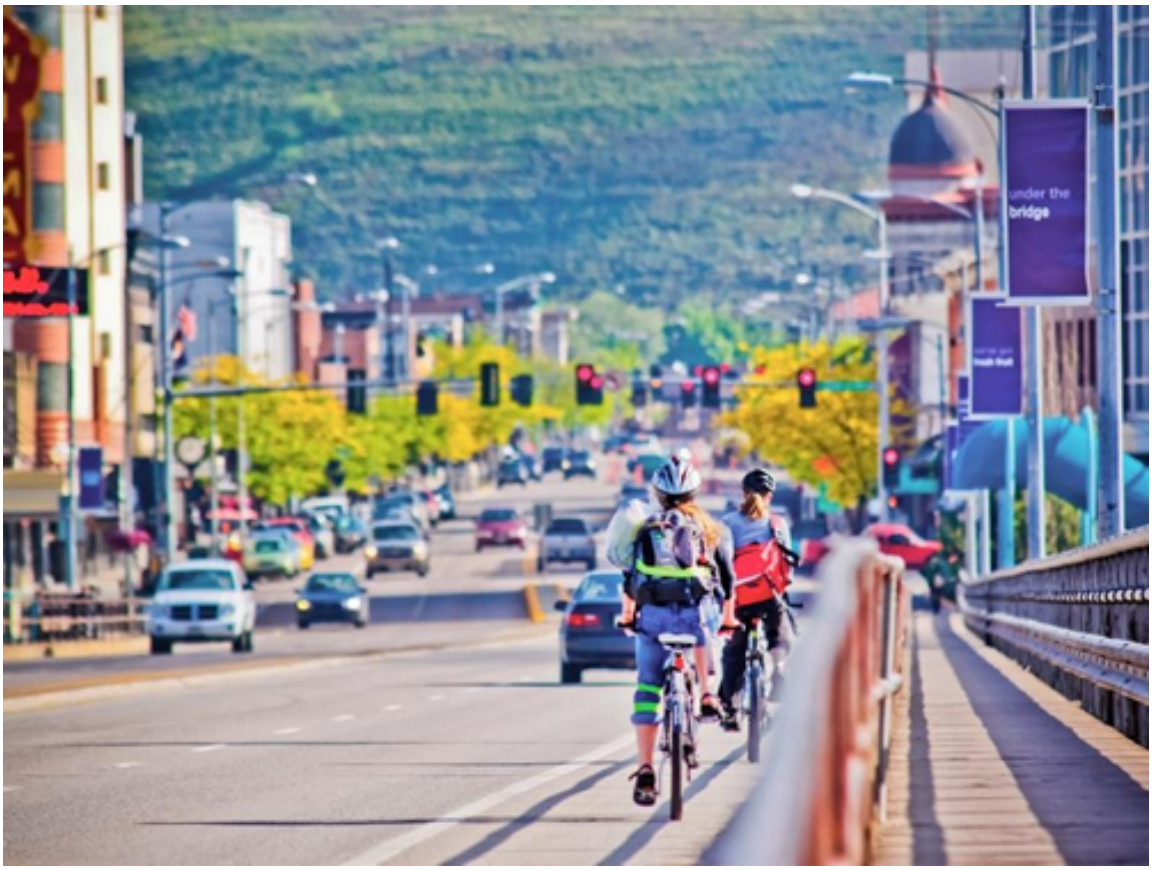
Missoula County, Montana

Community Health Improvement Plan

FY 2013 - 2015



Missoula City-County Health Department
April 2012

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INTRODUCTION

The Missoula City-County Health Dept. (department) and Board of Health have a long tradition of monitoring the health status of Missoula County with programs like Missoula Measures. (1) The department also has been involved in many multifaceted community planning processes and responses. These included scores of community stakeholders to address public health concerns, going all the way back to air quality coalitions in the late 1970s and 80s, responding to HIV pandemic in the late 1980s and 90s, initiating second-hand smoke policies in the 90's, and leading community-wide efforts to reduce obesity today.

In 2011, the department decided to continue this tradition using two new long term processes:

- Community Health Assessment (CHA)
- Missoula County Community Health Plan (MCCHIP).

The processes present some new elements and frameworks as clarified recently in emerging national standards for public health practice. The department has decided to pursue national voluntary public health accreditation through the Public Health Accreditation Board (PHAB). The CHA and MCCHIP are required as a part of accreditation and must be completed before submitting an application. (2) The department intends to submit the application to PHAB by end of May 2012.

Accreditation guidelines state that a local health department (LHD) must have an ongoing and broader community health improvement process that meets certain criteria addressed by the CHA and MCCHIP. CHA data needs to be used to identify priority issues, develop and implement strategies for action, and establish accountability to ensure measurable health improvement. (3). MCCHIP is designed to look beyond the boundaries of normal work conducted by the LHD. It must include the activities of many organizations that contribute to community health improvement. Missoula's new processes incorporate this guidance

Since the department is in the initial group of LHDs from around the country to seek accreditation through PHAB, we do not have the benefit of studying community health improvement plans that have in fact passed PHAB approval. LHDs in different locations serving different sized populations and circumstance clearly have flexibility to use different approaches and several models for study exist MCCHD is utilizing National Association of City and County Health Officials guidance and is integrating two approaches:

- Approach 1: Local health departments (LHDs) that co-lead the community health improvement process with a non-profit hospital(s)
- Approach 5: LHDs that receive assistance in undertaking the community health improvement process from academic institutions (4)

The department has identified three purposes served by the CHA and MCCHIP:

1) To engage community stakeholders and formally recognize and respond to their interests, ideas and concerns related to community health in Missoula County.

2) To acknowledge that a community improves its health in many ways and with many partners.
3) To identify community health priorities and mobilize a multi-faceted response beyond the normal scope of business of MCCHD. A plan will be developed and the Board of Health will monitor progress. The department is actively involved and partners with other organizations in these responses.

