Montana State Health Improvement Plan

2019–2023

Healthy Living...Healthy Futures for Montana

MONTANA DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services

Updated January 2020

A MESSAGE FROM THE DIRECTOR

Montana is an incredible place to live, work, and raise a family. Healthy people and healthy families are essential for thriving communities and a robust economy.

My vision for Montana, as the Director of the Department of Public Health and Human Services, is "Healthy People, Healthy Communities, Healthy Future." We plan to realize this vision by decreasing health disparities; increasing access to timely, affordable, and effective health services; strengthening prevention efforts to promote health and well-being; and improving the public health system capacity.

Montana has made great strides in promoting health equity and improving population health, but we can always do better to help all Montanans achieve their fullest potential. The 2017 State Health Assessment revealed that Montanans still face challenges, particularly in five priority areas that we have chosen to emphasize in the 2019-2023 State Health Improvement Plan. Those priority areas include:

- Behavioral health;
- Chronic disease prevention and self-management;
- Motor vehicle crashes;
- Healthy mothers, babies, and youth; and
- Adverse Childhood Experiences.

Finally, we know we cannot do this work alone. Over the next five years, we will emphasize creative collaborations with community partners across Montana to achieve the objectives outlined in this State Health Improvement Plan. We also call on the citizens of Montana to take action to maintain and improve their own health and that of their families.

I thank DPHHS staff and partners who worked together to bring you this information.

Working with you for a healthier Montana,

Sheila Hogan

Sheila Hogan, Director
Montana Department of Public Health and Human Services

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INTRODUCTION

Creating and maintaining a healthy Montana is critical to Montana's continued success. Healthy children are better students, healthy adults make a more productive work force, and healthy seniors enjoy more satisfying retirement years. A healthy population is essential to a strong economy, both statewide and in all our communities.

Montana has made progress improving the population's health. We are more physically active and less obese than the U.S. overall. We have made significant reductions in the use of commercial tobacco products among youth. However, many challenges, including substance abuse and mental health issues, still exist.

To ensure the positive health trends are not reversed and to create a healthier Montana, the Public Health and Safety Division (PHSD) of the Montana Department of Public Health and Human Services (DPHHS) initiated a strategic planning process in 2017. Twenty-four members, representing healthcare and public health agencies across the state, served on the steering committee for this process. This steering committee is called the State Health Improvement Coalition and it developed the five-year State Health Improvement Plan (SHIP) contained in this report.

The State Health Improvement Coalition operates under the following mission and guiding principles:

Mission: To protect and improve the health of every Montanan through evidence-based action and community engagement.

Guiding Principles:

- Use evidence-based strategies to address health priorities.
- Use strategies and actions that encourage connections across our communities.
- Promote health equity and value differences in cultures, attitudes, and beliefs.
- Strengthen our public health system to deliver results.

The State Health Improvement Coalition worked together to determine the top health priorities based on available data from the 2017 State Health Assessment, input from stakeholders, and a prioritization matrix.

This document was released for public comment during December 2018 and originally published in February 2019, and re-released in January 2020 to incorporate grammatical edits and refined objectives for improved monitoring and evaluation; several objectives in the version published in February 2019 had yet to have baseline data calculated and targets established, both of which are now included for most objectives.

The health priority areas identified to address over the next five years are:

1. Behavioral health, including substance use disorders, mental health, suicide prevention, and opioid misuse;
2. Chronic disease prevention and self-management;
3. Motor Vehicle Crashes (MVCs);
4. Healthy mothers, babies, and youth; and
5. Adverse Childhood Experiences (ACEs).

Each section of the plan describes the health priority, goals, objectives, evidence-based strategies, and key partners. The strategies are categorized in four action areas: prevention and health promotion, clinical/health systems, policy, and health equity.

Supporting Health Equity

The 2017 Montana State Health Assessment (SHA)[1] identified significant health disparities, particularly among American Indian communities. American Indians in Montana have higher mortality rates for many of the leading causes of death, significantly higher premature mortality, and higher prevalence rates for many risk factors and diseases compared to the state overall. Many of Montana's tribes are working on or have completed their Tribal Health Assessments and their Tribal Health Improvement Plans. These plans identify specific health priorities, strategies, and measures that each tribe will be focusing on to improve the health of their communities, many of which are the same as the health priorities outlined in the SHIP. DPHHS is committed to collaborating with the tribes and the Urban Indian Health Centers to address health equity and to improve the health status of American Indian communities. The 2019–2023 SHIP provides a common health agenda and framework for improving the health of all Montanans.

Healthy People 2020

The U.S. Department of Health and Human Services provides science-based, 10-year national objectives for improving the health of all Americans. The current objectives are called *Healthy People 2020*. Healthy People 2020 establishes targets that are measurable, achievable, and applicable at the national, state, and local levels. The 2019–2023 SHIP used Healthy People 2020 targets as benchmarks to establish its objectives. Each objectives section within the SHIP will have a Healthy People 2020 column and the Healthy People 2020 target next to an objective that aligns with a Healthy People (HP) 2020 objective.[2]

Collective Impact

Counties, tribes, and hospitals have identified specific community health priorities and community health improvement plans to address these priorities. It is not expected that counties, tribes, and other partners will focus on each specific priority area and the strategies described in the SHIP. However, through collective action of these organizations in collaboration with their community partners, Montana will make progress to address the health priority areas identified in the SHIP.

Monitoring and Evaluation

The SHIP is designed to be a living document, and will be monitored and updated annually as needed. For more information about SHIP monitoring and evaluation, visit https://dphhs.mt.gov/ahealthiermontana.

