2019-22 Community Health Needs Assessment

# Implementation Strategy

## Frances Mahon Deaconess Hospital

# Table of Contents

# Community Health Needs Assessment

# About Frances Mahon Deaconess Hospital

In the spring of 2019, Frances Mahon Deaconess Hospital (FMDH) embarked on a complete Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our community.

Frances Mahon Deaconess Hospital is a not-for-profit, 25-bed critical access hospital based in Glasgow, Montana serving the Valley County Region. With 250 employees, FMDH provides services primarily to residents of Valley County, but also serves those in neighboring cities and towns. FMDH is accredited by The Joint Commission.

It is FMDH's mission to advance the coordinated delivery of health services guided with respect for the individual needs of our patient thereby improving the health of our regional community. Frances Mahon Deaconess Hospital provides the following services:

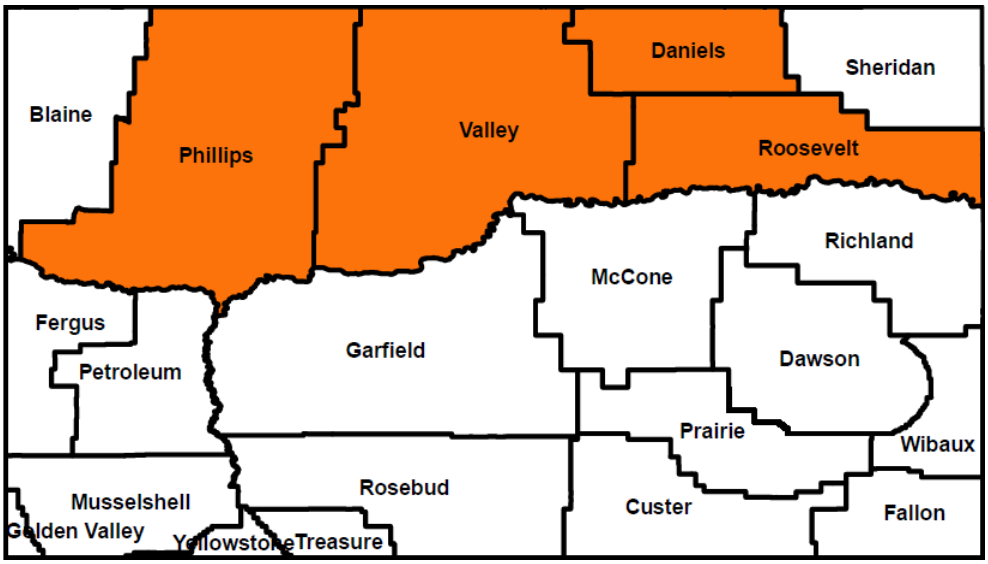
- Anesthesia/Pain Management Services
- Audiology & Hearing Aid Services
- Dietary
- DLC Diabetes Loving Care
- EMS Services
- Glasgow Clinic
- General Surgery
- Hi-Line Med Spa
- Home Oxygen and Durable Medical Equipment
- Labor, Delivery and Recovery
- Laboratory Services
- Nutrition Services
- Orthopedics and Sports Medicine
- Out Patient Infusion Therapy
- Pastoral Care
- Privacy Officer
- Radiology Services
- Rehab Services
- STAT Air
- Surgical Services
- WIC Program

FMDH completed its latest Community Health Needs Assessment in 2019 and also completed one in 2016 and 2013.

# Community Served

## *Community Defined for This Assessment*

The study area for this effort (referred to as the "Total Service Area" in this report) includes four Montana counties: Daniels, Phillips, Roosevelt, and Valley. This community definition, determined based on the areas of residence of most recent patients of Frances Mahon Deaconess Hospital, is illustrated in the following map.




## Demographics of the Community

## Total Population

The Frances Mahon Deaconess Hospital Service Area, the focus of this Community Health Needs Assessment, encompasses 13,847.01 square miles and houses a total population of 24,706 residents, according to latest census estimates.

