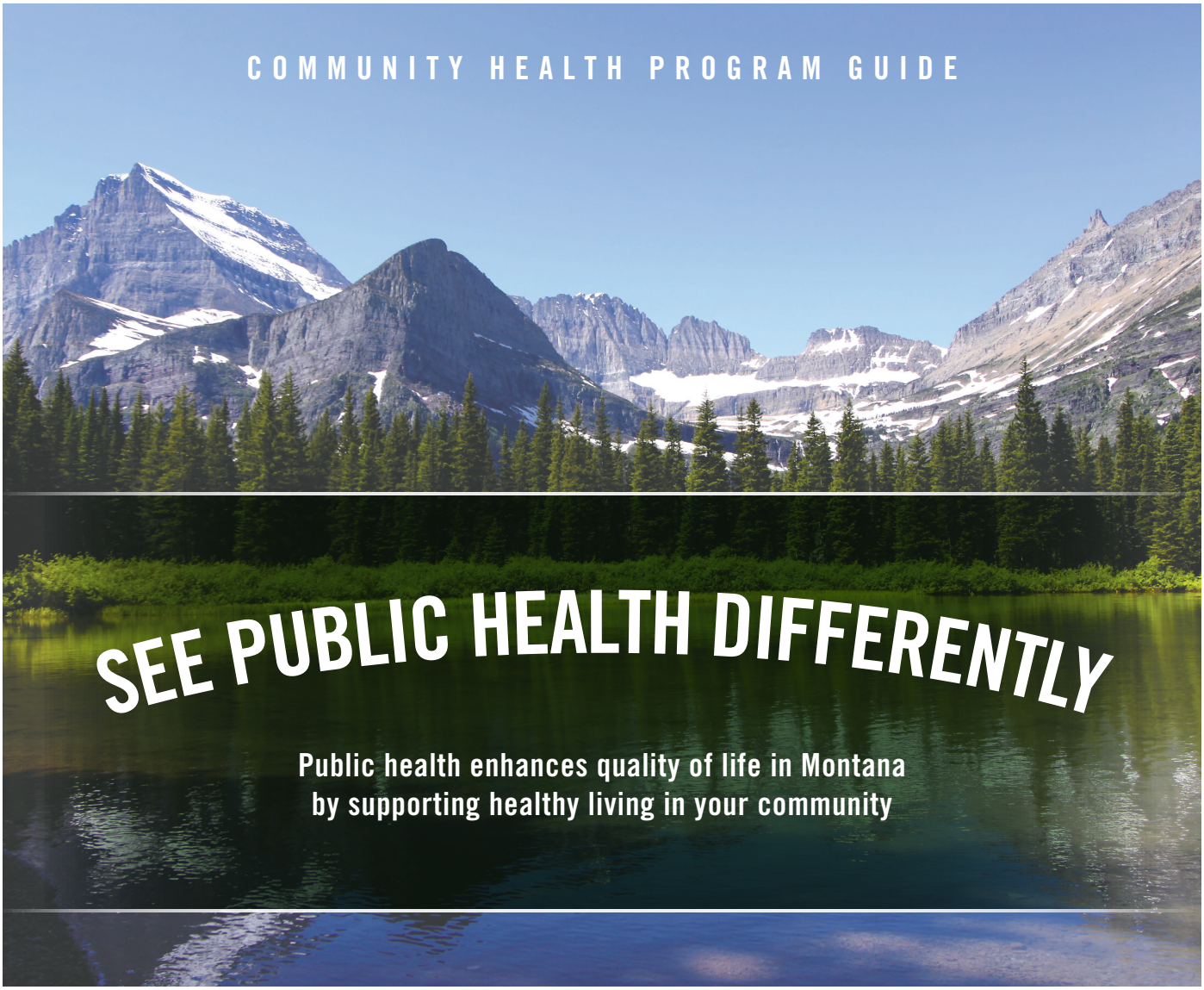




COMMUNITY HEALTH PROGRAM GUIDE



SEE PUBLIC HEALTH DIFFERENTLY

Public health enhances quality of life in Montana
by supporting healthy living in your community

PublicHealth IN THE 406

MONTANA DPHHS
Healthy People. Healthier Communities.
Department of Public Health & Human Services

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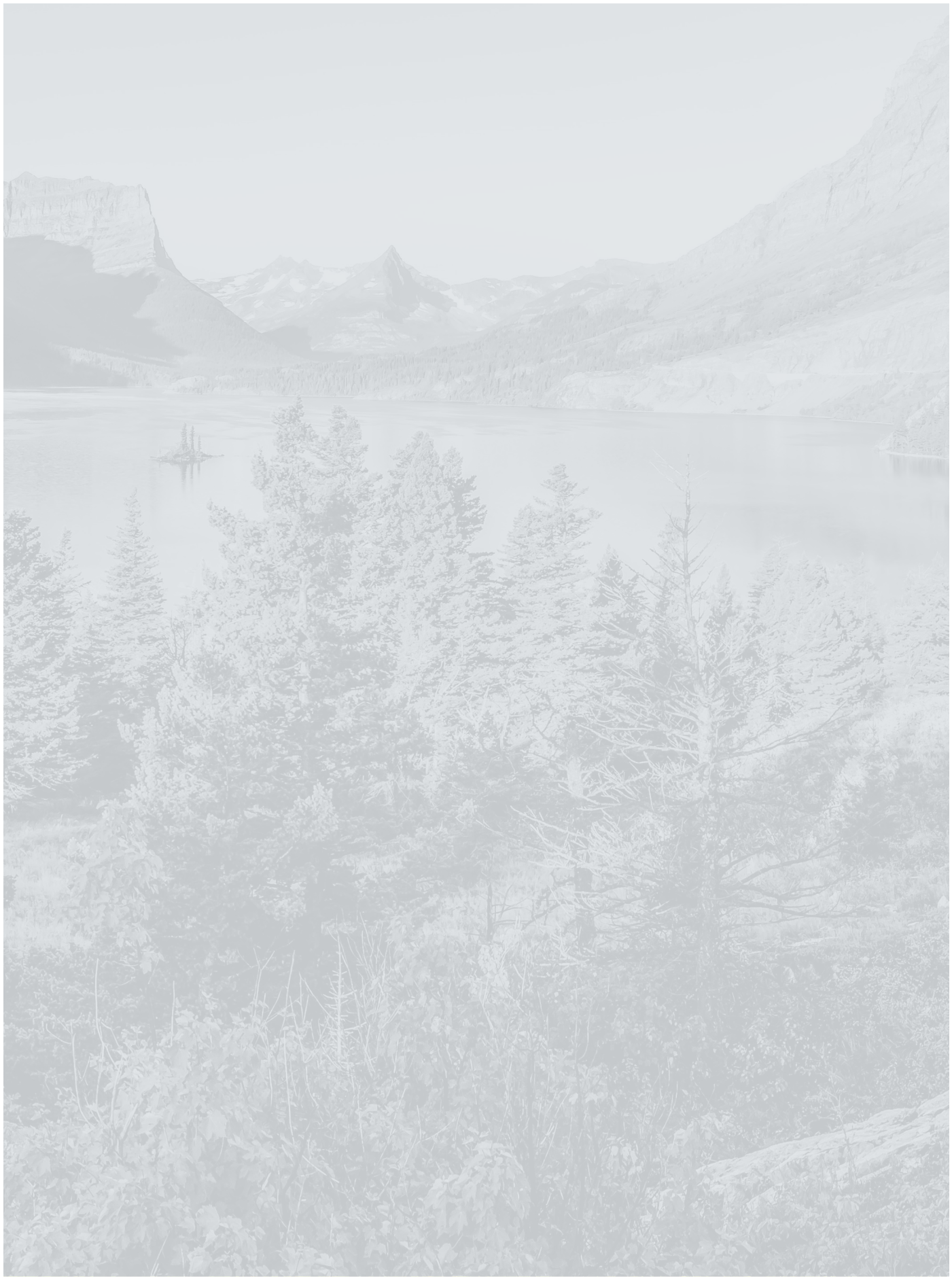