This is the first MCCHIP developed by the department and through this process, the department contended with several challenges. First, the accreditation guidance does not specify the extent to which department leadership and accountability for outcomes is expected in all parts of the plan. Second, we were unable to discern if the department was expected to utilize new resources to support the MCCHIP. We are in the middle of a very challenging recession that has hit the department and our partners very hard. The department assumed that a parameter for our MCCHIP was that there would be no extra resources available to support proposed work. The department would look for priorities and objectives that are "doable". There needed to be community readiness, promising work already underway and the capacity to make significant improvement. Third, it was not clear in the guidance who should monitor and oversee the MCCHIP. The Board of Health consists of important community members with community health knowledge and expertise and the charge to assure the health of the community. They have assumed this role, taken the assessment and suggestions from various processes and stakeholders, and have made final decisions about the content of the MCCHIP. A record of those deliberations is included in the Appendix under Process-MCCHIP.

The MCCHIP is a three year plan. The Board of Health will receive progress reports and updates every six months from the department. They recognize that there will be progress, setbacks, and significant changes over the course of three years. They will formally review modifications and provide guidance about annual plan revisions.

TWO COMMUNITY HEALTH PRIORITIES

The CHA has been completed. (5) The CHA/MCCHIP Community Work Group (Work Group) deliberated about priorities and structured and narrowed down contents and topics accordingly throughout the CHA process. At their final meeting, the Work Group met and identified their highest priority concerns. These recommendations were presented at the monthly Board of Health meeting in February 2012. The Board of Health held a special planning session and adopted the strategic priorities and determined the objectives included in this report. At the Board of Health's April meeting, they will receive the final draft of the MCCHIP and take comment from the public. In May, they will adopt the plan with any changes they deem necessary. Details about public process, involvement and meetings can be found in the Appendix.

The MCCHIP addresses two concerns that are also leading national concerns: 1) childhood obesity and 2) access to health care. These are enormous challenges and the MCCHIP has identified some objectives that community organizations are already actively committed to working on. Missoula is fortunate to be a healthy community that is accustomed to tackling concerns. We also have one of the highest national rates of nonprofits per capita and a rich

tradition of forming coalitions and partnerships. The department strives to work effectively with existing agencies, associations and organizations, frequently working through other cooperative configurations. In this MCCHIP, the department utilizes both coalitions that it has founded and coordinated (e.g. Let's Move) and groups led by others (e.g. the Family Medical Residency Program of Western Montana and Active Transportation Plan Implementation Team) to further these strategic priorities. All the objectives involve multiple community partners.

SOURCES

(1) http://www.co.missoula.mt.us/measures/

(2) http://www.phaboard.org/

(3) Durch J.S., Bailey L.A., & Stoto M.A. (1997). *Improving Health in the Community: A Role for Performance Monitoring*. Washington, DC: National Academy Press.

(4) http://www.naccho.org/topics/infrastructure/chachip/accreditation-demo-sites.cfm

(5) http://www.co.missoula.mt.us/measures/PDF/CommHlthAssess2012.pdf

PRIORITY ONE: REDUCE CHILDHOOD OBESITY

Indicator
12% of Missoula County third graders are obese compared to 17.4% nationwide. (1)

Background
Childhood obesity has more than tripled in the past 30 years. The percentage of children aged 6–11 years in the United States who were obese increased from 7% in 1980 to nearly 20% in 2008. Similarly, the percentage of adolescents aged 12–19 years who were obese increased from 5% to 18% over the same period. In 2008, more than one third of children and adolescents were overweight or obese. (2, 3) Short and long term health effects are well established. (4) Missoula has experienced similar trends.

Missoula has marshaled many efforts to increase healthy food options for residents, build conditions supportive of increased physical activity and assist those who wish to achieve a healthy weight. During the last year, Let's Move Missoula, a group of influential community leaders, have come together to enhance the focus on this concern and make some united, significant positive changes in the community.

Assets & Resources
Missoula has enormous assets, resources and potential focused on topics related to this concern in the form of agencies, organizations, interested citizens, and coalitions. See Appendix and lists of participants in Let's Move Missoula, Active Kids Coalition, Eat Smart Coalition, etc.

OBJECTIVE ONE

1A *By June 2015, have 15 active partner organizations in Let's Move Missoula and accomplish 3 major projects.*

Indicator
Baseline: there are currently 13 partners. See Appendix.

Background:
Missoula has applied for a few major federal grants related to childhood obesity during the last several years and been unsuccessful. One common requirement is that a successful community has a group of broad based community leaders that is committed to working on the concerns. We set about establishing that group in 2010. Inspired by the framing and ground work provided by the federal Let's Move campaign, we decided to sign on and call our efforts Let's Move Missoula. The existence of that group is a major reason that this strategic objective was selected as part of the MCCHIP.

Improvement strategies with time framed targets

1. Continue to organize Let's Move! Missoula Leadership Team to have two-three meetings per year. Meetings will be scheduled for summer 2012, summit September 2012 and one last meeting October 2012. Led by Ellen Leahy and Mary McCourt, MCCHD.

2. Project #1: organize the Let's Move! Missoula Childhood Obesity Summit for September 2012. Goal is that at least 150 people attend and to strategic targets are identified by attendees and are responded to by the Let's Move Missoula Leadership Group. Planning team will be led by Mary McCourt.

3. By June 2012 a subcommittee of the Let's Move! Missoula will be formed to look at school policies that can be examined that affect childhood obesity. Mary McCourt will be responsible for forming that subcommittee.

1B *By June 2015, increase access to healthier food options in public buildings by 20% and reduce access to unhealthy foods in public buildings by 20%.*

Indicator
We need to establish a baseline measure regarding vending machine inventory and content in public buildings, as well as school lunch options and policies for snacks or treats in all the Mssoula County schools.

Background
Missoula has made significant progress in increasing healthy options in schools and other public settings. Missoula County Public Schools has made several improvements in both their school lunch offerings as well as vending machine content. During the last two years, it has not had a Wellness Committee and internal changes have made it more difficult to address further change. Voluntary improvements have occurred in many other public sites including Splash Montana, the local public water park.

Improvement strategies with time framed targets

1. Objective 1B topic will be addressed at the upcoming Let's Move Childhood Obesity Summit and hopefully result in becoming one of two emerging strategic priorities.

2. By December 31, 2012, in conjunction with the Eat Smart Coalition, a Work Team will be established to determine vending/concession guidelines to be considered by city and county decision makers.
   Responsible: Mary McCourt, Mary Pittaway, and Rebecca Morley; Eat Smart Coalition

3. Assessment will be conducted and compiled to establish baseline. This will include identifying the current status in local schools and suggestions for improvement.
   Responsible: MC-CHD, lead, with UM HHP.