## Total Population

(Estimated Population, 2013-2017)

| | Total Population | Total Land Area (Square Miles) | Population Density (Per Square Mile) |
|---|---|---|---|
| **Total Service Area** | 24,706 | 13,847.01 | 1.78 |
| **Montana** | 1,029,862 | 145,545.42 | 7.08 |
| **United States** | 321,004,407 | 3,532,315.66 | 90.88 |

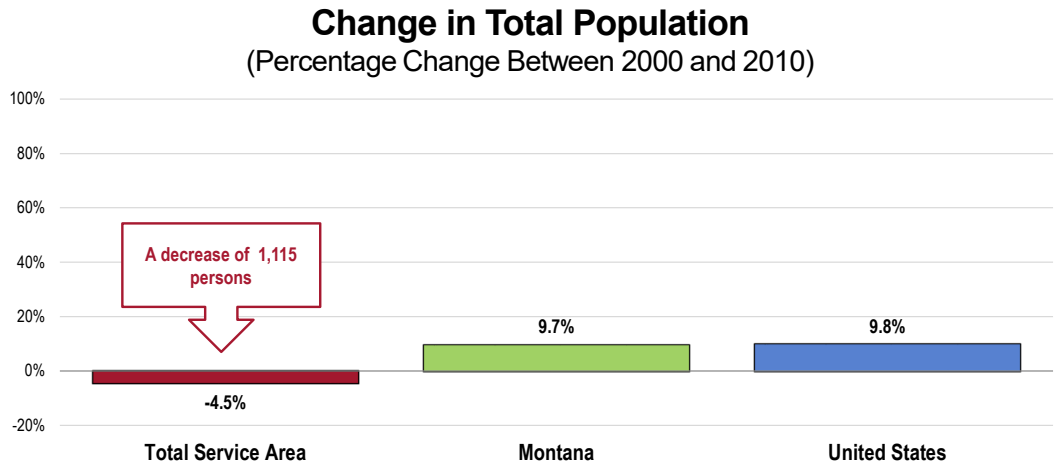
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

### Population Change 2000-2010

A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

**Between the 2000 and 2010 US Censuses, the population of the Total Service Area decreased by 1,115 persons, or 4.5%.**

- Both the Montana and U.S. populations increased during this time.




Sources:
- Retrieved April 2019 from Community Commons at http://www.chna.org.
- US Census Bureau Decennial Census (2000-2010).

Notes:
- A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

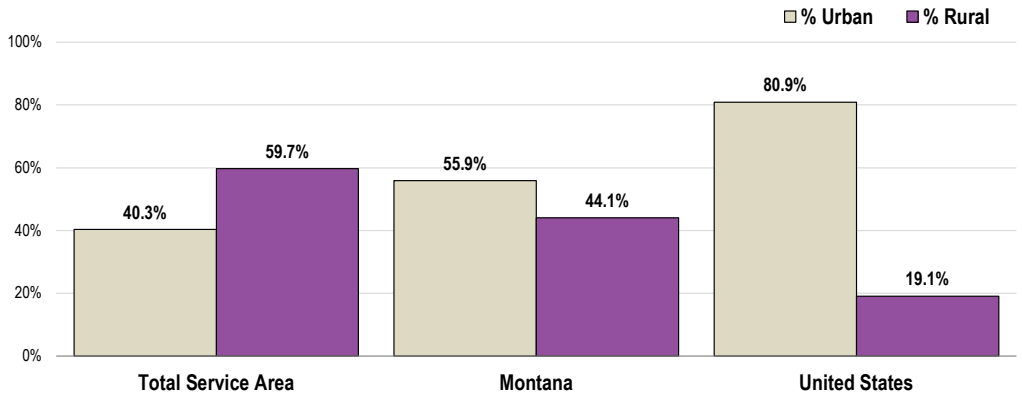
## Urban/Rural Population

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.

**The Total Service Area is predominantly rural, with 59.7% of the population living in communities designated as rural.**

- In contrast, over 50% of the state population and over 80% of the national population lives in urban areas.

**Urban and Rural Population**
(2010)




Sources:
- US Census Bureau Decennial Census.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