Community Health Program Guide

Public health enhances quality of life in Montana by supporting healthy living in your community. It touches everyone in Montana – from the minute you're born, throughout your entire life. Take a closer look at what public health programs are available in your community to make your life better and See Public Health Differently.

Purpose of guide

This guide highlights programs that address the prevention and management of chronic disease and preventable health issues experienced by Montanans, including people with disability who experience additional health concerns, such as pain and depression. These programs offer access to health promotion and healthy lifestyle opportunities.

Goal of community health programs

These programs aim to reduce and prevent illness and death through healthy lifestyles and self-management and by addressing specific health gaps and preventable health issues.

How to use the guide

The table of contents lists the community health programs and briefly provides:

- Program Description
- Time Commitment of Participant
- Target Audience
- Website for More Information

More information about each program is provided inside on:

- Why to Make a Referral
- Program Description
- Program Benefits
- What is Provided for Participants
- Resources & Contact Information

Public Health Interventions To Serve Montanans

PUBLIC HEALTH INTERVENTIONS & COMMUNITY-BASED PROGRAMS

Program/ Intervention	Description	Time Commitment of Participant	Target Audience	Website	Pg
Arthritis Foundation Exercise Program	Arthritis approved exercise program for adults with arthritis to improve mobility and flexibility through gentle, joint safe movements	8 weeks, (some locations offer ongoing classes), 2 times per week, 1 hour class	All Montana adults with arthritis	https://dphhs.mt.gov/publichealth/arthritis	4
Asthma Education	1-on-1 Asthma self-management tools, education, counseling and support regarding medications and triggers	1 hour – with opportunities for follow-up sessions	Children & adults with asthma; parents of kids with asthma	https://www.dphhs.mt.gov/Asthma	5
Montana Asthma Home Visiting Program (MAP)	Offers six contacts from a registered nurse or respiratory therapist in the home and over the phone to address factors related to an individual's uncontrolled Asthma	6-8 hours over the course of 1 year	Individuals with uncontrolled asthma	https://dphhs.mt.gov/asthma/asthmahomevisiting	6
Breast & Cervical Cancer Screening	Offers mammograms, pap test and some diagnostic tests to eligible Montanans; eligibility is based on age, income and insurance status	Office visit and time to complete screening test in medical facility	Eligibility is open to woman who are un- or under-insured and meet age and income guidelines	https://www.cancer.mt.gov https://www.mtcancercoalition.org	7
Community Integrated Health	Home visits for patient assessment, clinical care, health education, medication reconciliation, and care coordination/ referrals to help patients with chronic diseases or high-risk for hospital admission better manage their health at home.	Varies; 1 to 10 home visits	Individuals at high-risk for hospital admission or needing support to better managing their chronic disease(s).	https://dphhs.mt.gov/publichealth/EMSTS/chems/	8
Montana Diabetes Prevention Program	Offers comprehensive group-based education on healthy diet and exercise to help adults at high risk for type 2 diabetes to adopt healthy lifestyles	2-4 hours per week for 12 months	Adults who are overweight and have risk factors for type 2 diabetes and heart disease	https://dphhs.mt.gov/publichealth/diabetes/dpp	10
Diabetes Self-Management Education & Support	Connects people with diabetes to quality diabetes education to enhance engagement with positive self-management and improve quality of life	Individually tailored to each person's needs (e.g. up to 10 hours in year one, then 2 hours the following year)	People diagnosed with diabetes	https://dphhs.mt.gov/publichealth/diabetes/qdei	11
Health Coaches For Hypertension Control Class	A course to educate adults on lifestyle choices intended to help reduce and control high blood pressure (BP)	1.5 hour class 8 consecutive weeks	Individuals with hypertension (does not requre uncontrolled BP to be eligible)	https://arcg.is/1uP9jm	12

Public Health Interventions To Serve Montanans

PUBLIC HEALTH INTERVENTIONS & COMMUNITY-BASED PROGRAMS

Program/ Intervention	Description	Time Commitment of Participant	Target Audience	Website	Pg
Montana Living Life Well	A health promotion workshop for adults with one or more chronic disease to learn skills and coping strategies to manage health	6 weeks, meet once a week for 2.5 hours	Adults with 1 or more chronic diseases with family members and caregivers	https://dphhs.mt.gov/publichealth/arthritis	13
Living Well In The Community	A peer support workshop for people with physical disabilities (e.g., paralysis) that uses goal setting and adoption of healthy lifestyle to prevent & manage secondary conditions (e.g., depression, pressure sores, infection) and to maintain independence and quality of life	2 hours per week for 10 weeks	Adults with disability	https://livingandworkingwell.ruralinstitute.umt.edu https://mtdh.ruralinstitute.umt.edu	14
Stay Active & Independent For Life (SAIL)	Fall prevention fitness class for older adults who have fallen or who have a fear of falling	12 week, 2-3 times per week, 1-hour class	Adults aged 65+	https://dpphs.mt.gov/publichealth/EMSTS/prevention/falls	15
Stepping On Program	Multi-faceted falls prevention program that addresses the risks of falls and provides lifestyle adjustments to prevent falls	2 hours per week for 7 weeks + a 1-hour reunion class	65+ who have fallen or have a fear of falling	https://dphhs.mt.gov/publichealth/EMSTS/prevention/falls.aspx	16
Montana Tobacco Quit Line	Offers free telephone counseling, Nicotine Replacement Therapy (NRTs) and certain cessation medications at a reduced cost to Montana tobacco users	15-30 minutes per call for 5 calls *(online program also available)*	All Montana tobacco users	https://tobaccofree.mt.gov 1-800-QUIT-NOW (1-800-784-8669) http://www.QuitNowMontana.com	17
Walk With Ease	Walking program for anyone who wants to start or maintain a low impact exercise program	6 weeks: Group–meets 1 or 3 days per week, 1 hour class Self-Directed–independent, walk 3 days per week	All Montana adults wanting to establish an exercise routine	https://dphhs.mt.gov/publichealth/arthritis	18
Working Well With A Disability	A health promotion workshop for people with physical disabilities (e.g., paralysis) that considers the prevention and management of secondary conditions (e.g., depression, pain, fatigue) in the context of employment	2 hours per week for 6 weeks	Adults with disability who are preparing for or trying to maintain employment	https://livingandworkingwell.ruralinstitute.umt.edu https://mtdh.ruralinstitute.umt.edu	19