Priority Area 1

Behavioral Health

This Priority Area Includes:

- Mental Health
- Substance Use Disorders
- Unintentional Poisonings
- Opioid Misuse
- Suicide Prevention

The Problem:

Poor mental well-being affects thousands of Montanans. One in ten Montana adults (nearly 84,000) report frequent mental distress with 14 or more days of poor mental or emotional health in the past month.[3] Further, 41,000 Montana adults have serious mental illness.[4] Suicide, a mental health crisis, continues to affect every Montana community. Suicide-related deaths in Montana are two times higher than the U.S. An average of 240 suicide deaths occurred each year in Montana from 2011-2015.[5] The suicide rate was significantly higher in rural counties (population less than 10,000) compared to micropolitan (population between 10,000 and 49,999 people) counties.[6] The proportion of American Indian high school students who reported that they had attempted suicide in the past year was nearly two times higher (18%) than youth overall in Montana (10%).[7]

Nearly 64,000 Montana adults struggle with substance use disorder (SUD).[8] Alcohol is the most commonly abused substance in Montana. Use of illicit drugs like marijuana, cocaine, or heroin in Montana follows similar trends as the U.S. Methamphetamines continue to be a major concern in Montana; however, data regarding usage are limited, particularly among Montana's adult population. Among Montana youth, 2.2% of high school students reported having used methamphetamines during their lifetime.[7] Opioids are the leading cause of drug overdose deaths in Montana, accounting for 44% of all drug overdose deaths.

Access to treatment for both SUD and mental health is limited in Montana. Between 2015 and 2016, an estimated 73,500 Montanans aged 12 years and older (8%) needed but did not receive treatment for substance use in the past year.[8] From 2010 to 2014, only 39% of adolescents aged 12 to 17 years with a Major Depressive Episode received treatment within the last year.[9]

It is vital that health care providers are educated on delivery of care from a trauma-informed perspective, particularly in regards to historical trauma within the American Indian communities. The U.S. Administration for Children and Families defines historical trauma as "multigenerational trauma experienced by a specific cultural, racial, or ethnic group."[41] Trauma-informed care emphasizes "understanding, recognizing, and responding to the effects of all types of trauma in order to provide physical, psychological, and emotional safety for both consumers and providers."[42]

Goals:

1. Improve access to timely, affordable, and effective behavioral health services.
2. Prevent and treat depression, anxiety, and other mental health conditions.
3. Decrease the prevalence and adverse consequences of SUD.
4. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.
5. Decrease overdoses and deaths associated with prescription and illicit opiates through coordination of prevention, monitoring, enforcement, treatment, and recovery services.
6. Decrease behavioral health disparities among American Indian communities.
7. Support steps toward the integration of physical and behavioral health care at the community level.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease the proportion of adults who report frequent mental distress (≥14 days in past month with poor mental health status) from 10.4% to 9.9% (Baseline: MT BRFSS, 2016)	
2. Decrease percentage of high school students who report binge drinking in the past month from 17.6% to 16.7% (Baseline: MT YRBS, 2017)	X
3. Decrease the percentage of high school students who attempted suicide in the past year from 9.5% to 9.0% (Baseline: MT YRBS, 2017)	X
4. Decrease past month alcohol use from 9.9% to 9.4% and illicit drug use from 10.0% to 9.5% among adolescents aged 12 to 17 years (Baseline: MT NSDUH, 2014-2015 and 2013-2014)	X
5. Decrease the proportion of adults who report binge drinking in past 30 days from 19% to 18% (Baseline: MT BRFSS, 2016)	X
6. Decrease opioid overdose death rate from 4.2 per 100,000 people to 3.8 per 100,000 people (Baseline: MT Office of Vital Statistics, 2016)	

Objectives to Improve Health Equity: By 2023

	HP 2020:
1. Decrease proportion of American Indian adults who report frequent mental distress (≥ 14 days in the past month with poor mental health status) from 15.4% to 14.6% (Baseline: MT BRFSS, 2016)	
2. Decrease percentage of American Indian high school students who report binge drinking in the past month from 22% to 21% (Baseline: MT YRBS, 2017)	X
3. Decrease the percentage of American Indian high school students who attempted suicide in the past year from 18% to 17% (Baseline: MT YRBS, 2017)	X
4. Decrease the proportion of American Indian adults who report binge drinking in past 30 days from 20% to 19% (Baseline: MT BRFSS, 2016)	X

Prevention and Health Promotion Strategies:

- Implement evidence-based strategies in the Montana Suicide Prevention Plan.
- Increase the number of communities implementing the “Communities That Care” model to prevent underage substance use.
- Promote tobacco-free behavioral health programs.
- Implement a statewide public education campaign/media campaign that includes harm reduction, reducing stigma, proper storage and disposal of prescription medications, and awareness of the risks and protective factors to reduce adolescent substance use (such as binge drinking and prescription drug misuse).
- Increase awareness of and support for prescription drop boxes and disposal bags statewide.
- Support local and tribal health departments and non-profit organizations in Montana communities to implement evidence-based Opioid Use Disorder/SUD prevention activities.
- Retain Medicaid expansion.
- Increase access to behavioral health professionals within schools for youth with mental health and substance use needs.