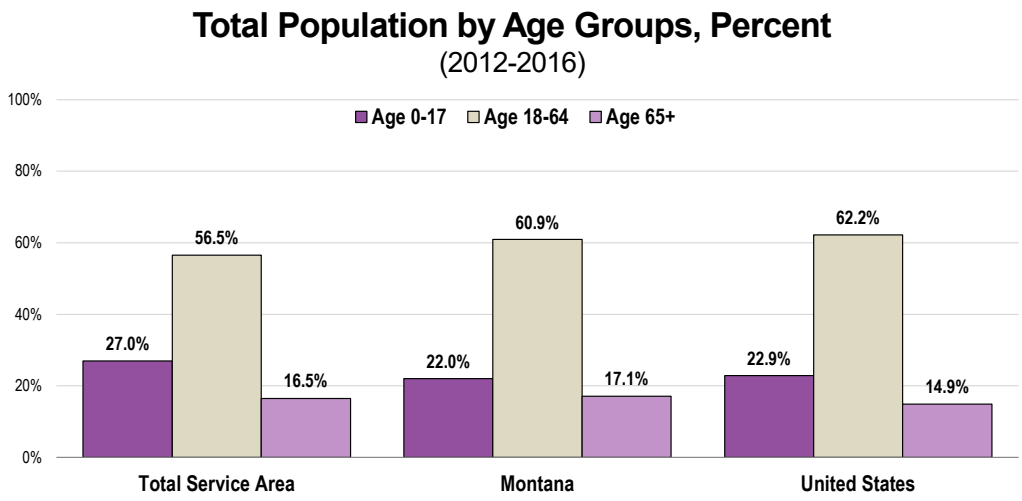
Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

## Age

It is important to understand the age distribution of the population, as different age groups have unique health needs which should be considered separately from others along the age spectrum.

**In the Total Service Area, 27.0% of the population are infants, children or adolescents (age 0-17); another 56.5% are age 18 to 64, while 16.5% are ages 65 and older.**

- The percentage of older adults (65+) is slightly higher than found statewide or nationally.



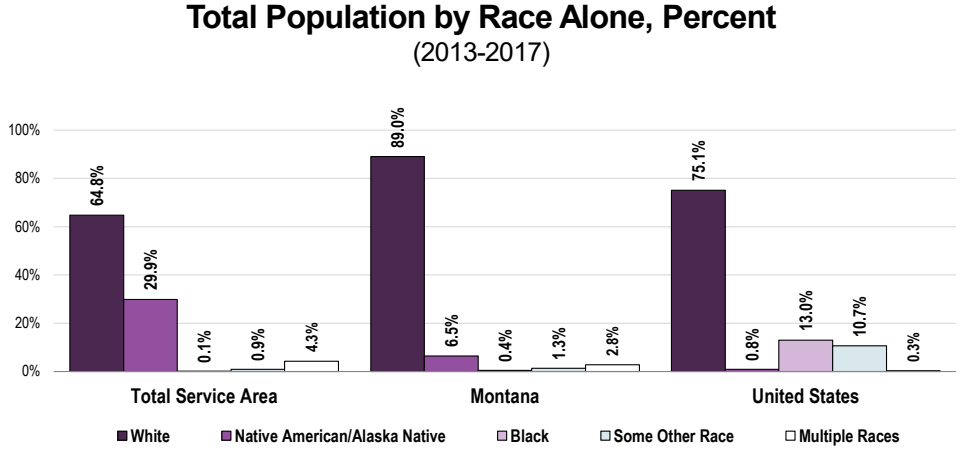

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

## Race & Ethnicity

### Race

**In looking at race independent of ethnicity (Hispanic or Latino origin), 64.8% of residents of the Total Service Area are White and 29.9% are Native American.**

- The distributions across the state and nation are predominantly White, with much lower proportions of native populations.




Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2019 from Community Commons at http://www.chna.org.

### Ethnicity

**A total of 2.8% of service area residents are Hispanic or Latino.**

- Considerably lower (in terms of percentage growth) than found statewide and nationally.

# Resources Available to Address the Significant Health Needs

Incorporating input from community stakeholders taking part in the Online Key Informant Survey, the following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

**Access to Healthcare Services**

- *Doctor's Offices*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Mental Health Services*
- *Northeast Montana Health Services*
- *VA Clinic*

**Arthritis, Osteoporosis & Chronic Back Conditions**

- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Hospital Clinic*
- *Massage Services*

**Cancer**

- *AA/NA*
- *Daniels County Public Health*
- *Daniels Memorial Healthcare Center*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Glasgow Hospital*
- *Health Department*
- *Indian Health Services*
- *Relay for Life*

**Dementias, Including Alzheimer's**

**Disease**

- *Council on Aging*
- *Doctor's Offices*
- *Frances Mahon Deaconess Hospital*
- *Home Care Services*
- *Hospitals*