Arthritis Foundation Exercise Program

PROGRAM DESCRIPTION

The Arthritis Foundation Exercise Program is an eight week gentle, joint-safe exercise program for adults with arthritis to reduce joint pain and stiffness and increase mobility.

- Trained instructors cover a variety of range of motion exercises, endurance-building activities, relaxation techniques, and health education topics.
- Exercises can be done sitting or standing to meet participant's fitness needs and abilities.

PROGRAM BENEFITS

- Improves functional ability of everyday tasks.[2]
- Decreases depression and pain.[2]
- Increases confidence in one's ability to exercise and perform daily activities.[2]

WHAT IS PROVIDED TO PARTICIPANTS

Each class offers:

- Light endurance exercises.
- Strength building exercise.
- Stretching to improve range of motion.
- Relaxation techniques.
- Health education.
- Social interaction.

RESOURCES

Visit this website for more information:
https://dphhs.mt.gov/publichealth/arthritis

WHY MAKE A REFERRAL?

- 1 in 4 Montana adults report ever being diagnosed with arthritis.[1]
- Highest rates of arthritis are found in adults with a disability, older age, lower income, and obesity.[1]
- Over 75% of Montana adults with arthritis report being limited in their everyday activity.[1]
- Nearly half of Montana adults with arthritis report little to no physical activity.[1]

Sources

1. Montana Arthritis Program (2017). *Burden of Arthritis in Montana, 2015.* [Surveillance Report].
2. Callahan, L. F., et al. (2008) *A randomized controlled trail of the People with Arthritis Can Exercise Program: symptoms, function, physical activity, and psychosocial outcomes.* Arthritis Care & Research 59; 92-101.

CONTACT

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1-844-MTHLT4U
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Asthma Education

PROGRAM DESCRIPTION

Individuals with asthma will improve their self-management by understanding how to control their asthma by working with a certified asthma educator. The asthma educator provides in depth knowledge and support equipping the patient with the necessary skills for effective self-management of their asthma. Program length is one hour with opportunites for follow-up sessions.

PROGRAM BENEFITS

Participating in this free program will allow patients to interact directly, one-on-one, with certified asthma educators (AE-Cs) who are specially trained in delivering asthma self-management education.

Patients will learn:

- The pathophysiology of their condition.
- How to identify and manage triggers.
- How to use their medication properly.
- Other components of self-management.

WHAT IS PROVIDED TO PARTICIPANTS

Certified asthma educators can teach patients:

- About the manner in which asthma affects their bodies.
- Inhaler technique.
- How to use medication appropriately to increase their control over the condition.
- How to develop a customized asthma action plan to help coordinate patient education and care by working with the patient and their health care team.

RESOURCES

Visit these websites for more information:
https://www.dphhs.mt.gov/asthma
To find a certified asthma educator in Montana:
https://www.naecb.com/find-certificant.php

WHY MAKE A REFERRAL?

- Over two thirds of adults and about half the children with current asthma in Montana report that their asthma is not well or very poorly controlled.[1]
- 6 in 10 adults up from 4 in 10 children with asthma report having ever received at least 3 of the 5 recommended pieces of asthma self-management education.[1]
- These health outcomes can be improved with the help of certified asthma educators.

Sources
1. Asthma Call Back Survey 2013-2017
2. National Asthma Educator Certification Board. (2013). "Certified Asthma Educator Candidate Handbook." Retrieved from http://naecb.com/pdf/NAECBhandbook.pdf

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Montana Asthma Home Visiting Program (MAP)

PROGRAM DESCRIPTION

The Montana Asthma Home Visiting Program (MAP) trains public health nurses to empower individuals with uncontrolled asthma and their families with the knowledge and tools they need to manage the disease. Ten sites covering 26 Montana counties are currently funded to implement MAP. See below for contact information.

- Anaconda-Deer Lodge Health Department, Anaconda (563-7863)
- Bullhook Community Health Center Havre (395-4305)
- Custer County oneHealth, Miles City (874-8700)
- Lewis and Clark City-County Health Department, Helena (457-8976)
- Missoula City-County Health Department Missoula (258-4298)
- Richland County Health Department Sidney (433-2207)
- Cascade City-County Health Department Great Falls (791-9299)
- Flathead City-County Health Department Kalispell (751-8110)
- Gallatin City-County Health Department, Bozeman (582-3100)

PROGRAM BENEFITS

Participants completing the program report:

- Fewer symptoms, emergency department visits, and activity limitations from asthma.
- Fewer missed school or work days due to asthma.
- More had good inhaler technique and asthma control upon completion of the program.[1,2]

WHAT IS PROVIDED TO PARTICIPANTS

The home visiting nurse provides specific information and support with six visits over 12 months regarding:

- Asthma medications and inhaler technique.
- Asthma action plans.
- The importance of regular medical care.

Families also receive allergen impermeable bed sheets for the participant's bed, educational materials, and a HEPA air filter when necessary.

RESOURCES

Visit this websites for more information:
https://www.dphhs.mt.gov/asthma

WHY MAKE A REFERRAL?

- Upon completion of the program, nearly all participants had well-controlled asthma and used tools such as an asthma action plan and proper inhaler technique to help them maintain their level of asthma control.[3]
- Our data show that fewer participants used their Short-Acting Beta Agonist every day, experienced symptoms every day, and reported less activity limitation due to asthma.[3]
- Nurses and respiratory therapists carrying out the Montana Asthma Home Visiting Program can work with primary care providers and specialists to provide more in-depth asthma education and improve asthma control among their patients.