Clinical Strategies:

- Promote routine screening for mental illness, anxiety, depression, SUD, and suicidal ideation in primary care and other medical settings using evidence-based screening tools (i.e. Screening, Brief Intervention, and Refer to Treatment, Alcohol Use Disorders Identification Test, Patient Health Questionnaire, Generalized Anxiety Disorder, and the Columbia Suicide Severity Rating Scale).
- Promote primary care-based interventions and, when appropriate, referrals and engagement in specialty services.
- Increase access to integrated behavioral health services and medical care, including telehealth and increased workforce, particularly in rural and frontier communities.
- Increase and promote use of evidence-based medication-assisted SUD treatment services for SUDs and opioid addiction.
- Increase access to SUD services for pregnant women with SUDs.
- Promote tobacco screening and cessation services and products in behavioral health, primary care, and other health settings.
- Increase training in Adverse Childhood Experiences (ACEs) and trauma-informed care among medical and behavioral health professionals.
- Increase the use of peer recovery supporters as a cost-effective way to improve the timeliness of entry to care and engagement in care throughout the treatment course, and to reduce recidivism after discharge from inpatient or residential treatment and incarceration.
- Train and increase number of Licensed Addiction Counselors and dually-licensed mental health and substance use providers and peer supporters.
- Increase the number of providers who have obtained the required training to prescribe buprenorphine (a DEA x-waiver). Buprenorphine is one of the three FDA-approved medications used to treat opioid addiction as Medication Assisted Treatment (MAT).

Alcohol is the most commonly abused substance in Montana.

Policy Strategies:

- Develop strategies to work across Montana's behavioral health system (mental health and SUD) to align payment reform, address workforce shortages, identify access barriers, ensure rapid and effective crisis response, and provide treatment in the least restrictive environment.
- Increase collaboration and successful "warm handoffs" for individuals admitted to and discharged from state-operated facilities, hospitals, residential behavioral health/psychiatric facilities, and community-based healthcare providers to lower annual readmission rates and to serve individuals in their own communities whenever possible.
- Increase the use of certified behavioral health peer specialists in recovery support to improve timeliness of entry to care and engagement in treatment and to reduce repeat hospitalizations and incarcerations.
- Increase direct collaboration and coordination of services between the SUD and mental health care system and the criminal justice and corrections system.
- Support administrative and legislative policies to increase prescribing according to the Centers for Disease Control and Prevention guidelines.
- Support policies requiring pharmacists to check identification before dispensing narcotics.
- Better utilize the Montana Prescription Drug Monitoring System to prevent over-prescribing of opioids or unintended drug-drug interactions.
- Improve data surveillance of suicide deaths in Montana through participation in the National Violent Death Review System.

Health Equity Strategies:

- Expand culturally relevant behavioral health services for diverse and health disparate populations (American Indian, LGBTQ, veterans, low income, rural, and frontier).
- Increase wraparound support services to individuals receiving or needing behavioral health services (crisis stabilization, care coordination, and recovery support).
- Increase number of integrated behavioral health programs providing SUD services who can access Medicaid reimbursement, including supporting tribally-operated clinics, Urban Indian Health Centers, FQHCs, Rural Health Clinics, and hospitals.
- Foster collaboration, particularly between frontier and rural areas and larger urban centers, to improve continuum of care in communities.

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Board of Behavioral Health
- Board of Medical Examiners
- Board of Medicine
- Board of Pharmacies
- Business Leaders
- Community Prevention Partners
- Corrections
- Department of Justice (DOJ)
- DOJ Division of Criminal Investigations
- DPHHS Addictive and Mental Disorders Division
- DPHHS Prevention Resource Center
- DPHHS Public Health and Safety Division
- Department of Revenue
- Department of Transportation
- DUI Task Forces
- Federal Qualified Health Centers
- Hospitals
- Indian Health Service
- Law Enforcement Agencies
- Licensed Mental Health Centers
- Local Advisory Councils
- Local Boards of Health
- Local Health Departments
- Mental Health America
- Montana Association of Counties
- Montana Behavioral Health Association
- Montana Chemical Dependency Center
- Montana Healthcare Foundation
- Montana Hospital Association
- Montana Medicaid
- Montana Medical Association
- Montana Nursing Care Center
- Montana Peer Support Network
- Montana Pharmacy Association
- Montana Primary Care Association
- Montana Public Health Association
- Montana State Hospitals
- Montana State University-Mental Health Research Center
- National Alliance on Mental Illness Montana
- Open Aid Alliance
- Opioid Treatment Programs
- Policy Leaders
- Psychiatric Residential Treatment Facilities
- Public Health Prevention Specialists
- Recovery Support Groups
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- Rural Health Clinics
- Schools
- Service Area Authorities
- Tribal Health Departments
- Urban Indian Health Centers
- Veterans Affairs

Priority Area 2

Chronic Disease Prevention and Self-Management

This Priority Area Includes:

- Tobacco Use Prevention and Cessation
- Obesity/Overweight Prevention
- Other Risk Factors for Chronic Disease

The Problem:

Much of the chronic disease burden is attributable to a short list of key risk factors, including tobacco use, obesity, physical inactivity, and poor nutrition. Tobacco use remains the leading cause of preventable death, with 1,600 tobacco-related deaths occurring in Montana each year.[13] Twenty-six percent of Montana adults and 33% of Montana youth currently use some type of tobacco product.[12, 7] This number is even higher for American Indians at 43% for adults and 40% for youth.[12, 7] Obesity results from a combination of poor dietary patterns and physical inactivity. More than one in ten Montana youth (12%) were obese in 2017 and one in four Montana adults (26%) in 2016.[7, 3] Again, this rate is much higher for Montana's American Indian population at 20% for youth and 32% for adults.[7, 3] Seventy-five percent of Montana adults and 72% of Montana youth do not meet the national physical activity recommendations.[7, 14] Montana ranks 46th in the nation for colorectal cancer screening, with only 62% of Montanans up-to-date with screening.[3]

Goals:

1. Prevent commercial tobacco use among youth and adults.
2. Make active living and healthy eating easy, safe, and accessible everywhere Montanans live, work, learn, and play.
3. Increase awareness and decrease prevalence of modifiable risk factors for chronic disease.