**Diabetes**

- *Bountiful Baskets*
- *Daniels Memorial Healthcare Center*
- *Diabetes Program*
- *Doctor's Offices*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Health Department*
- *Hospitals*
- *Northeast Montana Health Services*
- *Nutrition Services*
- *Pharmacists*
- *Roosevelt County Health Department*
- *Roosevelt Medical Center*
- *Telemed*

**Family Planning**

- *Churches*
- *Community Health Nurse*

- *Doctor's Offices*
- *Health Education*

**Heart Disease & Stroke**

- *Cardiac Rehab*
- *Daniels County Public Health*
- *Daniels Memorial Healthcare Center*
- *Doctor's Offices*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Northeast Montana Health Services*
- *Parks and Recreation*
- *Roosevelt Medical Center*
- *Smoking Cessation Programs*

**Immunization & Infectious Disease**

- *Frances Mahon Deaconess Hospital*

**Infant & Child Health**

- *BIA Social Services*
- *Montana Child Protective Services*

**Injury & Violence**

- *Frances Mahon Deaconess Hospital*
- *Hospitals*
- *Indian Health Services*
- *Love Should Not Hurt*
- *Mental Health Services*
- *School System*
- *Spotted Bull Treatment Center*

**Kidney Disease**

- *Diabetes Program*
- *Dialysis*
- *Doctor's Offices*
- *Telemed*

**Mental Health**

- *AA/NA*
- *Churches*
- *Counselors*
- *County Mental Health*
- *Daniels Memorial Healthcare Center*
- *Doctor's Offices*
- *Eastern Montana Community Mental Health Center*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Hospitals*
- *Indian Health Services*
- *Lifecoach*
- *Mental Health Center*
- *Mental Health Services*
- *Northeast Montana Community Mental Health*
- *Peer Recovery Coach*
- *School System*
- *State Mental Hospital*
- *Teaming Together Counseling*
- *Telehealth*
- *The Answer Within Counseling*
- *Valley County Mental Health*

**Nutrition, Physical Activity & Weight**

- *Civic Center*
- *Daniel Plan Program*
- *Food Co-op*
- *Fort Peck Tribes*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Glasgow Recreation Center*
- *Hospitals*
- *Just for Kicks*
- *Kraze Fitness Center*

- *Parks and Recreation*
- *Recreation Center*
- *Roosevelt County Health Department*
- *Telemed*
- *Weight Watchers*
- *Wellness Center*
- *Wolf Point High School Track*

**Oral Health**

- *Budde Family Dentistry*
- *Dentist's Offices*
- *Doctor's Offices*
- *Gentle Dental*
- *Health Department*
- *Indian Health Services*
- *Rimrock Pediatric Dentistry*

**Respiratory Diseases**

- *Doctor's Offices*
- *Home Oxygen*

**Sexually Transmitted Diseases**

- *Churches*
- *Community Health Nurse*
- *Doctor's Offices*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Indian Health Services*
- *Roosevelt County Health Department*
- *School System*

**Substance Abuse**

- *AA/NA*
- *Daniels Memorial Healthcare Center*
- *Doctor's Offices*
- *Eastern Montana Community Mental Health Center*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Glasgow Police Department*
- *Indian Health Services*
- *Mental Health Center*
- *Mental Health Services*
- *Ministerial Resources*
- *Peer Recovery Coach*
- *Spotted Bull Treatment Center*
- *Substance Abuse Counselors*
- *Teaming Together Counseling*
- *Valley County Mental Health*
- *Valley County Sheriff's Department*

**Tobacco Use**

- *1-800-Quit-Line*
- *Daniels Memorial Healthcare Center*
- *Doctor's Offices*
- *Fort Peck Tobacco Prevention Coordinator*
- *Frances Mahon Deaconess Hospital*
- *Glasgow Clinic*
- *Mental Health Services*
- *Montana Quit Line*
- *Montana Tobacco Use Prevention Program, Valley County Health Department*
- *Nutrition Services*
- *Roosevelt County Tobacco Prevention Coordinator*
- *Smoking Cessation Programs*

# How CHNA Data Were Obtained

## 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 implemented as part of this process. A list of recommended participants was provided by Frances Mahon Deaconess Hospital; 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. 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. In all, 64 community stakeholders took part in the Online Key Informant Survey, as outlined below:

| Online Key Informant Survey Participation | | |
|---|---|---|
| **Key Informant Type** | **Number Invited** | **Number Participating** |
| Physicians | 8 | 1 |
| Public Health Representatives | 10 | 8 |
| Other Health Providers | 50 | 38 |
| Social Services Providers | 12 | 3 |
| Community/Business Leaders | 12 | 4 |
| Other Community Leaders | 45 | 10 |

Final participation included representatives of the organizations outlined below.