Sources

1. https://www.dphhs.mt.gov/asthma
2. Nurmagambetov TA, Barnett SBL, Jacob V, Chattopadhyay SK, Hopkins DP, Crocker DD, Dumitru GG, Kinyota S, Task Force on Community Preventive Services. Economic value of home-based, multi-trigger, multicomponent interventions with an environmental focus for reducing asthma morbidity: a Community Guide systematic review. *Am J Prev Med* 2011;41(2S1):S33-47.
3. Montana Asthma Home Visiting Program Evaluation Data

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Breast And Cervical Cancer Screening

PROGRAM ACTIVITIES

Our free cancer screening services include mammograms, Pap tests, and some diagnostic tests.

Eligibility is open to women who are un- or under-insured and meet age and income guidelines.

- Women age 21-64, or
- meet other age criteria.

Patients need to be screened by an enrolled Montana Cancer Control Program (MCCP) Provider. To become an enrolled MCCP Provider, contact Montana Medical Billing at 1-888-227-7065.

PROGRAM BENEFITS

- Prevention and early detection of breast and cervical cancers.
- Free or low cost screenings to women who are un- or under-insured.
- Cancer treatment services through the Montana Breast and Cervical Cancer Treatment Program (breast and cervical cancers only).

WHAT IS PROVIDED TO PARTICIPANTS

- Patient education on screening guidelines and test options.
- Client navigation through screening process.
- Follow-up screening reminders to clients.
- Client referral to other free or low cost chronic disease management programs offered through the Montana Department of Public Health & Human Services, see https://dphhs.mt.gov/publichealth/chronicdisease.

RESOURCES

For information on free cancer screening services:
Call 1-888-803-9343

Visit these websites for more information:
www.cancer.mt.gov
www.mtcancercoaltion.org

WHY MAKE A REFERRAL?

- A **physician recommendation** is one of the most important factors in getting screened for cancer.
- **Cancer** is the leading cause of death among Montana residents. About **2,000 Montanans** die of cancer each year.[1]
- **40% of men** will be diagnosed with cancer in their lifetime.
- **38% of women** will be diagnosed with cancer in their lifetime.

Sources
1. Montana Office of Vital Statistics, 2012 – 2016
2. SEER Cancer Statistics Review, 1975—2014, National Cancer Institute. Bethesda, MD, https://seer.cancer.gov/csr/1975_2014/results_merged/topic_lifetime_risk.pdf, based on November 2016 SEER data submission, posted to the SEER web site, April 2017.

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PROGRAM DESCRIPTION

Community Integrated Health (CIH), often referred to as community paramedicine, is an emerging field in health care where emergency care providers (ECPs), such as EMTs and paramedics, operate in expanded roles to bridge healthcare gaps by connecting underserved populations with underutilized resources. CIH is not just another function of EMS, it is a specialty service that can only be provided by specially trained and credentialed ECPs. CIH works with the patient, their primary care provider, and social services to help patients better manage their conditions and better navigate their care.

CIH focuses on the following activities:

- Bridging healthcare gaps – community paramedics work with primary care and hospital providers to bring healthcare home when access can be challenging due to distance, impacted healthcare systems, or patient condition (hospice, high-risk, or bed confined).
- High-utilizer engagement – CIH takes a proactive role by engaging with high-utilizers of 9-1-1 and emergency department services by connecting them to care providers and services without an unnecessary and costly visit to the emergency room.
- Chronic disease management – community paramedics are specially trained to provide follow-up education and coaching for management of chronic conditions (i.e., blood pressure, diabetes, asthma, etc.) and patient management of medications. They help patients better understand their diagnosis, their medications, and lifestyle factors that affect their wellness.
- Readmission prevention – community paramedics help patients understand their care plans, assist with follow-up care (i.e., wound care, lab work, patient monitoring), conduct home safety checks and medication reconciliation, facilitate of telehealth visits, and care coordination with the patient's healthcare providers and social services.
- Community outreach – health screenings, education, vaccination clinics, and more!

While CIH programs share a lot of overarching goals, each is designed to meet the unique, evolving needs of the community they serve. Contact your local provider to see how CIH can partner with you to help foster healthier communities.

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Community Integrated Health (cont.)

PROGRAM BENEFITS

In general, ECPs are well respected and trusted members of their communities, this enables them to connect with patients and their families to overcome barriers related to cultural, language, and literacy differences.

By utilizing emergency care providers in an expanded role, CIH:

- increases patient access to primary and preventative care,
- provides wellness interventions,
- decreases emergency department utilization,
- saves healthcare dollars, and
- improves patient outcomes.

WHAT IS PROVIDED TO PARTICIPANTS

Services vary by site, but may include:

- Patient Assessment/Health Screenings (vital signs, mental health, weight, diet, exercise, etc.).
- Clinical Care (wound care, outpatient laboratory services, patient monitoring, medication administration, etc.).
- Care Plan Reviews.
- Medication Reconciliation.
- Patient Advocacy.
- Care Coordination with Healthcare Providers and Social Services.
- Health Education.
- Motivational Interviewing.
- Home Safety Checks.
- Facilitation of Telehealth Visits.

RESOURCES

Visit these websites for more information:

An informational video about CIH in Montana: https://youtu.be/lt_01YHexdQ [youtu.be]
The Department of Public Health & Human services site for CHEMS:
https://dphhs.mt.gov/publichealth/EMSTS/chems/

WHY MAKE A REFERRAL?

- To bring healthcare to the homes of patients when access can be challenging due to distance, impacted healthcare systems, or patient condition (hospice, high-risk, or bed confined).
- To gain a better understanding of home, socio-economic, and lifestyle factors affecting patient success with managing their own health and wellbeing.
- To help patients better manage their chronic diseases and conditions.
- To help prevent 30-day readmissions with patients that are at high-risk for readmission.

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Montana Diabetes Prevention Program

PROGRAM DESCRIPTION

The Montana Diabetes Prevention Program (DPP) is an evidence-based program that began in 2008, with the goal to prevent or delay the development of type 2 diabetes and cardiovascular disease among at risk Montanans.

PROGRAM BENEFITS

- Empowerment through education and application.
- Movement toward a healthier self one step at a time.
- Sustainability through behavior change.
- Increased physical activity:
  - Average physical activity of 204 minutes per week per person.
  - 63% of participants achieved the physical activity goal of at least 150 minutes per week.
- Weight loss:
  - Average weight loss of 15 pounds per person.
  - 60% of participants achieved at least 5% weight loss.
  - 46% of participants achieved a weight loss of 7%.