Objectives for all Montanans: By 2023

	HP 2020:
1. Decrease the percentage of Montana adults who currently use tobacco from 26% to 24% (Baseline: MT BRFSS, 2016)	X
2. Decrease the percentage of Montana high school students who currently use tobacco from 33% to 29% (Baseline: MT YRBS, 2017)	X
3. Decrease the percentage of Montana adults who are currently obese from 26% to 23% (Baseline: MT BRFSS, 2016)	X
4. Decrease the percentage of Montana high school students who are currently obese from 12% to 9% (Baseline: MT YRBS, 2017)	X
5. Increase the percentage of Montana men and women aged 50 to 75 who report being up-to-date with colorectal cancer screening from 62% to 80% (Baseline: MT BRFSS, 2016)	

Tobacco use remains the leading cause of preventable death, with 1,600 tobacco-related deaths occurring in Montana each year.

Objectives to Improve Health Equity: By 2023	HP 2020:
1. Decrease the percentage of Medicaid members who currently use tobacco from 15% to 14% (Baseline: Medicaid data, 2017)	X
2. Decrease the percentage of American Indian adults who currently use commercial tobacco from 43% to 39% (Baseline: MT BRFSS, 2016)	X
3. Decrease the percentage of American Indian youth who currently use commercial tobacco from 40% to 36% (Baseline: MT YRBS, 2017)	X
4. Establish a baseline and decrease the percent of adult Medicaid members who are currently obese	X
5. Decrease the percentage of American Indian adults who are currently obese from 32% to 28% (Baseline: MT BRFSS, 2016)	X
6. Establish a baseline and decrease the percentage of Medicaid youth who are currently obese	X
7. Decrease the percentage of American Indian youth who are currently obese from 20% to 15% (Baseline: MT YRBS, 2017)	X
8. Increase the percentage of Medicaid adults aged 50 to 75 who report being up to date with colorectal cancer screening from 9.9% to 10.4% (Baseline: Medicaid data, 2017)	
9. Increase the percentage of American Indian adults aged 50 to 75 who report being up to date with colorectal cancer screening from 46% to 63% (Baseline: MT BRFSS, 2016)	

Prevention and Health Promotion Strategies:

- Implement promising practices and evidence-based programs that facilitate chronic disease prevention and self-management and increase referrals to those programs (e.g. Walk with Ease, Worksite Wellness Programs, Rx Trails, Diabetes Prevention Program [DPP], Diabetes Self-Management Education and Support [DSMES] programs, Baby-Friendly Hospital Initiative, Women, Infants and Children [WIC] Breastfeeding Peer Counselor Program, Montana Tobacco Quit Line, American Indian Commercial Tobacco Quit Line).
- Implement public education campaigns to increase awareness of behaviors that address chronic disease prevention and self-management.
- Increase cancer screening using nationally recognized guidelines for breast, cervical, and colorectal cancers.

Clinical Strategies:

- Advocate for policy and workflow changes within healthcare systems to increase screening, counseling, referrals, and high quality care. Seek out involvement with Urban Indian Health Centers and tribal health departments to participate in such projects.
- Increase referrals to evidence-based chronic disease prevention and self-management programs (e.g. Montana Tobacco Quit Line, American Indian Commercial Tobacco Quit Line, Diabetes Prevention Program [DPP], Diabetes Self-Management Education and Support [DSMES], Walk With Ease, and Chronic Disease Self-Management Programs [CDSMP]).
- Provide ongoing resources and support to birth facilities and staff to become certified by the Baby-Friendly Hospital Initiative.
- Provide ongoing resources and culturally appropriate trainings to support breastfeeding among American Indian populations.
- Refer every WIC participant who is overweight/obese to a registered dietitian for nutrition education.
- Implement evidence-based interventions and supporting strategies to increase breast, cervical, and colorectal cancer screening rates in clinical health system settings.

Policy Strategies:

- Promote improvement and implementation of school wellness policies, including smoke-free and tobacco-free environments in communities and on reservations, access to nutritious food, active transportation, physical education, recreation facilities open to the community, and reduced screen time use.
- Promote and support the implementation of local community active transportation policies.
- Support creation of worksite policies that promote healthy work environments such as increasing opportunities for employees to engage in physical activity and improving access to healthy food.
- Support partners to implement Tobacco 21, include e-cigarettes in local Clean Indoor Air Act protocols, and increase the tobacco tax on all tobacco products.

Health Equity Strategies:

- Develop and disseminate culturally appropriate chronic disease prevention and self-management education materials for target populations.
- Increase access to evidence-based programs for chronic disease prevention and self-management for vulnerable populations (including telehealth to rural and frontier areas, accessibility adaptations for people with disabilities, locations on American Indian reservations, team-based care, training for healthcare professionals, and support for Medicaid members).

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Alliance for Healthy Montana
- American Association of Diabetes Educators
- American Cancer Society
- American Cancer Society Cancer Action Network
- American Diabetes Association
- American Heart Association
- Bike Walk Montana
- Billings Area Indian Health Service
- Comprehensive Primary Care Plus Clinics
- Local Health Departments
- Local Boards of Health
- Million Hearts Workgroup
- Montana Association of Counties
- Montana Diabetes Advisory Coalition
- Montana Diabetes Educators Network
- Montana Medicaid
- Montana Office of Public Instruction
- Montana Primary Care Association
- Mountain-Pacific Quality Health Foundation
- Montana Public Health Association
- Montana State University Office of Rural Health
- Montana Tobacco Prevention Specialists
- NASPA (Student Affairs Administrators in Higher Education)
- Patient-Centered Medical Homes Clinics
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- State of Montana Health Care & Benefits Division
- The Sonoran Institute
- Stroke Workgroup
- Tribal Health Departments
- University of Montana Rural Institute Disability & Health Program
- Western Transportation Institute

Priority Area 3

Motor Vehicle Crashes

This Priority Area Includes:

