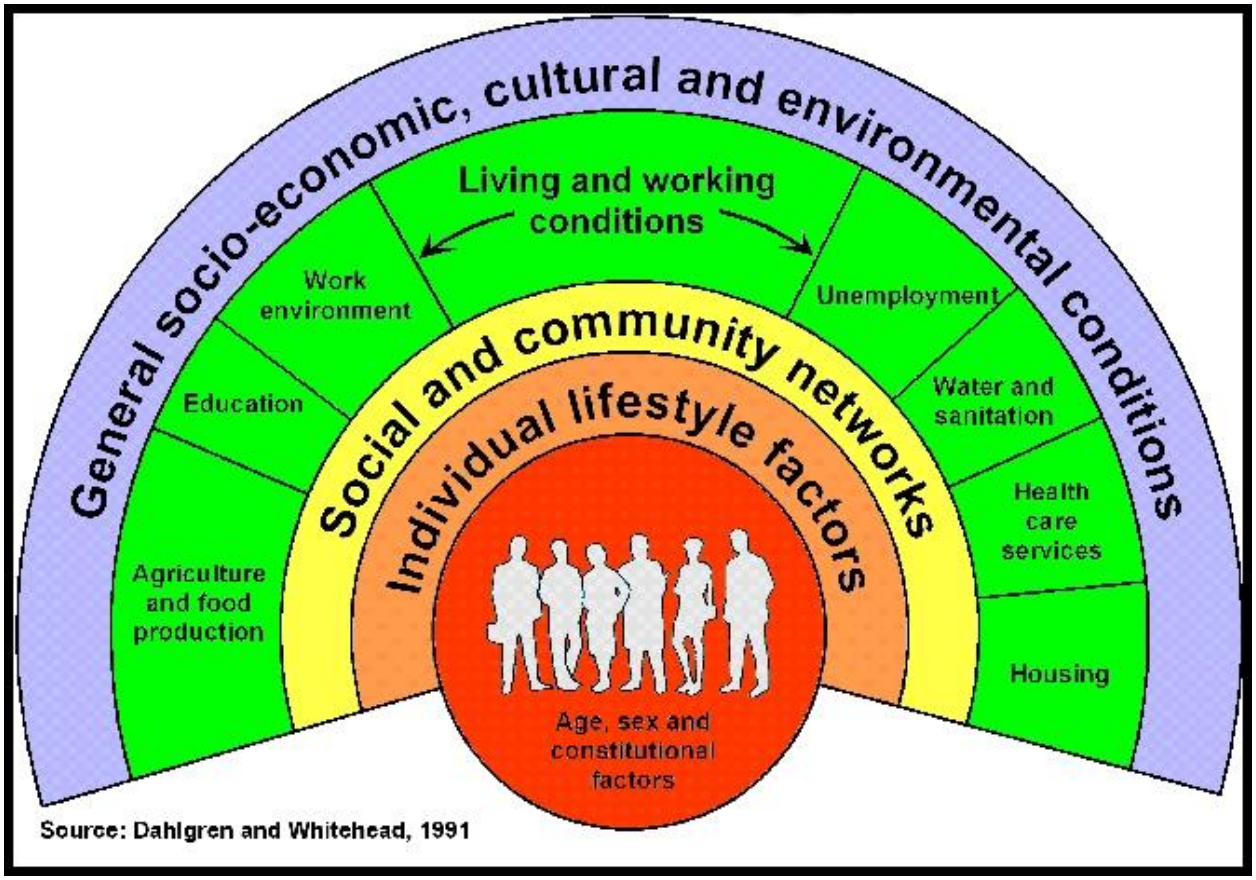
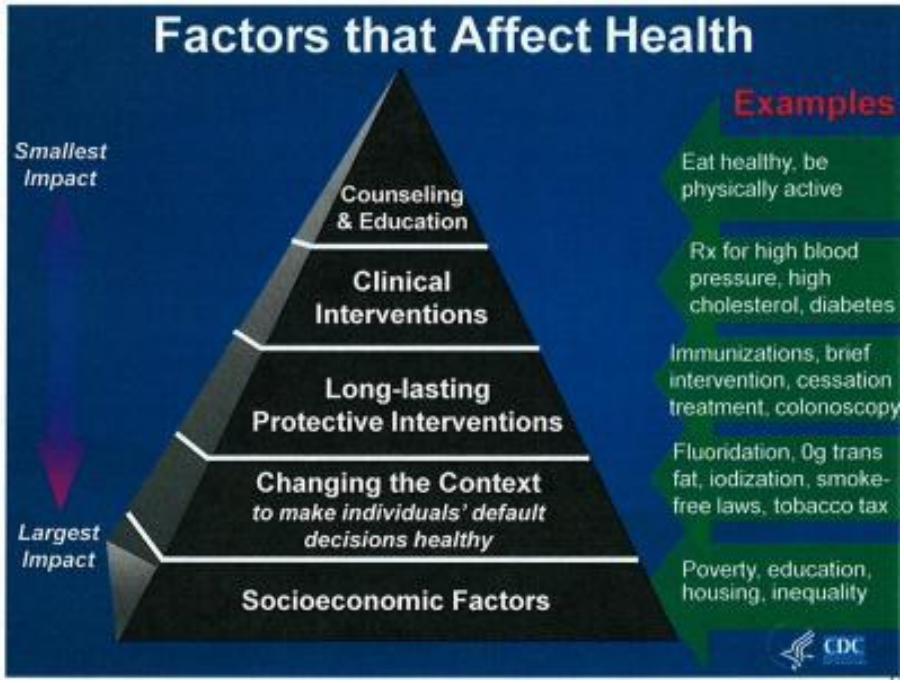
| | | | **Legislative 2013 Summary:**<br><br>*Policies Failing:*<br>• HB 43/69 – creating jail suicide prevention programs<br><br>*Policies Enacted:*<br>• HB 84 – 72-hour presumptive eligibility for crisis stabilization<br>• HB 583 – suicide review team<br>• SJ 20 – prescription drug abuse study<br><br>**HB 2 State Budget:**<br>• Community Crisis Diversion Grants ($1.6M) | Alliance. |
| Reduce the suicide rate in Yellowstone County<br>(CHNA 2011: 18.6) | • Increase depression screening in the primary care setting with the utilization of depression screening tools like PHQ<br><br>• Increase number of people in the community who have received suicide prevention training such as QPR – Question, Persuade, Refer (suicide prevention tool)<br><br>• Research evidence-based suicide prevention methods | No progress on objective has been evidenced to date (next CHNA scheduled for release early 2014) | • In late May 2013 RiverStone Health is sending one staff member to obtain QPR Gatekeeper training (this allows the staff member to train others on QPR).<br><br>• CHIP goals and objectives have been shared with the Yellowstone County Suicide Prevention Coalition to begin the discussion of ways to collaborate.<br><br>• The *2012 National Strategy for Suicide Prevention – Goals and Objectives for Action* was identified as a resource to use towards evidence-based prevention methods. | • Gather a group to determine the next steps for work on these strategies/interventions (Community Health Improvement Coordinator – lead)<br><br>• No changes to the CHIP needed at this time. |

## ***Appendix C:*** *Models Influencing goals, objectives and strategies*

**Social Determinants of Health**



**Health Impact Pyramid**




*Source: Frieden, T.A Framework for Public Health Action: The Health Impact Pyramid. Am J Public Health. 2010; April; 100(4): 590-595*


*Source: Prevention Institute*