WHAT IS PROVIDED TO PARTICIPANTS

- 12-month intensive lifestyle change program with 22 group sessions focusing on:
  - Behavior change.
  - Healthy eating strategies.
  - Ways to become more physically active.
  - Goal of 150 minutes of physical activity per week.
  - Goal of 7% weight loss.
- Facilitated by trained lifestyle coaches that encourage, coach and motivate participants to adopt sustainable lifestyle changes.

RESOURCES

Visit these websites for more information:
https://dphhs.mt.gov/publichealth/diabetes/dpp
https://arcg.is/0C19H

WHY MAKE A REFERRAL?

- An estimated 38% of U.S. adults aged 18 years or older (96 million) have prediabetes.[1]
- 48% of U.S. adults 65 years or older (26.4 million) have prediabetes.[1]
- Type 2 diabetes can be prevented or delayed by lifestyle changes.
- The Diabetes Prevention Program intensive lifestyle intervention has been shown to reduce the incidence of type 2 diabetes by 58%, and this risk reduction is sustained over time.[2]

Sources
1. Centers for Disease Control and Prevention (2022). National Diabetes Statistics Report. Available at https://www.cdc.gov/diabetes/data/statistics-report/index.html
2. Diabetes Prevention Program Research Group. Long-term effects of lifestyle intervention or metformin on diabetes development and microvascular complications over 15-year follow-up: The Diabetes Prevention Program Outcomes Study. Loncet 2015; 3(11): 866-875.

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Diabetes Self-Management Education & Support Programs

PROGRAM DESCRIPTION

Diabetes education is a collaborative process that helps people with diabetes learn how to successfully manage their disease. The goal of diabetes education is to help people with diabetes practice self-care behaviors every day and be as healthy as possible. It is also known as Diabetes Self-Management Education Support (DSMES) and is provided by diabetes educators. Diabetes Care and Education Specialists (DCES) are nurses, dietitians, pharmacists and other health professionals with an expertise in diabetes.

PROGRAM BENEFITS

- Real-life guidance and coaching to help people understand exactly how to best manage their diabetes, and to feel supported while doing it.
- Four key times to see a diabetes educator:
  1. Upon diagnosis with diabetes.
  2. Annually or when health goals are not being met.
  3. When faced with a new challenge.
  4. When there are changes in health care or life stages.
- Focuses on seven self-care behaviors so that people with diabetes can be healthy and fully enjoy life:
  1. Healthy eating
  2. Being active
  3. Monitoring
  4. Taking medication
  5. Problem solving
  6. Healthy coping
  7. Reducing risks

WHAT IS PROVIDED TO PARTICIPANTS

- Education, understanding, and support on all aspects of diabetes care by diabetes care and education specialists individual or group settings.
- Individualized plan that includes the tools and support to help make the plan easy to follow.
- DSMES is a covered benefit by Medicare, MT Medicaid, and many private health insurance providers.

RESOURCES

Visit this website for more information:
http://dphhs.mt.gov/publichealth/diabetes/qdei
https://arcg.is/KnyzG

WHY MAKE A REFERRAL?

- 11.3% of the U.S. population (37.3 million) have diabetes. 23% of adults (8.5 million) are undiagnosed.
- In Montana, 8% of adults, including 14.9% of American Indians, reported having been diagnosed with diabetes in 2019.[1]
- Diabetes self-management education and Support (DSMES) results in improved A1C, blood pressure, and cholesterol levels as well as fewer complications and reduced rates of hospitalizations.[2]
- DSMES is a cost-effective strategy that results in reduced diabetes-related health care cost.[3]

Sources
1. Montana BRFSS, Montana Department of Public Health & Human Services, 2019.
2. Robbins JM, Thatcher GE, Webb DA, Valdmanis VG. Nutritionist visits, diabetes classes, and hospitalization rates and charges: the Urban Diabetes Study. Diabetes Care. 2008 Apr;31(4):655-60.
3. Boren SA, Fitzner KA, Panhalkar PS; Specker, J. Costs and Benefits Associated with Diabetes Education: A Review of the Literature. The Diabetes Educator. 2009;31(1):72-96.

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Health Coaches For Hypertension Control Class

PROGRAM DESCRIPTION

Health Coaches for Hypertension Control (HCHC) is an evidence-based program created by Clemson University and funded through the Centers for Disease Control & Prevention. Montana adopted the program in 2018. This 8-week course educates patients on lifestyle choices intended to help them reduce and control their high blood pressure. The courses are offered in several counties throughout the state and are conducted by county health departments, a wellness program, and a clinic. The classes are intentionally kept small (maximum 12 attendees per class) to improve personal interaction and encourage a collaborative process that helps people learn. HCHC is targeted for people with high blood pressure, but they are not required to have uncontrolled blood pressure to be eligible. The goal of the course is to help improve blood pressure self-management and raise awareness about the increased risks of heart disease, stroke and kidney disease in people with uncontrolled high blood pressure.

PROGRAM BENEFITS

- Real-life guidance and coaching to help people understand exactly how to best manage and reduce high blood pressure - and to feel supported while doing it.
- A focus on several areas of self-care that may allow participants to lower their blood pressure or even reduce or eliminate medications:
  - Nutrition.
  - Physical activity.
  - Properly taking blood pressure measurements at home.
  - Medication management.
  - Stress management.
  - Tobacco use cessation.
  - Creating action plans.

WHAT IS PROVIDED TO THE PARTICIPANTS

- Education and support to help with lifestyle choices that can lower blood pressure and reduce risk for heart attacks, stroke and kidney disease.
- Participants are also given a free BP monitoring cuff, stress ball, cookbook, pedometer and other health education materials.

RESOURCES

Visit this website for more information:
https://arcg.is/1uP9jm

WHY MAKE A REFERRAL?

- In Montana, almost 30% of adults reported having high blood pressure (BP) in 2019.[1]
- Health Coaches for Hypertension Control is a free course that helps people with high blood pressure improve lifestyle choices. Over a two-year period, participants' systolic BPs decreased and confidence in managing and handling their hypertension improved.

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Sources
1. Montana BRFSS, Montana Department of Public Health & Human Services, 2019.

Montana Living Life Well

PROGRAM DESCRIPTION

Montana Living Life Well, also known as the Stanford Chronic Disease Self-Management Program (CDSMP) is a workshop designed to help individuals living with chronic condition(s) to manage and improve their day-to-day health through new tools and skills to learn how to manage any chronic health condition.

Montana Living Life Well is an interactive workshop that focuses on challenges that are common to individuals dealing with any chronic condition and how to overcome them. Family members and caregivers are encouraged to attend.