- Motor Vehicle Crash-Related Injury and Mortality
- High-Risk Driving Behaviors

The Problem:

Motor vehicle crashes (MVCs) are one of the most common causes of both fatal and non-fatal injuries in Montana. MVCs result in huge medical and productivity loss, especially since younger people are disproportionately affected.[15] High-risk driving behaviors, such as not wearing a seatbelt consistently, speeding, impaired driving, and distracted driving, are prevalent in Montana.[16]

From 2011–2016, 60% of all MVC related fatalities involved a driver impaired by alcohol or drugs, and among fatalities to occupants of vehicles with seatbelts available, nearly 67% were unrestrained.[17] Distracted driving is also common; 54% of high school students reported texting or emailing while driving in 2017.[7]

From 2011–2016, Montana had an unintentional motor vehicle fatality rate of 19 per 100,000 people compared to the national rate of 11 per 100,000. During this time period, the MVC mortality rate was more than three times higher among American Indians than whites.[18] Furthermore, from 2011-2015, Montana residents of rural counties (populations of less than 10,000 people) had more than double the MVC mortality rate than residents of micropolitan or small metro counties.[5]

Goal:

1. Prevent deaths and traumatic injuries due to motor vehicle crashes by mitigating the pre-crash, during crash, and post-crash factors among Montanans overall and among American Indians.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease age-adjusted mortality rate due to MVCs from 19 deaths per 100,000 people to 12 deaths per 100,000 (Baseline: MT Office of Vital Statistics, 2012-2016)	X
2. Increase the proportion of adult motor vehicle occupants that report always wearing seatbelts from 75% to 79% (Baseline: MT BRFSS, 2016)	X
3. Increase the proportion of high school students that report always wearing seatbelts while riding in a car driven by someone else from 52% to 55% (Baseline: MT YRBS, 2017)	X
4. Decrease the proportion of MVC fatalities that involve alcohol-impaired drivers from 40% to 38% (Baseline: FARS, 2012-2016)	
5. Decrease proportion of high school students who report texting or emailing while driving from 54% to 51% (Baseline: MT YRBS, 2017)	
6. Decrease age-adjusted rate of non-fatal ED visits related to MVCs from 389 per 100,000 people to 370 per 100,000 (Baseline: MHDDS, 2016)	
7. Decrease age-adjusted rate of non-fatal hospitalizations related to MVCs from 37 per 100,000 people to 36 per 100,000 (Baseline: MHDDS, 2016)	

Objectives to Improve Health Equity: By 2023	HP 2020:
1. Decrease age-adjusted mortality rate due to MVCs among American Indians from 55 per 100,000 people to 52 per 100,000 people (Baseline: MT Office of Vital Statistics, 2012-2016)	X
2. Increase the proportion of adult American Indian motor vehicle occupants that report always wearing seatbelts from 69% to 72% (Baseline: MT BRFSS, 2016)	X
3. Increase the proportion of American Indian youth less than 18 years of age that report always wearing seatbelts while riding in a car driven by someone else from 32% to 34% (Baseline: MT YRBS, 2017)	X

Prevention and Health Promotion Strategies:

- Promote Montana Department of Transportation's (MDT) Comprehensive Highway Safety Plan's Vision Zero: zero deaths and zero serious injuries on Montana roadways.
- Support efforts of MDT SOAR project (Safe On All Roads), which focuses on reducing American Indian traffic fatalities and serious injuries.
- Increase awareness of high-risk driving behaviors.
- Support improved surveillance of MVCs through data linkages.
- Support efforts of the MDT teen peer-to-peer traffic safety program and campaigns.

Clinical Strategies:

- Support further development of the trauma system (both EMS and trauma facilities) to reduce severity of injury outcomes.

Policy Strategies:

- Support primary seatbelt law.
- Support policies to reduce distracted driving.
- Support increasing age requirements on child passenger restraints from aged 5 years to 8 years.
- Support increasing age requirements for graduated licensing learners permits from aged 14 years to 16 years.
- Support increasing age requirements for graduated licensing unrestricted license from aged 16 years and 6 months to 18 years old.
- Encourage the use of alcohol/drug monitoring, such as the 24/7 program (which includes ignition interlocks), for DUI offenders.
- Encourage community design policies that keep all road users safe.
- Engage with tribal governments to implement proven policy interventions in their jurisdictions.

Health Equity Strategies:

- Utilize data on age groups, geographic regions, and gender to identify high-risk groups.
- Develop and implement culturally competent materials and programs to address disparities in MVC fatalities and high-risk driving behaviors.

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Billings Area Indian Health Service
- City Planners
- Montana's Comprehensive Highway Safety Plan Partners
- Department of Corrections
- Department of Justice
- Department of Revenue
- Highway Patrol
- Local Health Departments
- Local Boards of Health
- Montana Association of Counties
- Montana Department of Transportation
- Montana Judicial Branch
- Montana Public Health Association
- Office of Public Instruction
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- Schools
- Sheriffs
- Tribal Governments
- Tribal Health Departments

High-risk driving behaviors, such as not using a seatbelt consistently, speeding, impaired driving, and distracted driving are highly prevalent in Montana.