4. During school year 2013-2014, the Work Team will establish a school policy improvement group and plan to make changes with local schools.

5. Implement a campaign to pass a Healthy Options City ordinance.

Policy Changes Needed
Local ordinance requiring healthier vending machines in public buildings; individual policies of school districts.

Related evidence based, best or promising practices
Restaurants and vending machine operators subject to the new requirement in the Affordable Care Act should be encouraged to begin displaying calorie counts as soon as possible.

Schools should be encouraged to make improvements in their school meal programs through the Healthier US Schools Challenge in advance of updated Federal standards.

Schools should adopt the Institute of Medicine's Tier 1 and Tier 2 approach for age appropriate competitive food options allowed in the schools at any time.

After school programs should adhere to the IOM Tier recommendations

Encourage publicly and privately-managed facilities that serves children, such as hospitals, afterschool programs, recreation centers and parks to implement policies and practices consistent with the Dietary Guidelines, to promote healthy foods and beverages and reduce or eliminate the availability of calorie-dense, nutrient-poor foods.

Assist local governmental agencies to adopt policies that restrict the sale of non-healthy foods on their campuses.

1C ***By June 2015, increase the rate of mothers enrolled in WIC prenatally, who exclusively breastfeed (EBF) for 6 months to 20%.***

Indicator
In 2011, 17% of infants whose mothers are enrolled in WIC were exclusively breastfed for 6 months.

Background:
Breastfeeding has long been recognized as a proven disease prevention strategy. Among its other well-documented effects, breastfeeding also has recently been found to play a foundational role in preventing childhood overweight. A recent analysis, which included 61 studies and nearly 300,000 participants, showed that breastfeeding consistently reduced risks for overweight and obesity (5). The greatest protection is seen when breastfeeding is exclusive (no formula or solid foods) and continues for more than 3 months (6, 7). Missoula's Community Medical Center has made major strides in supporting breastfeeding as have recent changes in state law.

Improvement strategies with time framed targets

1. Maintain a WIC client based QI process for breastfeeding interventions identifying which intervention, demographic; environmental factors impact EBF initiation and duration.

2. Continue work with CMC and local health care providers (HCP's) to follow evidenced based practices relating to breastfeeding support and education.

3. Coordinate an education event in Fall 2012, for professional and para-professional staff to obtain and maintain credentials as certified breastfeeding counselors.

4. Assign prenatal WIC clients a breastfeeding peer counselor who follows the evidence based practices associated for increased exclusive breastfeeding support, education and counseling with prenatal and post-partum mothers.

5. Maintain WIC based QI process for BF intervention with WIC program staff, identifying areas effective interventions, and those not producing the desired impact.

Policy Changes Needed
Health care provider office policies and workplaces.

Related evidence based, best or promising practices
Hospitals and health care providers should use maternity care practices that empower new mothers to breastfeed, such as "baby friendly" hospital standards.

Health care providers and insurance companies should provide information to pregnant women and new mothers on exclusive breastfeeding for the first six months of life, including the availability of breastfeeding support and education resources, and to programs to help them make an informed infant feeding decision.

Local health departments and community-based organizations, working with health care providers, insurance companies, and others should develop peer support programs that empower pregnant women and mothers to get the help and support they need from other mothers who have breastfed.
Early childhood settings should adopt policies and practices that support breastfeeding.

1D *By June 2015, establish a sustainable method for measuring numbers of Missoula County elementary and middle school aged children and youth who achieve 60 minutes of daily moderate to vigorous physical activity(PA) on school day.*

Indicator:
Baseline: percent of students meeting physical activity health guidelines- (60 minutes moderate to vigorous PA)

- Elementary School = 78%
- Middle School = 54%
- High School = 11%

"A Report on Physical Activity of Missoula County Youth 2008" (8)

Background:
The benefits of PA go way beyond their valuable impact on reducing overweight and obesity in children and improving the health of those who are overweight and obese. (8). Missoula County has made considerable progress increasing PA over the last 10 years. With our outdoor amenities and "active friendly" environment and lifestyle, Missoula is more supportive than most

places in PA. That said, we still are seeing the decline in PA noted around the country due to factors like reductions of physical activity in schools, increases in screen time, parental changes related to unsupervised free play and travel outdoors, and new social norms among children and youth. When we initially considered Objective 1D, we wanted to increase PA among kids with the kinds of projects and initiatives below that we've worked hard to develop. We recognized that we had no reliable way to measure the impact of these efforts and the way that PA minutes accomplished with subpopulations in each contributed to our overall status. We are looking for a system such as our third grade BMI measurements. It required a monumental effort by a team of professors and graduate students and extensive coordination with schools and parents to conduct the study cited above and cannot be replicated on any regular basis.

Improvement strategies with time framed targets

The Missoula City-County Health Department, with partners in the Active Kids Coalition particularly the University of Montana Health and Human Performance Department, will develop a "doable" way to monitor the moderate to vigorous daily physical activity of Missoula County children in youth. Local schools will also be partners.
Responsible lead: Mary McCourt, MC-CHD

The following Missoula County programs and initiatives have emerged to increase PA. They will be continued and enhanced and will be included in the PA measurements:

1. In school year 2012-2013 organize and successfully partner with The University of Montana (UM), Missoula Parks and Recreation and Russell Elementary School to run an active recess that can be used by interested schools. Planning team run by Mary McCourt.

2. In school year 2012-2013 work with UM Health and Human Performance students to survey schools about their current recess status and interest in using the Russell School recess model.

3. By June 2013 identify and train three schools in the active recess model. Lead: Mary McCourt

4. Continue coordination and development of the Active Kids Coalition and the participation of partners in their respective realms to increase PA in children and youth
   Responsible: Mary McCourt

5. Continue and build Active Six Program, a major community partnership to increase non-school opportunities for PA for 6th graders.
   Responsible: Jason Shearer, YMCA

6. Three pilot Active School projects will be conducted in Missoula County Public Schools, in an elementary, middle and high schools to add PA to regular class time, breaks, and before and after school
   Responsible: Steve Gaskill, UM HHP

7. Continue and build Safe Routes to School program (SRTS)

Responsible: Phil Smith, City Public Works Bike Ped Program

8. Continue and develop Hellgate Elementary School Wellness Program
   Responsible: Hellgate Elementary

9. Continue the CATCH Program in local schools and monitor and increase the PA components in curriculum.
   Lisa Tims, St. Patrick Hospital

(More information is available on all these projects and initiatives upon request.)