PROGRAM BENEFITS

- Develop skills and coping strategies to manage health conditions.
- Increase confidence to manage own chronic conditions.
- Helps decrease depression, fear, and frustration about chronic health conditions.[2]
- Improve communication with friends, family, and health care providers.[2]
- Decrease emergency department visits and hospitalization.[2]

WHAT IS PROVIDED TO THE PARTICIPANTS

All Montana Living Life Well participants receive a *Living a Healthy Life with Chronic Conditions* book.

Topics covered during the Montana Living Life Well workshop include:

- Techniques to deal with problems such as frustration, fatigue, pain and isolation.
- Communicating effectively with family, friends, and health professionals.
- How to deal with difficult emotions.
- Problem solving and decision-making.
- Many more topics.

RESOURCES

Visit these websites for more information:
https://dphhs.mt.gov/publichealth/arthritis

WHY MAKE A REFERRAL?

- 2 in 3 Montana adults report having at least one chronic disease.[1]
- Over a third of Montana adults have two or more chronic conditions.[1]
- 15% of Montana adults report their health as fair or poor.[1]
- Most common chronic conditions in Montana are[1]:
  - Arthritis
  - Asthma
  - Cancer
  - Depression
  - Diabetes
  - Heart Disease

Sources

1. Koeppen H. 2016 Montana BRFSS Annual Report: Survey Results from the Behavioral Risk Factor Surveillance System. Helena, MT: Montana DPHHS, Public Health and Safety Division, November 2017.
2. Ory, M. G., et al. (2013) *National study of Chronic Disease Self-Management: Six-month outcomes findings.* Journal of Aging Health, 25(7): 1258-1274.

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Living Well In The Community

PROGRAM DESCRIPTION

Living Well In The Community (LWC) is a 10-week evidence-based health promotion workshop for people with physical disabilities or mobility impairments.[1] This program helps participants develop goals for meaningful activities that link to the management of secondary health conditions and healthy lifestyle.* See below for contact information for Centers for Independent Living.

- Living Independently for Today and Tomorrow (LIFTT), Billings (259-5181)
- Montana Independent Living Project (MILP), Helena (442-5755)
- North Central Independent Living Services (NCILS), Black Eagle (452-9834)
- Summit Independent Living Center (Summit), Missoula (728-1630)

PROGRAM BENEFITS

- 20%-25% fewer limitations from preventable secondary conditions.
- Reduction in use of health care services.
- Reduced health care costs.
- Improvements in outlook, lifestyle, and health.[2]

WHAT IS PROVIDED TO PARTICIPANTS

- Peer support and facilitated guidance.
- A workbook and skills training for:
  - Setting goals.
  - Solving problems.
  - Managing health.
  - Communicating with service providers.
  - Avoiding frustration and depression.
  - Increasing physical activity and nutrition.
  - Maintaining healthy lifestyle practices.

RESOURCES

Visit these websites for more information:
http://livingandworkingwell.ruralinstitute.umt.edu
https://www.dphhs.mt.gov/detd/independentliving

WHY MAKE A REFERRAL?

- Studies have shown that individuals with disabilities are more likely than people without disabilities to report: poorer overall health, less access to adequate health care, smoking and physical inactivity.[3]
- 39% of Montana adults with disabilities report their general health as fair or poor compared to 7% without disabilities.[4]
- 30% of Montana adults with disabilities report that their health had prevented their usual activities compared to 5% without disabilities.[4]
- Montana adults with disabilities report higher rates of obesity and diabetes compared to those without disabilities.[4]

CONTACT

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@mt.gov
1-844-MTHLT4U
1-844-684-5848

Sources

1. Ravesloot C, Seekins T, Traci M, et al. Living Well with a Disability, a Self-Management Program. MMWR Suppl 2016;65place_Holder_For_Early_Release:61–67. DOI: http://dx.doi.org/10.15585/mmwr.su6501a10.
2. Ipsen, C., Ravesloot, C., Seekins, T. & Seninger, S. (2006). A financial cost-benefit analysis of a health promotion program for individuals with mobility impairments. Journal of Disability Policy Studies, 16(4) 220-228.
3. http://www.cdc.gov/ncbddd/disabilityandhealth/relatedconditions.html
4. Montana Behavioral Risk Factor Surveillance System, www.brfss.mt.gov, www.cdc.gov/brfss 3. Ravesloot, C., Seekins, T., Cahill, T., Lindgren, S., Nary, N.E., White, G. (2006). Health promotion for people with disabilities: Development and evaluation of the Living Well with a Disability Program. Health Education Research.

* A secondary condition is any medical, social, emotional, mental, family, or community problem that a person with a primary disabling condition (stroke, MS, brain injury, etc.) likely experiences. http://www.christopherreeve.org/site/c.mtKZKgMWKwG/b.4453157/k.6464/Secondary_conditions.htm

Stay Active & Independent For Life (SAIL)

PROGRAM DESCRIPTION

The Stay Active & Independent for Life (SAIL) is a 12-week strength, balance, and fitness program for older adults (aged 65+).

- Every class focuses on balance, strength, and stretching exercises.
- Exercises can be done sitting or standing.
- Fitness checks are done every 12 weeks to assess participants' improvement.
  - Fitness checks include:
    1. 8-foot timed up and go.
    2. Bicep curls.
    3. Chair-stand.

PROGRAM BENEFITS

- Reduce risks of falling.
- Improve balance, mobility and leg strength, all known risk factors for falls.
- Maintain independence by building strength, improve balance and agility.
- Fewer falls mean fewer injuries, fewer visits to the emergency room, fewer hospitalizations, and fewer deaths due to a fall.

RESOURCES

Visit the Montana Falls Prevention Program website for more information:
https://dphhs.mt.gov/publichealth/EMSTS/prevention/falls

BURDEN FACTS

- Falls are the **leading cause** of both fatal and nonfatal injuries for adults aged 65+.[1]
- **One out of four** older adults fall each year.[2]
- **Falling once doubles** your chances of falling again.[2]
- **Over 95%** of hip fractures are caused from falling.[2]

Sources

1. Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. Web-based injury statistics query and reporting system (WISQRS). http://www.cdc.gov/injury/wisqrs/index.html
2. Centers for Disease Control and Prevention, (2017) Home and Recreational Injury. Older adult falls. https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html

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Stepping On Program

PROGRAM DESCRIPTION

Stepping On is an evidence-based falls prevention program that addresses fall risk factors in the home and community and provides practical lifestyle adjustments to reduce the chances of falling.

About 30% of older people who fall lose their self-confidence and start to go out less often. Inactivity leads to loss of muscle strength and balance, increasing the risk of falling.[3] Stepping On aims to break that cycle, engaging people in a range of relevant fall preventive strategies.