Priority Area 4

Healthy Mothers, Babies, and Youth

This Priority Area Includes:

- Unintended Pregnancy
- Breastfeeding
- Low Birth Weight
- Pre-Term Births

The Problem:

The well-being of mothers, infants, and children influences the health of the next generation and forecasts the future health challenges of Montana families, communities, and the health care system. Unintended pregnancy can result in adverse maternal and child health outcomes. In 2015, 32% of Montana births were unintended and of these, 7% were the result of an unwanted pregnancy.[19] Among American Indian women and young adult women (aged 18 to 24 years), one in three pregnancies are reported as intended.[19] Women with unintended pregnancies are more likely to engage in risky behaviors during pregnancy, such as smoking and drinking. Drinking alcohol while pregnant can cause Fetal Alcohol Spectrum Disorders (FASD), which can lead to intellectual and developmental disabilities for the growing child.[40]

Approximately 12,000 live births occur each year in Montana, and while the infant mortality rate remains lower than the national rate (5.7 and 6.2 deaths per 1,000 births, respectively), American Indians are disproportionately affected with a rate of 10 per 1,000 births.[20] The majority of infant deaths in Montana are sleep-related incidents.[21]

In 2015, the American Academy of Pediatrics reported the national breastfeeding initiation rate was 65% while the rates among WIC participants was 70%. Montana's WIC breastfeeding rate at 78% is higher than the national WIC rate, but lower than the Healthy People 2020 target rate of 82%.[22, 23] However, the American Indian women participating in Montana's WIC program had a much lower rate of breastfeeding initiation (63%) than white women in the same program.[22]

Each year in the United States, approximately 8% low birth weight (LBW) births (less than 2,500 grams) and 10% preterm births (PTB) (less than 37 weeks gestation) occur. LBW and PTB are associated with numerous poor birth outcomes including respiratory distress syndrome, retinopathy, jaundice, infections, and other serious conditions. LBW and PTB are associated with diabetes, heart disease, high blood pressure, developmental disabilities, and obesity later in life.[24] Montana's American Indian populations have disproportionately higher rates of PTB at 13% compared to 9% for all Montana births.[25]

Goals:

1. Decrease unintended pregnancies by increasing the use of effective contraception methods.
2. Increase home visiting services for all Montana families.
3. Increase education and awareness of the importance of prenatal care, birth outcomes, postpartum care, and childhood health.
4. Increase childhood and adolescent immunizations.
5. Decrease maternal and child health disparities among American Indian populations.

Objectives for all Montanans: By 2023	HP 2020:
1. Decrease the infant mortality rate for all Montanans from 6 per 1,000 live births to 5 per 1,000 live births (Baseline: MT Office of Vital Statistics, 2016)	X
2. Decrease the number of sleep-related infant deaths from 1.4 per 1,000 to .84 per 1,000 (Baseline: MT DPHHS FICMR Data System, 2016)	
3. Decrease the percentage of births resulting from unintended pregnancy from 23% to 22% (Baseline: PRAMS, 2017)	X
4. Decrease the percent of live births that were low birth weight (less than 2,500 grams) for all Montanans from 7.9% to 5.9% (Baseline: MT Office of Vital Statistics, 2016)	X
5. Decrease the prevalence of premature births (less than 37 weeks gestation) for all Montanans from 9% to 7% (Baseline: MT Office of Vital Statistics, 2016)	X
6. Increase the percentage of pregnant women who receive early and adequate prenatal care from 86% to 91% (Baseline: MT Office of Vital Statistics, 2016)	X
7. Increase breastfeeding initiation rates of WIC-participating infants from 78% to 82% (Baseline: MT DPHHS WIC Data System, 2017)	X
8. Increase the percentage of children aged 24–35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and pneumococcal conjugate vaccine from 62% to 70% (Baseline: National Immunization Survey, 2018)	X
9. Increase the percentage of adolescents aged 13–17 years who have at least one dose each of Tetanus, Diphtheria and Pertussis (Tdap), Meningococcal (MCV4), and Human Papillomavirus (HPV) from 90% (Tdap), 71% (MCV4), and 49% (HPV) to 93%, 80%, and 70% respectively (Baseline: National Immunization Survey, 2017)	
10. Increase the percentage of people immunized against influenza in all children aged 6 months to 17 years from 49% to 60%, adults aged 19 to 64 years from 34% to 60%, and adults aged 65 and older from 65% to 70% (Baseline: National Immunization Survey, BRFSS, 2017-2018)	X
11. Increase the percentage of women who are screened for postpartum depression after delivery from 91% to 96% (Baseline: PRAMS, 2017)	
12. Increase the percentage of babies in safe sleep environments from 80% to 84% (Baseline: PRAMS, 2017)	

Objectives to Improve Health Equity: By 2023

	HP 2020:
1. Decrease the infant mortality rate for American Indians from 13 per 1,000 live births to 11 per 1,000 live births (Baseline: MT Office of Vital Statistics, 2016)	X
2. Decrease the percent of live births that were preterm births (less than 37 weeks gestation) for American Indians from 13% to 11% (Baseline: MT Office of Vital Statistics, 2016)	X
3. Increase the percent of pregnant women who receive early and adequate prenatal care for American Indians from 41% to 43% (Baseline: MT Office of Vital Statistics, 2016)	X
4. Increase breastfeeding initiation rates of American Indian infants from 80% to 84% (Baseline: PRAMS, 2017)	X
5. Establish a baseline measure for children aged 19–35 months enrolled in Medicaid who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and pneumococcal conjugate vaccine	X

Breastfeeding has numerous health benefits for both mother and infant. Montana's WIC breastfeeding rate at 78% is higher than the national WIC rate.

Prevention and Health Promotion Strategies:

- Promote the use of effective birth control methods for women not desiring pregnancy, especially for youth, low-income women, and American Indian women.
- Promote home visiting services through outreach to health clinics, local and tribal health departments, WIC, birthing hospitals, and local Child Protective Service (CPS).
- Provide Breastfeeding Peer Counseling services at local agencies and Breastfeeding Learning Collaborative training at Baby-Friendly Hospitals.
- Promote and increase the number of local and tribal health departments that provide access to public health services and education, child immunizations, and postpartum care.
- Promote and increase the number of local and tribal health departments providing education and support of safe-sleep environments.
- Increase awareness about adult vaccines, including influenza.
- Participate in HPV/Adolescent Working Group activities, including MT TeenVax.