Policy Changes Needed
Many policies in individual schools, school districts and community programs related to emphasis and monitoring.

Related evidence based, best or promising practices
Developers of local school wellness policies should be encouraged to include strong physical activity components.

Local educational agencies should be encouraged to increase the quality and frequency for sequential, age- and developmentally appropriate physical education for all students, taught be certified PE teachers.

Local educational agencies should be encouraged to promote recess for elementary students and physical activity breaks for older students, and provide support to schools to implement recess in a healthy way that promotes physical activity and social skill development.

Local educational agencies in partnership with communities and businesses, should work to support programs to extend the school day, including afterschool programs, which offer and enhance physical activity opportunities in their programs.

The Federal Safe Routes to School Program (SRTS) should be continued and enhanced to accommodate the growing interest in implementing SRTS plans in communities.

Increase the number of safe and accessible parks and playgrounds particularly in underserved and low-income communities.

1E *By June 2015, increase the numbers of Missoula city residents biking and walking by 5%.*

Indicator
Baseline: Office of Planning and Grants conducts annual bike/walk counts at multiple locations each spring and fall. We have baseline counts for 2010 and 2011. (9)

Background:
This objective reflects Missoula progress of being more walkable and bikeable and developing a culture and built environment increasingly supportive of walking and biking. For example,

Missoula has achieved Silver and is soon to be rated a Gold Bicycle Friendly Community (May 2012) status by the national League of American Bicyclists. Our assumption is that this rising tide throughout Missoula builds an environment resulting in more children, youth and their families are increasingly active.

Improvement strategies with time framed targets

1. The 2011 Missoula Active Transportation Plan (MATP) replaces the previous 2001 Non-Motorized Transportation plan. It provides guidance for the public and private development of active transportation facilities in the Missoula Metropolitan Planning Area within the context of the Missoula County Growth Policy. It also informs the MPO's Long Range Transportation Plan, which addresses all modes of transportation over a twenty-five year time horizon. The MATP lays out the community's vision for the bike and pedestrian components of the larger, multi-modal transportation system, recommends new policies and designs and provides a list of proposed projects from which the MPO can draw in prioritizing federal aid transportation funding for bike and pedestrian infrastructure.

2. The 2011 Missoula Active Transportation Plan fills the need for current policy and planning recommendations for an active transportation system that helps meet that community vision. As used in this Plan, "active transportation" means any form of human-powered transportation—walking, travel by wheelchair or other assistive device, biking (assisted by transit as needed)—and a host of strategies that are supportive of these modes, including connectivity, street design and the proximity of trip origins and appealing destinations. An active transportation plan implementation team will be meeting over the next three years to implement the plan. (10)

3. The Long Range Transportation Plan (LRTP) (11) is a federally mandated planning document intended to establish a vision of how future transportation spending will be allocated within the planning area. Missoula's Metropolitan Planning Organization (MPO) updates the LRTP every four years, looking ahead and laying the groundwork for 30 years of projects and maintenance to ensure that Missoula's transportation needs will be met in the future.

4. The LRTP planning process will extend over much of 2012, starting in January with consultant selection and officially starting off with a kick-off event open to the public in March. The LRTP update process is designed to be cooperative and to foster involvement from all users of the transportation system, including the business community, citizen's organizations, the general public, freight operators, and environmental groups. Along with gathering public input from a wide variety of community interests, the document will analyze and evaluate all modes of transportation including:
    - Roadways
    - Transit
    - Bicycle
    - Pedestrian
    - Mobility Impaired

5. The Missoula Metropolitan Planning Organization (MPO) uses its Congestion Mitigation Air Quality (CMAQ) monies to fund several agencies and programs that provide transportation demand management services to the region. In tandem with the 2012 update of the MPO's Long Range Transportation Plan, the MPO's decision making body, the Transportation Policy Coordinating Committee (TPCC) has requested a comprehensive review of the Transportation Demand Management (TDM) services in Missoula and a set of recommendations for improving service delivery. (12) These include Missoula In Motion (the agency that promotes non-motorized commuting, City Bike Ped Program, Mountain Line (Missoula's bus line that allows people to walk and bike more), and UM Transportation (the agency that promotes biking, walking related to the University of Montana).
   Responsible: Ann Cundy, Transportation Director, Office of Planning and Grants

Policy Changes Needed

There are many public policies at play in the processes described above including decisions about financial allocations to walk and bike friendly facilities and programs, Complete Streets, versus other more automobile focused investments.

Related evidence based, best or promising practices

Continue to maintain, build and improve streets, trails, parks and neighborhoods in accordance with guidelines from Active Living Research and other national organizations for the benefit of healthy urban design.

SOURCES

(1) http://www.co.missoula.mt.us/measures/PDF/CommHlthAssess2012.pdf

(2) Ogden CL, Carroll MD, Curtin LR, Lamb MM, Flegal KM. Prevalence of high body mass index in US children and adolescents, 2007–2008. *Journal of the American Medical Association* 2010; 303(3):242–249.

(3) National Center for Health Statistics. Health, United States, 2010: With Special Features on Death and Dying. Hyattsville, MD; U.S. Department of Health and Human Services; 2011.

(4) http://www.cdc.gov/healthyyouth/obesity/facts.htm

(5) Owen CG, et al. Effect of infant feeding on the risk of obesity across the life course; a quantitative review of published evidence. Pediatrics 2005;115:1367-1377.

(6) Arenz S, et al. Breastfeeding and childood obesity – a systematic review. Int J Obesity 2004;28:1247-1256.

(7) Harder T, et al. Duration of breastfeeding and risk of overweight: a meta-analysis. Am J Epidemiol. 2005;162(5):397-403.