The Stepping On workshop is seven weeks, offered once a week for two hours.

Eligible Participants:

- 60 years or older.
- Have fallen or have a fear of falling.
- Live independently in own home or apartment.
- Do not have dementia.

PROGRAM BENEFITS

- Reduce falls by a third.[3]
- Decrease fear of falling and maintain independence.
- Increase performance of safe behaviors.
- Fewer falls mean fewer injuries, fewer visits to the emergency room, fewer hospitalizations, and fewer deaths due to a fall.

WHAT IS PROVIDED TO PARTICIPANTS

- Interactive classes.
- Individualized plans and follow-up by the Stepping On leader.
- Topics reviewed in the Stepping On class:
  - Balance and strength exercises
  - Identifying home hazards
  - Safe footwear
  - Link between vision and falling
  - Medication review
  - Community mobility and safety in public places
  - Coping after a fall
- Social interaction.

RESOURCES

Visit this website for more information:
https://dphhs.mt.gov/publichealth/EMSTS/prevention/falls

WHY MAKE A REFERRAL?

- Falls are the leading cause of both fatal and nonfatal injuries for adults aged 65+.[1]
- One out of four older adults fall each year.[2]
- Falling once doubles your chances of falling again.[2]
- Over 95% of hip fractures are caused from falling.[2]

Sources

1. Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. Web-based injury statistics query and reporting system (WISQRS). http://www.cdc.gov/injury/wisqrs/index.html
2. Centers for Disease Control and Prevention, (2017) Home and Recreational Injury. Older adult falls. https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html
3. Wisconsin Institute of Healthy Aging (2019). Stepping On. https://wihealthyaging.org/stepping-on-consumer.

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Montana Tobacco Quit Line

PROGRAM DESCRIPTION

The Montana Tobacco Quit Line is a free cessation service, offering counseling, quit plans, educational materials, nicotine replacement therapy (NRT) and cessation medications to Montana residents. Counseling is available via phone, chat or text (for those under 25). The Quit Line helps Montanans who use tobacco end their addiction to all tobacco products (cigarettes, smokeless, cigars, e-cigarettes).

SPECIAL PROGRAMS

The Quit Now Montana Pregnancy Program offers additional benefits to pregnant women. The program includes nine coaching calls with a dedicated female coach, cash incentives for completed coaching calls and additional NRT postpartum (when physician-authorized).

The American Indian Commercial Tobacco Quit Line (AICTQL) is a culturally appropriate program for American Indians who honor the traditional role of tobacco, while attempting to quit their commercial tobacco addiction. Participants receive 10 coaching calls with an American Indian coach.

My Life, My Quit offers free coaching sessions either by text, chat, or phone to help those under the age of 18 quit all forms of tobacco, including e-cigarettes. Participation is confidential.

PROGRAM BENEFITS

- **Increase chances of quitting-** People who use the Montana Tobacco Quit Line are 7-10 times more likely to quit than those who try on their own.[1]
- **Save money-** Not only will you save money by not buying tobacco, but you will also save on health care costs.
- **Live a longer and healthier life-** Quitting reduces the risk for stroke, heart disease and cancer.[2]

WHAT IS PROVIDED TO PARTICIPANTS

- FREE coaching by phone, chat or text (for those under 25).
- FREE enrollment by phone or online.
- FREE personalized quit plans.
- FREE Nicotine Replacement Therapy (NRT) including gum, patches, or lozenges.
- FREE or Reduced Cost Cessation Medications (Varenicline and Bupropion when available).
- FREE educational materials.

RESOURCES

Visit our website for more information:
quitnowmontana.com

Call toll-free 1-800-QUIT-NOW
(1-800-784-8669)
We're here 7 days a week, 5 a.m. – 11 p.m., Mountain Standard Time

Sources
1. National Jewish Health 2018 Montana Outcomes Report
2. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2019 May 02]

WHY MAKE A REFERRAL?

- Eliminates any barrier the tobacco user might have toward initiating the first call, and places the responsibility of calling on the Quit Line.
- Allows the provider/clinic to ensure a proactive follow up step.
- Creates an easy opportunity for the provider to engage with the patient about their tobacco use.
- Provides feedback to the provider on the patient's enrollment status.

Three types of referrals

- **Fax*-**Located on our website under "How to Refer a Patient."
- **Web*-**Found on our website under "How to Refer a Patient."
- **Electronic-** closed loop system built into the EMR that sends referrals electronically to the Quit Line and the Quit Line sends feedback reports to the EMR.

*Feedback reports are returned to HIPAA compliant providers when fax back numbers are provided on fax form/web referral.

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Walk With Ease Program

PROGRAM DESCRIPTION

The Walk With Ease program is a six week walking program for anyone who wants to start or maintain a low-impact exercise program.

Two Walk With Ease Program Options:

- Walk With Ease Group:
  - Group meets one to three times per week (depending on group).
  - Trained instructor reviews health topic and safety tips.
  - Walk together as a group.
- Walk With Ease Self-Directed:
  - Independent walking program, ideal for worksite wellness.
  - All communication is through email.
  - Instructors send a weekly motivational email.
  - Participants keep track of walking minutes and report back to the instructor via email.

PROGRAM BENEFITS

- Participants start at their fitness level.
- Increases physical activity.[2]
- Decreases pain, fatigue, and depression.[2]
- Increases confidence in one's ability to exercise and perform daily activities.[2]

WHAT IS PROVIDED TO PARTICIPANTS

Participants receive:

- A Walk With Ease book.
- Healthy walking tips.
- Increased confidence to be physically active and maintain walking after six months.[3]
- Group class participants have social interaction with peers.
- Self-directed receive weekly, encouraging emails.

RESOURCES

Visit this website for more information:
https://dphhs.mt.gov/publichealth/arthritis

WHY MAKE A REFERRAL?

- 20% of Montana adults report not engaging in physical activity.[1]
- 2 out of 3 Montana adults are overweight or obese.[1]
- Regular physical activity improves overall health and reduces risk for chronic diseases.
- Recommended—150 minutes of moderate-intensity aerobic activity each week.