Clinical Strategies:

- Increase the percentage of Title X Family Planning clients and Medicaid members using effective birth control methods.
- Increase the number of health systems implementing pregnancy support interventions, such as the Medicaid Promising Pregnancy Care program.
- Build new functionality into imMTrax, the state immunization registry, so clinics can review coverage levels in real time.
- Provide monthly missing immunization reports to participating providers.
- Pilot stand-alone clinic assessment (AFIX) visits for select providers.
- Health systems adopt integrated, team-based behavioral health services to screen for and treat perinatal SUD and mental illness during prenatal care.

Policy Strategies:

- Implement evidence-based teen pregnancy prevention programming in Montana public schools.
- Support integration and collaboration between Maternal and Child Health population-based programs with other DPHHS programs that support this group (e.g., asthma home visiting, tobacco cessation, chronic disease self-management, and communicable diseases prevention and treatment for Sexually Transmitted Infections, immunizations, and HIV/AIDS).
- Annually examine existing requirements for licensed childcare facilities and update as necessary to align, as feasible, with the Advisory Committee on Immunization Practices.

Health Equity Strategies:

- Develop culturally competent materials for American Indian communities.
- Promote the use of social media to reach youth populations.
- Secure funding for public health programs that serve low-income populations.

Key partners to engage include, but are not limited to:

- Association of Montana Public Health Officials
- Best Beginnings
- Healthy Mothers, Healthy Babies
- Indian Health Service
- Local Health Departments
- Local Boards of Health
- Montana Association of Counties
- Montana Health Care Foundation
- Montana Medicaid
- Montana Medical Association
- Montana Office of Public Instruction
- Montana Office of Vital Statistics
- Montana Personal Responsibility and Education Program
- Montana Primary Care Association
- Montana Public Health Association
- Montana Title X Family Planning Program
- Mountain-Pacific Quality Health Foundation
- National Campaign to Prevent Teen and Unintended Pregnancy
- Office of Population Affairs
- Rocky Mountain Tribal Leaders Council
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- Service Area Authorities
- Tribal Health Departments
- Urban Indian Health Centers

Priority Area 5

Adverse Childhood Experiences (ACEs)

A Cross-Cutting Issue

The Problem:

Adverse Childhood Experiences (ACEs) are traumatic events and include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence, substance misuse within the household, household mental illness, parental separation or divorce, and having an incarcerated household member. The harmful effects of ACEs on health status throughout the lifespan have been well documented.[35]

Studies have shown an association between ACEs and chronic disease, behavioral health issues, and initiation of risky health behaviors. Studies have also documented a dose-response relationship between ACEs and adverse health and behavioral health outcomes, meaning that persons with more ACEs (a higher ACE score) are more likely to have more adverse health outcomes.[30]

A recent systematic review and meta-analysis of the published literature on ACEs indicated that persons with four or more ACEs were at increased risk for all negative health outcomes examined in the study. The strongest associations were found with problematic drug use, interpersonal and self-directed violence, sexual risk taking, poor mental health, and problematic alcohol use, followed by moderate associations with smoking, heavy alcohol use, poor self-rated health, cancer, heart disease, and respiratory disease. While considered weak or modest, associations were nonetheless documented with physical inactivity, overweight or obesity, and diabetes.[31]

Since multiple ACEs can be considered a major risk factor for many health conditions, a public health approach to ACEs and childhood trauma is warranted. While clinical treatment of psychological trauma is well-established, population-based strategies for prevention are still emerging.[33]

Recognizing ACEs/trauma-informed strategies need to be applied across the health priorities addressed in this plan, the SHIP Coalition determined this special section of the plan should describe key cross-cutting strategies. Every effort should be made to support populations that are potentially disproportionately affected by this issue. In 2011, 60% of Montana adults reported having one or more ACEs. A higher percent of American Indian than white non-Hispanic adults reported experiencing four or more ACEs, as did adults who had not completed high school compared to those who had more education, adults with lower annual incomes compared to those with higher incomes, and adults with disabilities compared to those without disabilities.[32]

ACEs Strategies:

- Implement community-based strategies recommended by the Centers for Disease Control and Prevention to prevent ACEs and trauma and increase resiliency, including: providing quality and affordable child care and education early in life; strengthening economic supports for families; changing social norms to support parents and positive parenting; enhancing parenting skills to promote positive child development; and intervening to lessen harms and prevent future risk to children.[38]
- Integrate knowledge about the wide-spread effects of ACEs and trauma into policies, procedures, practices, and environments of health, human service, education, and other organizations serving children, with the goals of providing trauma-informed approaches and reducing re-traumatization. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides direction in implementing trauma-informed approaches across 10 organizational domains in its publication, "Concept of Trauma and Guidance for a Trauma-Informed Approach." Those domains are: governance and leadership, policy, physical environment, engagement and involvement, cross-sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing, and evaluation.[36]
- Implement resiliency-building and trauma informed educational and behavioral approaches in schools and early childhood settings (e.g., Montana Behavioral Initiative, social-emotional learning practices, and restorative rather than punitive disciplinary practices).
- Promote the use of early childhood home visitation programs, as recommended by the Community Preventive Services Task Force and based on strong evidence of effectiveness in reducing child maltreatment among high-risk families. Home visitation to prevent violence includes programs in which parents and children are visited in their home by nurses, social workers, paraprofessional and community peers. Visits must occur during the child's first two years of life, but they may be initiated during pregnancy and may continue after the child's second birthday.[39]
- Increase awareness of and referrals to evidence-based early childhood home visitation programs among healthcare, human service, and other professionals.
- Develop and maintain a state-level resource to share information about ACEs and trauma-informed approaches (e.g., resources for various fields of practice, training and education opportunities, support for organization moving toward trauma-informed approaches, and resources for individuals, families, and communities).