(8)http://www.co.missoula.mt.us/healthpromo/ActiveKids/pdfs/PAMslaCoYouthMar2008.pdf

(9) http://www.co.missoula.mt.us/transportation/current_activities.htm#Non-Motorized_Transportation_Count_Program

(10) ftp://www.co.missoula.mt.us/opgftp/Transportation/MPO/Documents/NON_MOTORIZED/Final_MATP_070811.pdf

(11) http://www.co.missoula.mt.us/Transportation/LRTP_2012.htm

(12) http://www.co.missoula.mt.us/transportation/TDM_review.htm

PRIORITY TWO: INCREASE NUMBERS OF UNDERINSURED AND NONINSURED WHO HAVE ACCESS TO APPROPRIATE POPULATION-BASED HEALTH AND MEDICAL SERVICES.

Overall Indicators
Baseline: Approximately 11% of the Missoula County population does not have health insurance coverage (Community Health Assessment 2011).
Baseline: number of individual patients enrolled at Partnership Health Center

Background
During the CHA process, stakeholders identified increasing access to health care as their number one concern. This is a leading concern nationally as well. The Affordable Care Act may increase numbers with health insurance in 2014 (and hopefully resulting in corresponding access to care). Whether this occurs is currently in limbo until the U.S Supreme Court makes a decision in June 2012. This priority is also a difficult thing to measure because it is so broad. For example, do we define access to be access for all health care needs? What if vision and dental aren't included or one has health care insurance that provides inadequate mental health care?

The strategic priority coincides with the mission of the Partnership Health Center (PHC) (1). PHC is both a freestanding community health center with its own Board of Directors and a Division of the department. We have identified five objectives that PHC and/or the department are significantly involved with. Each represents collaborative community undertakings underway.

Assets & Resources
The CHA identifies health services available in Missoula County. The two hospitals, the University of Montana, the Missoula Indian Center, and area health care providers are major assets with their history of community contribution, leadership and innovation.

OBJECTIVES

2A *By June 2015, increase the numbers of Lowell Elementary School students and their families who have access to appropriate medical services to 90%.*

Indicator/measures
Baseline: Currently, Lowell School has 285 children and 854 family members. We do not know how many of this population is underinsured and has reduced access to medical services. Another confounder is the high annual turnover rate of students moving into and out of the school area.

Background:
Lowell Elementary School serves a neighborhood with high poverty rates and many single parent families. Lowell School is a Title One school as designated by the Missoula Public School District (MCPS), with 80% of its student population enrolled in the Federal Free and Reduced Lunch Program. Families qualifying for the Free and Reduced Lunch program have incomes below 50% of the median income and are considered low to very low income according to the

HUD income limits for funding. Additionally, 25% of the 285 students are homeless, living in vehicles, hotels or with relatives. Lowell Elementary School is considered by MCPS officials and the Missoula community to be one of the highest-need schools in Missoula, with the lowest family incomes in the district.

In 2010, Lowell 4th graders scored the lowest in the district for reading proficiency on the state's primary standardized test, MontCas. District average proficiency was 87%, Lowell's was 62%. Lowell's absentee rates are also among the highest in the district, and the school's student mobility rate of 46% is nearly double the district average of 28%. Lowell School serves the Northside/Westside neighborhoods of Missoula. Thirty-two percent of this area's residents live in poverty, compared to a citywide average of 26.1%.

For several years, MCPS has been lobbying for a school based health center. An opportunity arose in 2011 when the U.S. Department of Health and Human Services announced a grant program as a part of Affordable Health Care Act to build more such centers around the United States. In July 2011 PHC received a $500000 grant which was enough to build a 25000 square foot clinic.

Improvement strategies with time framed targets
Lowell Health Clinic will serve as the front line of health care for up to 300 Lowell children and their families, providing primary, dental and even behavioral care right next door to the school. This is the first school based health care clinic in the state of Montana. The clinic will staff a primary care physician, a nurse, a dental hygienist, a behavioral specialist, a receptionist and someone to link parents and children with other health care services in the county. Some of the operational details are yet to be worked out such as the clinic's after school hours, or how a parent will give consent for their children's care, or how long the student or family is eligible to be treated if they move out of the school's boundaries.
Projected to open Winter 2013
Responsible: PHC

Partner individuals and organizations include
Lowell Elementary School
Missoula County Public Schools
Healthy Mt. Children

Related evidence based, best or promising practices
The model of primary care clinic in public schools goes back more than 20 years. They are largely concentrated in urban schools. Meant to serve schools with high poverty levels, these school-based health centers have been highly researched regarding their effectiveness in helping ill students become well as well as correlation between student health and student success.

2B *By June 2016, increase the number of FTE health care providers available to underinsured and noninsured patients at PHC by 4.5 by developing a family medical residency program..*

Indicator/Measures

Residency physicians serving at Partnership Health Center

Matriculating class	FY 2014- first year	FY 2015	FY 2016
Additional FTE Physicians equivalent	1.4	2.6	4.5
Total add patient visits	6960	12954	22232
Additional patients est.	3132	5829	10000 new patients

Background:
Currently, at 2 per 100,000, Montana has the lowest ratio of graduate medical education (GME) training positions per capita of any state in the U.S. The national median is 25. Because physicians tend to locate where they last trained (over the last 10 years, 70% of the Billings graduates have stayed in Montana), it is vital that Montana develop more primary care residency positions if we are to meet our future need for physicians. Together with The University of Montana, four medical facilities are collaborating to create a three-year family practice residency based at UM. Community Medical Center, St. Patrick Hospital, Partnership Health Center in Missoula, and Kalispell Regional Medical Center will be the primary training sites for the residents and will be the guarantors of the funding required. An advisory board, with membership representing the four medical facilities and UM, will advise the Dean of the College of Health Professions and Biomedical Sciences on operational matters related to the program.

Partnership Health Center currently has also increased its physician FTE with its association with this project, adding new providers who will be half-time faculty for the Residency program.