- Frances Mahon Deaconess Hospital (FMDH)
- Daniels Memorial Healthcare Center (DMHC)
- Valley County Health Department (VCHD)
- Eastern Montana Community Mental Health Center
- Fast Farms
- Glasgow Police Department
- Glasgow Recreation Department
- Hi-Line Eye Care, PLLC
- Prairie Ridge Village
- Riverside Family Clinic (RFC)
- Roosevelt County Health Department
- Valley County Health Board
- Youth Dynamics

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

**Minority/medically underserved populations represented:**

> *Adopted/foster care children, those with developmental disabilities, Filipinos, the homeless, non-White/minority/indigenous populations, low-income residents, Medicare/Medicaid recipients, those with mental health issues, Native Americans, older adults, rural residents, transient workers, the unemployed/underemployed, the uninsured/underinsured*

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.

*NOTE: The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area. Thus, these findings are based on perceptions, not facts.*

### Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Environmental Systems (CARES)
- 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, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- 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 data are not available for all counties for all measures.

# Community Stakeholder Input

### Project Assistance

This assessment was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

### Vulnerable Populations

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs for our population.

### Information Gaps

While this Community Health Needs Assessment is quite comprehensive, FMDH and PRC recognize that 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.

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 a great number of medical conditions that are not specifically addressed.

# Public Dissemination

This Community Health Needs Assessment is available to the public using the following URL: https://fmdh.org/community-health-needs-assessments/

FMDH will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. FMDH will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.

# Health Needs of the Community

## Prioritization of Health Needs

On May 29, 2019, internal and external stakeholders of Frances Mahon Deaconess Hospital met to evaluate, discuss and prioritize health issues for the community, based on findings of the 2019 PRC Community Health Needs Assessment (CHNA). The meeting began with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above) and input from community stakeholders (key informants).

Following the data review, there was a dialogue to evaluate the scope and severity of the issues covered, as well the ability of Frances Mahon Deaconess Hospital to have significant impact on each. Through discussion, a consensus was reached to establish the following as priorities for Frances Mahon Deaconess Hospital to include in its Implementation Strategy to address the top health needs of the community in the coming years:

1. **Mental Health**
2. **Nutrition, Physical Activity & Weight**
3. **Access to Health Services**

Additional significant health needs that emerged from this Community Health Needs Assessment are outlined below. These will not be specifically addressed in the Implementation Strategy, although some may be addressed in some way through addressing access to healthcare services.

- Cancer
- Diabetes
- Heart Disease & Stroke
- Infant Health & Family Planning
- Injury & Violence
- Respiratory Diseases
- Sexually Transmitted Diseases
- Substance Abuse
- Tobacco Use

# Summary of Findings

## Identified 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 and the guidelines set forth in Healthy People 2020. 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).

| Areas of Opportunity Identified Through This Assessment | |
|---|---|
| **Access to Healthcare Services** | • Lack of Health Insurance<br>• Primary Care Physician Ratio<br>• Health Professional Shortage Area Designation |
| **Cancer** | • Colorectal Cancer Incidence<br>• Female Breast Cancer Screening<br>• Cervical Cancer Screening<br>• Colorectal Cancer Screening<br>• *Cancer ranked as a top concern in the Online Key Informant Survey.* |
| **Diabetes** | • Diabetes Prevalence |
| **Heart Disease & Stroke** | • Heart Disease Deaths<br>• Stroke Deaths |
| **Infant Health & Family Planning** | • Infant Mortality<br>• Teen Births |
| **Injury & Violence** | • Unintentional Injury Deaths |
| **Mental Health** | • Suicide Deaths<br>• *Mental Health ranked as a top concern in the Online Key Informant Survey.* |
| **Nutrition, Physical Activity & Weight** | • Low Food Access<br>• Obesity [Adults]<br>• Leisure-Time Physical Activity<br>• Access to Recreation/Fitness Facilities |
| **Respiratory Diseases** | • Lung Disease Deaths<br>• Pneumonia Vaccination [65+] |
| **Sexually Transmitted Diseases** | • Gonorrhea Incidence<br>• Chlamydia Incidence |
| **Substance Abuse** | • Excessive Drinking<br>• *Substance Abuse ranked as a top concern in the Online Key Informant Survey.* |
| **Tobacco Use** | • Cigarette Smoking Prevalence<br>• *Tobacco Use ranked as a top concern in the Online Key Informant Survey.* |