Sources

1. Montana Arthritis Program (2017). *Burden of Arthritis in Montana, 2015.* [Surveillance Report].
2. Callahan, L. F., et al. (2008) *A randomized controlled trail of the People with Arthritis Can Exercise Program: symptoms, function, physical activity, and psychosocial outcomes.* Arthritis Care & Research 59; 92-101.
3. Silverstein RP, VanderVos M, Welch H, Long A, Kabore CD, Hootman JM. Self-Directed Walk with Ease Workplace Wellness Program—Montana, 2015-2017. MMWR Morbidity and Mortality Weekly Report 2018: 67: 1295-1299. DOI: http:dx.doi.org/10.15585/mmwr.mm6746a3

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Working Well With A Disability

PROGRAM DESCRIPTION

Working Well With A Disability (WWD) is a six week health promotion workshop for people with physical disabilities that considers the prevention and management of secondary conditions in the context of employment. Primary disabling conditions place people at greater risk of secondary health conditions like pain, fatigue, and depression that undermine long-term employment.* WWD is for individuals with disabilities preparing for, or trying to maintain employment.[1] See below for contact information for Centers for Independent Living.

- Living Independently for Today and Tomorrow (LIFTT), Billings (259-5181)
- Montana Independent Living Project (MILP), Helena (442-5755)
- North Central Independent Living Services (NCILS), Black Eagle (452-9834)
- Summit Independent Living Center (Summit), Missoula (728-1630)

PROGRAM BENEFITS

- Reductions in limitation from secondary conditions.
- Improved health and capacity to work.
- Reduced isolation.[2]

WHAT IS PROVIDED TO PARTICIPANTS

- Peer support and facilitated guidance.
- A workbook and skills training for:
  - Managing health and secondary conditions
  - Addressing competing life demands
  - Managing stress
  - Increasing physical activity and nutrition
  - Maintaining work/life balance through healthy lifestyle practices

RESOURCES

Visit these websites for more information:

http://livingandworkingwell.ruralinstitute.umt.edu
https://www.dphhs.mt.gov/detd/independentliving

WHY MAKE A REFERRAL?

- 37% of adult Montanans with disabilities are employed compared to 75% of Montanans without disabilities.[3]
- 10% of Montanans with disabilities are actively seeking work.[3]

Sources

1. Ipsen, C., Seekins, T., & Arnold, N. (2011). A prospective study to examine the influence of secondary conditions on Vocational Rehabilitation client employment outcomes. Disability and Health Journal, 4, 28-38.
2. Ipsen, C., Ravesloot, C., Arnold, N., & Seekins, T. (2012). Working Well with a Disability: Health promotion as a means to employment. Rehabilitation Psychology, 57(3), 187-195.
3. Erickson, W., Lee, C., von Schrader, S. (2014). Disability Statistics from the 2012 American Community Survey (ACS). Ithaca, NY: Cornell University Employment and Disability Institute (EDI). Retrieved Aug 06, 2014 fromwww.disabilitystatistics.org

* A secondary condition is any medical, social, emotional, mental, family, or community problem that a person with a primary disabling condition (stroke, MS, brain injury, etc.) likely experiences. http://www.christopherreeve.org/site/c.mtKZKgMWKwG/b.4453157/k.6464/Secondary_conditions.htm

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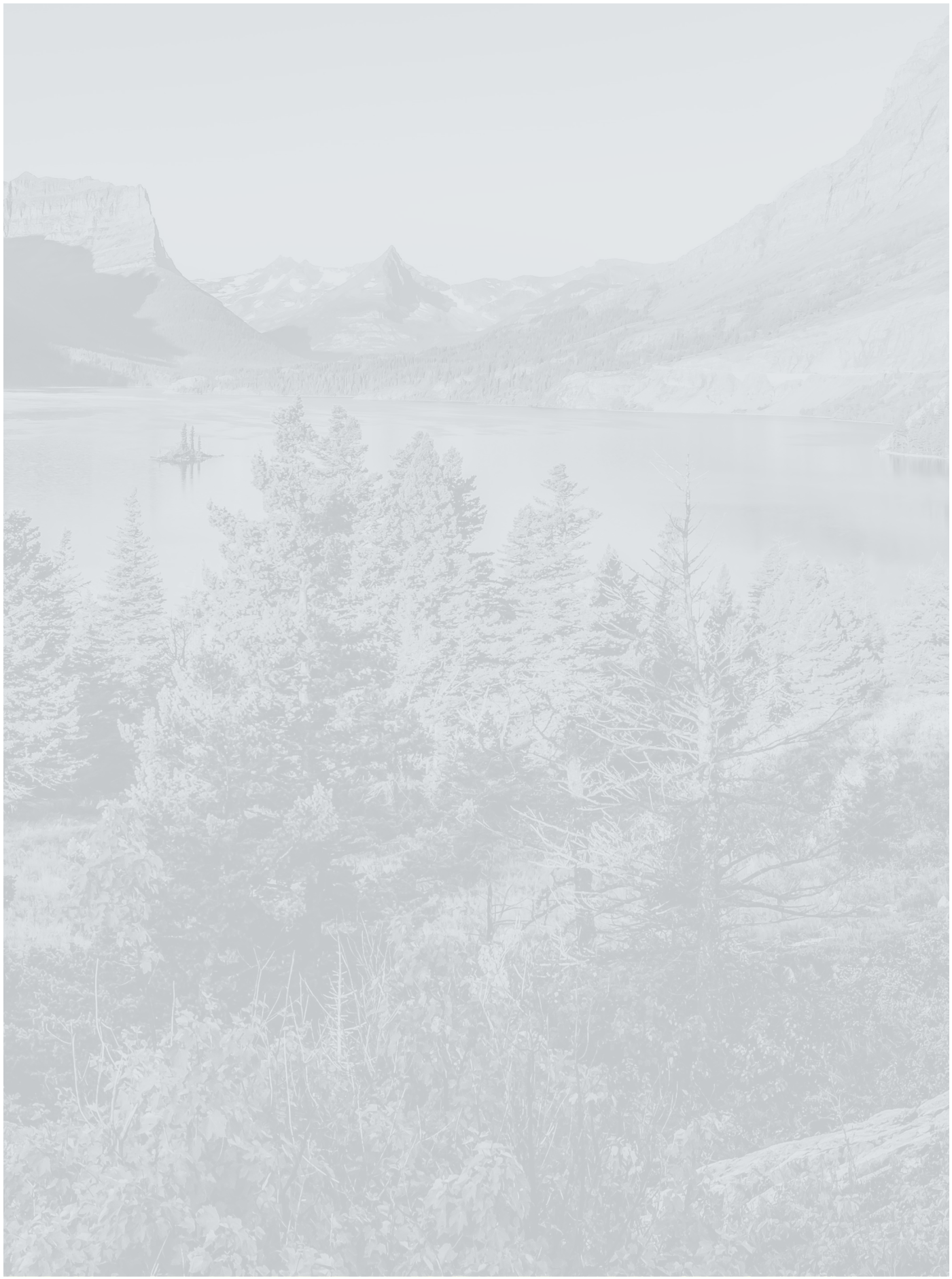
Notes



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