Improvement strategies with time framed targets

Family Medical Residency Program of Western Montana
Program Structure**:** Board certification in Family Medicine requires completion of a three-year residency at a program accredited by the Accreditation Council for Graduate Medical Education (ACGME). Accreditation is also necessary before a program can participate in the National Resident Matching Program. At this time we are targeting between 24 and 27 residents when the program is fully developed in its third year of operation. Two or three residents (with appropriate faculty) will be in Kalispell after their first year (internship year) in Missoula. The residents will do their training at the Missoula and Kalispell hospitals and at Partnership Health Center and its counterpart in Kalispell. Additionally, elective rotations will be available in rural hospitals as well as in Butte. Matriculation of the first class is planned for July 2013.
Funding**:** The participating hospitals and community health centers will earn patient services revenues from resident and faculty services. Through long term and annual contracts, the four collaborating medical facilities will reimburse The University of Montana the total costs of

operating the residency. Faculty and resident grants may comprise a small percentage of total funding. (2)

Responsible Individuals and Organizations include:
Western Montana Area Health Education Center (AHEC) based at The University of Montana.- lead
Partnership Health Center
Community Partnership Center
St. Patrick Hospital
Kalispell Regional Hospital

2C *By June 2015, PHC will serve at least 200 additional dental care patients than 2011 baseline.*

Indicators/Measures
Baseline: children vs. adults. Currently, the baseline is zero since we are not providing services in either of these sites. Projections are as follows: Lowell School: 205 children vs. 854 adults; Seeley Lake: 250 children vs. 777 adults

Measures for both sites will be number of patients seen as identified in baseline information above. Additionally, we anticipate dental work to shift to a preventative focus. Estimates are that 70% of visits in year one will be urgent need based with this number reducing to 50% by year three.

Background
The disparities of the Lowell School neighborhood are described in Objective 2A. They are compounded by the overall poor dental health of Missoula County and surrounding areas. Missoula County has two Dental Health Professions Shortage Area (DHPSA) Designations. The low-income population has a DHPSA score of 17; Partnership Health Center has a DHPSA score of 26. Please note that Missoula County's score of 26 exceeds the DHPSA scoring scale of 0-25, and to the best of our knowledge is one of only four sites in the country with a score as high as 26. The rural and sparsely populated counties surrounding Missoula also have DHPSA Designations.

School-based health centers have shown to dramatically improve the health and education of students and their families. In some areas, attendance has improved by as much as 50%, tardiness has decreased and disciplinary issues have steadily declined. Our new health center will focus on a patient centered delivery model, to include medical, dental and behavioral health services.

Seeley Lake: Missoula County has two Dental Health Professions Shortage Area (DHPSA) Designations. The low-income population has a DHPSA score of 17; Partnership Health Center has a DHPSA score of 26. Please note that Missoula County's score of 26 exceeds the DHPSA scoring scale of 0-25, and to the best of our knowledge is one of only four sites in the country with a score as high as 26. The rural and sparsely populated counties surrounding Missoula also have DHPSA Designations.

Many individuals from the Seeley Swan area travel to Missoula's Partnership Health Center to access care. Based on randomized chart audits 64% of the patients had periodontal disease, over two-thirds of the patients had caries present, and more than 80% had edentulism. Furthermore, as part of a recent *Study of Oral Health Needs in Montana,* third graders and Head Start children across Montana were screened using nationally-accepted methods. Significant differences in the oral health of children were found across the state. Children screened in Missoula and Seeley Lake were representative of all children in our region. Most notably, children in Missoula and Seeley Lake were found to have higher prevalence rates for untreated cavities than children elsewhere in the state. The study also found that children in Seeley Lake, along with other counties in the western part of the state, had greater early treatment needs when compared with children in the eastern part of Montana. Two of the main reasons for these distressing statistics—lack of access to affordable oral health care and lack of oral health education—will be mitigated through the activities planned with this proposal.

Improvement strategies with time framed targets
Lowell School: New dental clinic will be operational by 01/01/2013
Seeley Lake: Received notice 04/06/2012 of $150,000 annual grant for three years to provide dental services in Seeley Lake; scheduled mobile visits to begin May, 2012; expanded facility to be opened by Seeley Swan Hospital District scheduled to open July 2013.

Policy Changes Needed: Lowell School will require parent authorizations to be in place; we anticipate having these policies in place prior to December 1, 2012
Seeley Lake: No anticipated policy changes necessary; existing PHC policies will remain in place.

Related evidence based, best or promising practices
Patient Centered Medical Homes will be in place at both Lowell School and in Seeley Lake. For Lowell School, a fully integrated system will include medical, dental and behavioral health on-site. For Seeley Lake, medical and dental will be on-site and behavioral health will be referred to PHC in Missoula.
Association of State and Territorial Dental Directors Best Practice Approaches are employed. (3)

Responsible Parties
Partnership Health Center- lead

2D *By June 2015, increase access to childhood immunizations outside the urban area.*

Indicators/Measures
Baseline: 0

Background:
Missoula County is a large county. Many residents live outside the urban area up to an hour and a half away. It can be difficult for residents to get their school aged children to Missoula based providers during business hours.

Improvement strategies with time framed targets
Offer off site clinics during convenient hours in Seeley Lake, Potomac, Frenchtown, and Evaro.

Related evidence based, best or promising practices
Centers for Disease Control and Prevention: Vaccine Recommendations & Guidelines (4)

Responsible parties
Missoula City-County Health Dept. - lead

2E *By June 2015, determine the rate of Type 2 diabetes in underinsured and minorities as compared to general population.*

Indicators/Progress Measures
The Community Health Assessment p. 39-40

Background:
One goal of CHA Community Work Group was to increase the number of high risk pre-diabetic and diabetic American Indians and Alaska Natives who are receiving appropriate health care and preventive services. The director of the Missoula Indian Center wanted community help in assessing the diabetes Type 2 status of urban American Indians and Alaska Natives as well as developing improved ways of working together to provide related preventive services. The Board of Health is also interested in status of diabetes in the adult population as a whole and building a foundation in which the community can understand better what is needed and respond more effectively to this national epidemic.

Improvement strategies with time framed targets
The department will take the lead and build a community team of providers and representative interested in Type 2 diabetes to analyze local data and find ways to standardize information that is located in different clinics.

The Missoula Indian Center is currently working with the Urban Indian Health Institute in Seattle to better understand their own caseload. They are also being funded by the Indian Health Service to provide more focus and research on Type 2 diabetes in Missoula.