# Identifying & Prioritizing Health Needs

## Identification of Health Needs

### Top Concerns

Among those rating the issue in the heading listed below as a "major problem," reasons frequently related to the following:

***Access to Care/Services***

> *This is a major problem for getting the care that is needed, specifically for VA patients. That go across many other problems for VA patients. I considered this a major problem because of its prevalence in this area. — Other Health Provider (Valley County)*
>
> *No specialty care. Long distance to secondary or tertiary care. — Other Health Provider (Roosevelt County)*

***Obesity***

> *Obesity, smoking, lack of physical activity, etc., are likely similar or worse than average rates across Northern Plains. In case of heart attack or stroke, air ambulance to Billings or similar facility is 90+ minutes after incident. — Community/Business Leader (Daniels County)*
>
> *This is a huge issue. Obesity, diabetes, lack of exercise facilities. Aging population. — Other Health Provider (Valley County)*

***Aging Population***

> *Older generation of folks. Rural area. — Other Health Provider (Valley County)*

***Awareness/Education***

> *The largest issue is that there is not a dynamic enough educational approach available to deal with the precursors to heart disease and stroke in our community. As well, the medical resources to deal with this issue are not truly supportive or accurate. — Social Services Provider (Valley County)*

***Comorbidities***

> *Heart disease and stroke are linked to diabetes and tobacco abuse, as well as alcohol abuse. Due to the rural nature of Valley County, heart disease and strokes are often fatal. — Other Health Provider (Valley County)*

***Co-occurrences***

> *Diet, genetics, lifestyle. — Other Health Provider (Roosevelt County)*

The significant health needs ("Areas of Opportunity" outlined above) were determined after consideration of various criteria, including: standing in comparison with benchmark 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.

# Implementation Strategy

## Implementation Strategy Adoption

This summary outlines Frances Mahon Deaconess Hospital's plan (Implementation Strategy) to address our community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and 3) promoting an understanding of these health needs among other community organizations and within the public itself.

On Wednesday, August 28th, the Board of FMDH approved this Implementation Strategy to undertake the outlined measures to meet the health needs of the community.

This Implementation Strategy document is posted on the hospital's website at: **http://www.fmdh.org**.

## Hospital-Level Community Benefit Planning

### Priority Health Issues To Be Addressed

In consideration of the top health priorities identified through the CHNA process — and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined that FMDH would focus on developing and/or supporting strategies and initiatives to improve:

- **Mental Health**
- **Nutrition, Physical Activity & Weight**
- **Access to Health Services**

## Priority Health Issues That Will Not Be Addressed & Why

In acknowledging the wide range of priority health issues that emerged from the CHNA process, FMDH determined that it could only effectively focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence.

| Health Priorities Not Chosen for Action | *Reason* |
|---|---|
| Substance Abuse | ***FMDH** has limited resources, services and expertise available to address alcohol, tobacco and other drug issues. Other community organizations have infrastructure and programs in place to better meet this need. FMDH feels that efforts outlined herein to improve mental health will have a positive impact on the community's substance abuse, and that a separate set of substance abuse initiatives was not necessary given limited resources.* |
| Tobacco Use | ***FMDH** has limited resources, services and expertise available to address alcohol, tobacco and other drug issues. Other community organizations have infrastructure and programs in place to better meet this need. FMDH feels that efforts outlined herein to improve Cardiovascular health will have a positive impact on the community's Tobacco Use, and that a separate set of Tobacco initiatives was not necessary given limited resources.* |
| Cancer | *Advisory committee members felt that more pressing health needs existed. Limited resources and lower priority excluded this as an area chosen for action.* |
| Respiratory Diseases | *Advisory committee members felt that more pressing health needs existed. Limited resources and lower priority excluded this as an area chosen for action.* |
| Injury & Violence Prevention | ***FMDH** believes that this priority area falls more within the purview of the county health department and other community organizations. Limited resources and lower priority excluded this as an area chosen for action.* |
| Infant Health & Family Planning | ***FMDH** believes that this priority area falls more within the purview of the county health department and other community organizations. Limited resources and lower priority excluded this as an area chosen for action.* |
| STD HIV/Aids | ***FMDH** believes that this priority area falls more within the purview of the county health department and other community organizations. Limited resources and lower priority excluded this as an area chosen for action.* |
| Diabetes | ***FMDH** feels that efforts outlined herein to improve nutrition, weight and physical activity will have a positive impact on the community's diabetic population, and that a separate set of diabetic-specific initiatives was not necessary given limited resources.* |
| Heart Disease & Stroke | ***FMDH** feels that efforts outlined herein to improve nutrition, weight and physical activity will have a positive impact on the community's propensity toward heart disease and stroke, and that a separate set of specific initiatives was not necessary given limited resources.* |