ACEs Strategies Continued:

- Continue to support training and train-the-trainer initiatives addressing ACEs and trauma-informed approaches for health and human service providers, educators, early childhood service providers, schools, communities and other organizations, including those provided by the DPHHS, ChildWise Institute, Elevate Montana, and the National Native Children's Trauma Center.
- Screen for ACEs and trauma among high-risk parents and children using age-appropriate and setting -specific screening tools, as recommended in professional guidelines for various disciplines. When results are positive, assure appropriate referrals and follow-up services.
- Promote the use of group and individual cognitive-behavioral therapy for symptomatic youth who have been exposed to traumatic events, as recommended by the Community Preventive Services Task Force based on strong evidence of effectiveness in reducing psychological harm.[39]
- Promote the use of evidence-based clinical interventions included in the Substance Abuse and Mental Health Services Administration National Registry for Evidence-Based Programs. This registry includes 14 evidence-based interventions that are targeted to specific populations and/or settings.[34]
- Implement strategies described in this plan to mitigate the health consequences of ACEs/trauma which include increased prevalence of chronic disease; increased risk for depression, mental illness, substance use disorders and suicide attempts; early initiation and continued misuse into adulthood of alcohol, tobacco and other drugs; and increased prevalence of high risk sexual behaviors.
- Continue to collect and analyze data to monitor the burden of and progress toward reducing ACEs and trauma in Montana (e.g., data regarding the prevalence of ACEs, the extent to which training and education regarding ACEs is being provided, implementation of trauma-informed approaches, and provision of home visitation services).

Studies have shown an association between ACEs and chronic diseases, behavioral health issues, and initiation of risky health behaviors.

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Appendix A: Development and Implementation of the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP)

The PHSD established the State Health Improvement Coalition in 2017. The goal of this coalition is to support DPHHS in the development, implementation, and monitoring of the 2019–2023 SHA and SHIP. The SHA describes the current population-level health status of Montanans. It includes multiple quantitative data sources (e.g., birth and death records, hospitalization data, Behavioral Risk Factor Surveillance System, and Youth Risk Behavioral Surveillance System data) that describe the health status of Montanans. In addition, the SHA also includes summarized qualitative data compiled from the 52 local community health assessments and community health improvement plans completed by local and tribal health departments and the community health needs assessments completed by hospitals across Montana. The coalition used this information to identify and prioritize the health improvement areas, goals, strategies, and objectives described in this plan. In addition to the work of the SHIP coalition, the findings from the SHA and the proposed SHIP priority areas were presented to multiple stakeholder and partner groups who provided valuable feedback on the assessment and the plan.

Appendix B: Acknowledgements

We would like to thank those groups and agencies that were involved in developing and providing feedback on the State Health Assessment and State Health Improvement Plan:

- Addictive and Mental Disorders Division, Department of Public Health and Human Services
- Association of Montana Public Health Officials
- Blackfeet Tribal Health Department
- Cascade City-County Health Department
- Developmental Services Division, Department of Public Health and Human Services
- Fallon County Health Department
- Health Resources Division, Department of Public Health and Human Services
- Helena Indian Alliance
- Lewis and Clark City-County Health Department
- Lincoln County Health Department
- Montana Association of Counties
- Montana Chapter of American Academy of Pediatrics
- Montana Department of Environmental Quality
- Montana Diabetes Coalition
- Montana Environmental Health Association
- Montana Healthcare Foundation
- Montana Hospital Association
- Montana Medical Association
- Montana Pharmacy Association
- Montana Public Health Association
- Montana State University, Office of Rural Health
- Office of Public Instruction
- Park County Health Department
- Public Health and Safety Division, Department of Public Health and Human Services
- Rocky Boy Clinic
- Rocky Mountain Tribal Leaders Council Epidemiology Center
- Toole County Health Department
- University of Montana, School of Public and Community Health Sciences

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How to use the State Health Improvement Plan

Top five health issues

The five issues addressed in the State Health Improvement Plan are:

- Behavioral Health
- Chronic Disease Prevention and Self-Management
- Motor Vehicle Crashes
- Healthy Mothers, Babies, and Youth
- Adverse Childhood Experiences (ACEs)

The 2019-2023 State Health Improvement Plan (SHIP)

The SHIP is an action-focused 5-year plan to address key health issues and improve the health and well-being of Montanans. Groups across Montana are working together to improve behavioral, maternal, and child health and reduce chronic disease and motor vehicle crashes.

The SHIP is a tool for everyone. Here are some ways it can be used:

Read the SHIP. *Access a copy of the SHIP online using the website below. Does it match what you see in your community? Is your community or organization working on these health issues? How can you team up with partners in your area to work on them?*

Get involved. *Many local and tribal health departments lead efforts to identify health issues and make plans to improve health. Be a champion for community health planning; contact your local or tribal health department to learn about their work and ask how you can participate.*

Align plans or policies. *Ask local government, businesses, schools, non-profits, and other groups to align their efforts with the key health issues in the SHIP and to include the SHIP in their planning documents and policies. It will take everyone working together to successfully improve the health of Montanans.*

Tell us how you are using the SHIP with the "A Healthier Montana" comment box at https://dphhs.mt.gov/ahealthiermontana.

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RESOURCES

For more information and to download the SHIP, visit the A Healthier Montana website at https://dphhs.mt.gov/ahealthiermontana. You'll also find:

The 2017 State Health Assessment (SHA), a report about the overall health of Montanans.

Additional statewide health improvement plans, such as the Comprehensive Cancer Control Plan, the Montana Suicide Prevention Plan, and more.

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