Policy Changes Needed
Not clear at this point

Related evidence based, best or promising practices
Centers for Disease Control and Prevention: Diabetes-Successes and Opportunities for Population-Based Prevention and Control at a Glance 2011 (5)

Responsible parties
Missoula City-County Health Dept.-lead
Partnership Health Center
Missoula Indian Center
Indian Health Service

SOURCES

(1) http://www.co.missoula.mt.us/PHC/

(2) http://mus.edu/board/meetings/2011/may2011/ARSA/InformationItem-FamilyMedicineResidency.pdf

(3) http://www.astdd.org/best-practices/

(4) http://www.cdc.gov/vaccines/recs/default.htm

(5) http://www.cdc.gov/chronicdisease/resources/publications/AAG/ddt.htm

APPENDIX

Contributing Community Members

Missoula City-County Board of Health
Jean Curtiss, Missoula County Board of County Commissioners
Dr. Tom Roberts, Internist, President Western Montana Clinic
Teresa Henry, Nursing Professor, Montana State University
Ross Miller, Attorney, Mountain Water
Ed Childers, Missoula City-Council
Debbie Johnston, Engineer, Morrison Maierle
Garon Smith, PhD, Chemistry, University of Montana

Community Health Assessment/MCCHIP Community Workgroup
Linda Green, Director, Health Promotion, Curry Health Center, University of Montana
Ellen Leahy, Director, Missoula City-County Health Dept.
Guy Hanson, Air Quality Advisory Council rep, Axeman Propane Supply
Merry Hutton, Community Services, St. Patrick Hospital
Susan Kohler, Director, Missoula Aging Services
Ian Magruder, Water Quality Advisory Council rep
Kim Mansch, Director, Partnership Health Center
Kara McCarthy, Community Medical Center
Jeanne Moon, Maternal Child Health Advisory Council
Stacy Rye, Director, Womens Opportunity & Resource Development
Patrick Weasel Head, Director, Missoula Indian Center
Cindy Weese, Director, YWCA
Mary Windecker, Planning Director, Community Medical Center
Cindy Hotchkiss and Greg Oliver, Coordinators

Partnership Health Center Board of Directors
Bill Carey, Missoula County Board of County Commissioners
Joyce Dombrouski, Vice President of Patient Services, St. Patrick Hospital
Starla Gade
Georgia Honey
Linda Jordan, Mayor's Office
John Lehman
Barbara Munro
Jennifer Robohm, University of Montana Clinical Psychology Center
Peggy Seelye
Tom Todd
Jeffrey Weist
Bruce Wehling
Forrest Winkler
Erik Wood, Community Medical Center

Let's Move Missoula
Alex Apostle, Superintendent, Missoula County Public Schools
Jean Curtiss, Missoula Board of County Commissioners
Jeff Fee, CEO, St. Patrick Hospital 7 Health Science Center
Donna Gaukler, Director, Missoula Parks and Recreation
Linda Green, Curry Health Center, University of Montana
Jon Lange, CEO Missoula Family YMCA
Judy Wahlberg, Missoula Chamber of Commerce
Ellen Leahy, Missoula City-County Health Dept.
Erin Lipkind, Missoula County Superintendent of Schools
Ginny Merriam, Communicaitons, Mayor's Office, City of Missoula
Susan Hay Patrick, Director, United Way of Missoula County
Mary Windecker, Community Medical Center
Chris Siegler, Missoula Family YMCA Board
Missoulian

Eat Smart Missoula Coalition
Amanda Henry, Chamber of Commerce
April Fox, Community Medical Center Maternity
Arwyn Welander, Health Dept. Nutrition
Bernie O'Connor, Missoula Aging Services
Blakley Brown, U of M Health & Human Performance
Bob Giordano, Missoula Institute of Sustainable Transportation
Bonnie Buckingham, CFAC
Chelsea Bond, Health Insurance Industry
Curtis Hammond, Missoula Aging Services
Denise Zimmer,Registered Dietician, Connections to Hellgate School District Wellness Council
Diana Reetz-Stacey,Health Depart.,Cancer Prevention
Diann Pommer, EFNEP
Emily Seitz, Good Food Store
Erin Lipkind, County Superintendent of Schools
Guy Bingham, Valley Vending
Healther Sauro, Health Dept. Diabetes Prevention
Heidi Fritchen, County Risk and Benefits
Heidi Meili, TV News Reporter KECI Media Obesity Prevention
Ian Finch,U of M Food and Agriculture
Jeff Hainline, Montana Restaurant Association
Susan Barmyer, Missoula Children and Youth Forum
Joe Toth,MCOS School Board
Jonathan Weisul, Chief Medical Officer, Community Medical Center
Judy Pfaff, American Cancer Society
Kate Siegrist, Public Health Nursing
Kathy Humphries, Rural Institute Disabilities
Kathy Revello, MSU Extension
Kelsey Gauthier, St. Patrick Hospital Registered Dietician
Kim Latrelle, Chamber of Commerce

Laura Bayliss, Early Head Start
Linda Green, U of M, Curry Health Center
Lisa Tims, CATCH
Lou Ann Crowley, CFAC and Farmer's Market
Mary McCourt, Health Department Health Promotion
Michelle Hailey, Mountain Water
Mary Pittaway, Health Department
Maureen Leonard, U of Bastier
Meg Traci, Rural Institute U of M
Michelle Hutchins, Environmental Health, Water Quality District
Mike Mayer, Summit Independent Living
Minkie Medora, Food Security Council
Mark Thane, MCPS
Nina Cramer, Planning and Grants
Peggy Seel, Office of Planning and Grants
Rebecca Wade, U of M, Food Services
Roger Parchen, Arts and Images
Sheila Callahan, Radio
Rebecca Morley and Mary Pittaway, Coordinators

Active Kids Coaliton
Steve Gaskill, Professor, Health & Human Performance, UM
Jason Shearer, Missoula Family YMCA
Phil Smith, City Bike Ped Coordinator
Shanna Nickerson, Missoula Family YMCA
Shirley Kinsey & Ryan Yearous, Missoula Parks & Recreation
Layne Rolston, Good Food Store
Ben Weiss, Missoula in Motion
Eva Dunn-Froebig, Missoula Run Wild
Kara McCarthy, Community Medical Center
Darren Larson, Summit Independent Living
Jens Sundem, Missoula Forum for Children & Youth
Monica Shaw, intern for CATCH, SPH
Carol Conkell, St. Cloud State University
Lisa Tims, St. Patrick Hospital
Rebecca Morley & Mary McCourt, Missoula City-County Health Department
Donna Gaukler Missoula Parks and Recreation
Linda Henderson & Christy Nelson, MSU College of Nursing
Patty Holman, UM Rural Institute
Sally Hoover, Family Resource Center, Lewis & Clark School