# Implementation Strategies & Action Plans

The following displays outline Frances Mahon Deaconess Hospital's plans to address those priority health issues chosen for action in the FY2019-FY2021 period.

| Access to Care | |
|---|---|
| **Community Partners/ Planned Collaboration** | • Valley C.A.R.E. Coalition<br>• Valley County Health Department<br>• Valley County Transit<br>• Council on Aging |
| **Goal** | **To improve cardiovascular health by implementing and supporting evidence-based approaches to impact behaviors affecting cardiovascular health.** |
| **Timeframe** | FY2019-FY2021 |
| **Scope** | This strategy will focus on residents in Glasgow and other communities in Valley County as often as possible. |
| **Strategies & Objectives** | **Strategy #1: Rural Transportation Services**<br>• Develop and promote opportunities to connect patients to services in Glasgow and extended communities.<br><br>**Strategy #2: Training in Medical Education**<br>• Promote training in medical education and provide opportunities for rotations and preceptorships as appropriate in our setting.<br><br>**Strategy #3: Community Integrated Health**<br>• Implement a program using community-based paraprofessionals to augment patients transition to settings outside the hospital setting and to promote patient's success in their homes. |
| **Financial Commitment** | $ *Pending* |
| **Anticipated Impact** | • Increased patient compliance with discharge instructions and therapies ordered by their attending physician.<br>• Decrease 30 day all cause readmission rates. |
| **Plan to Evaluate Impact** | • Continue to monitor and compare smoking rates and patient reported compliance with physical activities through Valley Care Coalition Community Surveys. (Triannual CASPER SURVEY)<br>• Monitor readmission rates through our ACO and Caravan Health Reports |
| **Results** | *Pending* |

| **Nutrition, Weight, and Physical Activity** | |
|---|---|
| **Community Partners/ Planned Collaboration** | • Valley C.A.R.E. Coalition<br>• Kiwanis<br>• Soroptimist Society<br>• City of Glasgow, Glasgow, Ft Peck, Nashua, Hinsdale, Opheim<br>• Valley County<br>• Glasgow School District |
| **Goal** | **To improve the health of our community by implementing and supporting evidence based approaches to impact behaviors related to nutrition, weight and physical activity thereby having a positive impact on a multitude of health conditions.** |
| **Timeframe** | FY2016-FY2018 |
| **Scope** | This strategy will focus on residents in Glasgow and other communities in Valley County as often as possible. |
| **Strategies & Objectives** | **Strategy #1: Outdoor Experiential Education and Wilderness Therapy**<br>• Investigate launching or supporting through community partners activities that focus on outdoor and experiential education and wilderness therapy focusing on overcoming obstacles.<br><br>**Strategy #2: Community Based Social Support for Physical Activity**<br>• Community-based social support interventions for physical activity combine physical activity opportunities and social support to build, strengthen, and maintain social networks that encourage positive behavior changes. Interventions can also include education, group or individual counseling, or plans tailored to individual needs.<br><br>**Strategy #3: Competitive Pricing for Health Foods**<br>• Competitive pricing assigns higher costs to non-nutritious foods than nutritious foods. Competitive pricing can include incentives, subsidies, or price discounts for healthy foods and beverages as well as disincentives or price increases for unhealthy foods and beverages. Competitive pricing can be implemented in various settings, including schools, worksites, grocery stores or other food retail outlets, cafeterias, and vending machines. |
| **Financial Commitment** | $ *Pending* |
| **Anticipated Impact** | • Increased patient/community compliance with physical activity recommendations.<br>• Improved patient/community health status |
| **Plan to Evaluate Impact** | • Continue to monitor and compare patient reported compliance with physical activities and nutritional behaviors through Valley Care Coalition Community Surveys. (Triannual CASPER SURVEY)<br>• Monitor Health Behavior rankings pertinent to this category in the County Health Rankings Report issued by the Robert Woods Johnson Foundation |