Breast Feeding Coaliton
Jackie McCoy RNC IBCLC
Mary Strand IBCLC
Rebecca Morley
Terry Miller

Ali Kelly
Annette VanDomelen
Carrie Miller
Charlotte Creekmore
Colleen Morris
Dianne Grutsch
Eva Dunn-Forebig
Janel Chin
Jen Hudson
Jen Stires
Jenn Kirscher
Joey Lenaburg
Kara Robinson
Kari Sproull
Kate Siegrist
Kimberly Hardwick
Kitty Felix
La LecheLeague
Mary Dickson
Mary Pittaway
Trudy Mizner
Scoshy Chandler
Stacy Campbell
Susan Barmeyer
Tami Adams
Teresa Messerman
Trudy Mizner
Jessica Welborn
Linsey Wiesmann,
Ann Lowry

Active Transportation Plan Implementation Team
Ginny Sullivan, Adventure Cycling Association
Nancy Wilson, ASUM Transportation
Ethel Montgomery, Bike Walk Alliance Missoula
Rod Austin, Missoula Business Improvement District
Bob Wachtel, Missoula City Bike and Pedestrian Advisory Board
Phil Smith, Missoula City Bike and Pedestrian Office
Dave Shaw,Missoula City Parks and Recreation Department
Steve King, Missoula City Public Works Department
Jackie Corday, Missoula City Public Works Department
Missoula City-County Health Department
Missoula City Office of Neighborhoods
Alex Taft, Missoula Advocates for Sustainable Transportation
Missoula Chamber of Commerce

Jon Wolverton, Missoula Community Forum
Missoula County Parks and Recreation
Missoula County Public Schools
Missoula County Public Works
Linda McCarthy,Missoula Downtown Association
Bob Giordano, Missoula Institute for Sustainable Transportation
Jean Nye, Missoula to Lolo Trail Alliance
Missoula Police Department
Missoula Redevelopment Agency
Montana Department of Transportation
Specialized Transportation Advisory Committee
Mirtha Becerra, Coordinator, OPG

Previous and Current Process & Involvement

MCCHIP- General
The CHA/MCCHIP Community Work Group (Work Group) deliberated about priorities and structured and narrowed down contents and topics accordingly throughout the CHA process which occurred during 2011.
2/19/12 the report was finally adopted with revisions according to public comment and recommendations from the Health Board
2/6/12 the Work Group met and identified their highest priority concerns to send to the Board of Health.
2/16/12 these recommendations were made at the monthly Board of Health meeting.
3/2/12 the Board of Health held a special strategic planning meeting and adopted the strategic priorities and determined the objectives included in this report.
3/21/12 meeting of Board of Health MCCHIP Liaison Subcommittee
4/15/12 Board of Health received the final draft of this document and took comment from the public.
5/17/12 Board of Health adopted the plan.

Greg Oliver, Special Projects Manager, met with;
1/17/12- Mary McCourt
1/19/12- Julie Serstad
1/26/12- Mary Windecker
1/30/12- Susan Kohler
1/3012- Merry Hutton
1/31/12-Kim Mansch
1/31/12- Jim Carlson
2/2/12 Teresa Henry
2/3/12 Tom Roberts
2/7/12 Deborah Johnson
2/9/12 Mary McCourt
2/9/12 Garon Smith
2/13/12 Ross Miller
2/13/12 Kim Mansch

2/13/12 Mary McCourt

Specific Priorities and Objectives

Objective 1
Let's Move Missoula meeting
6/3/2011

Let's Move Summit Planning Team meetings
12/8/11
12/22/11
1/6/12
2/23/12

Active Kids Coalition meetings
10/4/11
12/6/11
4/9/11

Eat Smart Coalition meetings
5/03/2011
6/07/2011
7/05/2011
8/02/2011
9/06/2011
10/04/2011
11/01/2011
1/11/2012
3/27/2012

Objective 1A
Let's Move Missoula meetings (see Objective One)

Objective 1B
Eat Smart Coalition meetings (See Objective One)

Objective 1C
Missoula Breastfeeding Coalition Meetings
5/24/2011
6/06/2011
7/19/2011
9/20/2011
10/25/2011
2/13/2012
3/19/2012

Objective 1D
Active Kids Coalition (see Objective One)

Objective 1E
Active Transportation Plan (ATP)
The Technical Advisory Committee met monthly during 2010-2011 to work through the plan, Pages H-1 to H-41 identify comments from agencies and public
ftp://www.co.missoula.mt.us/opgftp/Transportation/MPO/Documents/NON_MOTORIZED/Final_MATP_070811.pdf

The ATP Implementation Team has met quarterly since fall 2011 and is working though subcommittees that are meeting more than monthly to do Bike Friendly Community planning.

LRTP process: http://www.co.missoula.mt.us/Transportation/LRTP_2012.htm

TDM review process (http://www.co.missoula.mt.us/transportation/TDM_review.htm

Objective 2
Partnership Health Center Board meets monthly.

Objective 2A
Starting in 2011 PHC and MCPS have been meeting with residents in the Lowell neighborhood asking them how they want the clinic to function and even what they want it to look like. Overwhelmingly, they wanted it to look like a home in the neighborhood. McArthur Means and Wells were the architect firm that co-led the following planning meetings:
1/10/12 Kick off meeting
1/18 /12 Informational meeting at school
1/24/12 First design charrette
2/16/12 Second design charrette
3/15/12 Last informational meeting at school

Objective 2B
The Billings Family Medicine Residency program and the University of Washington School of Medicine, the medical communities of Missoula and Kalispell have been engaged in a planning process to create a second Family Medicine residency program for Montana. Since September 2009, this effort has been directed out of the Western Montana Area Health Education Center (AHEC) based at The University of Montana. Together with The University of Montana, four medical facilities are collaborating to create a three-year family practice residency based at UM. Community Medical Center, St. Patrick Hospital, Partnership Health Center in Missoula, and Kalispell Regional Medical Center will be the primary training sites for the residents and will be the guarantors of the funding required. An advisory board, with membership representing the four medical facilities and UM, will advise the Dean of the College of Health Professions and Biomedical Sciences on operational matters related to the program.

Objective 2C

Objective 2D
Missoula City-County Health Dept. & Board of Health

Objective 2E
CHA Advisory Committee meetings
Missoula City-County Health Dept. & Board of Health