| | |
|---|---|
| **Results** | *Pending* |

| Mental Health | |
|---|---|
| **Community Partners/ Planned Collaboration** | • Valley C.A.R.E. Coalition<br>• Eastern Montana Community Mental Health Center |
| **Goal** | **To utilize evidence based tactics to address barriers to accessing mental health services by augmenting the range and accessibility of mental/behavioral health services.** |
| **Timeframe** | FY2016-FY2018 |
| **Scope** | This strategy will focus on residents in Glasgow and other communities in Valley County as often as possible. |
| **Strategies & Objectives** | ○ **Strategy #1:** Text Message-Based Health Interventions<br>Text messaging interventions provide patients with reminders, education, or self-management assistance for health conditions. Interventions are most frequently used as part of broader health promotion efforts or to help individuals manage chronic diseases. Text messaging is a low-cost platform which can be combined with other approaches or delivered as part of a stepped care or progressive intervention that is tailored to patients' needs, beginning with the least intensive treatment and moving to more intensive, and often expensive, treatments as needed<br><br>○ **Strategy #2:** EAP (employee assistance program)<br>Employee Assistance Programs (EAPs) are confidential worksite-based services that provide employees with counseling and referrals to address personal and workplace challenges, such as physical and mental health concerns, family problems, legal and financial issues, and conflict and stress at work. Services can be delivered by internal EAP counselors or consultants, or external service vendors contracted by the employer, and are typically provided at no cost to employees<br><br>○ **Strategy #3** Crisis Lines: advertised in schools for kids to call themselves<br>Crisis lines provide free and condential counseling via telephone-based conversation, web-based chat, or text message to individuals in crisis, often those with severe mental health concerns such as suicidal thoughts. Crisis line counselors provide emotional support to callers, assess suicide risk, and refer callers to resources including counseling, social services, and emergency services. Counselors can be professionals or volunteers |
| **Financial Commitment** | $ *Pending* |
| **Anticipated Impact** | • Increased availability of Mental Health Services in Valley County<br>• Improved patient/community health status |

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| **Plan to Evaluate Impact** | • Continue to monitor patient reported perception of health status through Valley C.A.R.E. Coalition Community Surveys. (Triannual CASPER SURVEY)<br>• Monitor Quality of Life and Clinical rankings in the County Health Rankings Report issued by the Robert Woods Johnson Foundation<br>  ○ Poor Mental Health Days<br>  ○ Excessive Drinking<br>  ○ Premature Death<br>  ○ Ratio of Population to Mental Health Providers |
| **Results** | *Pending* |

| MHA Montana Health Improvement Initiatives | |
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| **Increase Immunizations** | • Valley County currently has a 77% overall immunization rate due to its well established immunization program. Diphtheria and Pertussis, Polio, Measles Mumps Rubella, Hepatitis B, Meningitis, and Pneumonia vaccination rates are all over 90%. These rates exceed the targets set by MHA of 75% for under 3 years of age and 70% for adolescents in three years.. Due to our success in immunization and our prioritization process FMDH has chosen to not invest significant resources in this initiative. FMDH has implemented age based clinical decision support software in its EMR to support provider recommendation to parents.<br>• FMDH will join MHA in advocacy for:<br>○ A default opt-in for parents regarding use of their child's data for imMTrax (state immunization registry)<br>• FMDH will continue to employ evidence-based best practices regarding immunizations. |
| **Decrease Prevalence of Obesity** | FMDH has identified this as a shared goal and will address issues related to obesity in addressing needs related to nutrition, weight and physical activity as well as cardiovascular disease. |
| **Decrease Premature Death** | FMDH has identified this as a shared goal and will address issues related to premature death in addressing needs related to mental health, nutrition, weight and physical activity, and access to health care services. |
| **Improve Access to Healthcare** | FMDH will support MHA's legislative advocacy initiatives regarding this issue including insurance coverage FMDH supported the MHA initiative to sponsor and support Medicaid Expansion. |