

SHA/SHIP Coalition Minutes
October 11, 2017
12:30pm-4:00pm
Public Health and Safety Division's Cogswell Building
1400 Broadway, Helena, MT.
Room C205 & C207

SHA/SHIP Coalition Attendees:

- **Kristi Aklestad** (Toole County Health Department—Small County Member)
- **Karin Olsen Billings** (Office of Public Instruction)
- **Autumn Cummings** (Health Resources Division, DPHHS)
- **Natalie Claiborne** (Montana State University Office of Rural Health)
- **Kim Cuppy** (Fallon County Public Health Department—Frontier County Member)-Webinar
- **Hillary Hanson** (Flathead City-County Health Department—AMPHO)-Webinar
- **Todd Harwell** (DPHHS, PHSD Administrator)-Co-Chair
- **Greg Holzman** (State Medical Officer, DPHHS)
- **Heather Jurvakainen** (Park County Public Health Department—Medium County Member)-Webinar
- **Jack King** (Montana Hospital Association)
- **Rosemary Cree Medicine** (Blackfeet Tribal Health Department—Tribal Health Department Member)
- **Bobbi Perkins** (Addictive and Mental Disorders Division, DPHHS)
- **Tara Preston** (Montana Medical Association)
- **Melanie Reynolds** (Lewis and Clark City-County Public Health Department—Large County Member)
- **Kari Smith** (Department of Environmental Quality)
- **Helen Tesfai** (Rocky Mountain Tribal Epidemiology Center)
- **Dan Carlson-Thompson** (Developmental Services Division, Children's Mental Health Bureau, DPHHS)
- **Aaron Wernham** (Montana Healthcare Foundation)—Webinar
- **Todd Wilson** (Helena Indian Alliance)

Other Attendees:

- **Stacy Campbell** (Chronic Disease Bureau, PHSD)
- **James Mayberry** (System Improvement Office, PHSD)
- **Joan Miles** (SHA/SHIP Facilitator)
- **Jessica Miller** (System Improvement Office, PHSD, Coordinator)
- **Jim Murphy** (Communicable Disease Bureau, PHSD)
- **Kerry Pride** (System Improvement Office, PHSD)
- **Terry Ray** (System Improvement Office, PHSD)
- **Lisa Schmidt** (Chronic Disease Bureau, PHSD)
- **Jane Smilie** (Population Health Partners, LLC, Facilitator)
- **Laura Williamson** (State Epidemiologist, PHSD)

Excused SHA/SHIP Members:

- **Mike Andreini** (Rocky Mountain Tribal Epidemiology Center)
- **Jean Curtiss** (Montana Association of Counties)
- **Bill Gallea** (Montana Medical Association)
- **Eric Higginbotham** (Developmental Services Division, Children's Mental Health Bureau, DPHHS)
- **Kristin Juliar** (Montana State University Office of Rural Health)
- **Kathy Moore** (Lewis and Clark City-County Public Health Department—MEHA)
- **Janet Runnion** (Rocky Boy's Health Board—Tribal Health Department Member)
- **Tony Ward** (School of Public and Community Health Sciences)
- **Lora Wier** (MPHA)-Co-Chair

Welcome and Introductions

Todd Harwell reviewed the agenda for the day and introduced two new members and agencies of the SHA/SHIP Coalition. Bonnie Lorang has retired and her replacement for the Montana Medical Association will be Bill Gallea and Tara Preston. We also now have Autumn Cummings representing the Health Resources Division.

Jessica Miller reviewed the communication plan for the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP). We completed seven SHA/SHIP presentations throughout the month of September. We have one upcoming presentation at the Healthy Communities Pre-conference on November 1, 2017. Our next meeting will be on December 13, 2017 from 1:30-3:00pm. The final meeting is tentatively scheduled for February 28th and will be a webinar as well.

Laura Williamson gave an update on the 2017 SHA. We are in the final stages of drafting the chapters for the SHA and will be sending them out to the Coalition members for feedback with the October 11th meeting minutes. She asked the coalition members to share the draft SHA with any key stakeholders for more comments. Please send Jessica Miller at JMiller5@mt.gov any comments you have on the draft SHA, and she will send them to Laura Williamson.

August 16th Meeting Survey Results

Jane Smilie reviewed the results from the survey sent out to Coalition members after the August 16th meeting. The first question asked members if the vision of the health of Montanans, and the mission and guiding principles of the coalition were satisfactory. All survey respondents agreed that the mission, vision, and guiding principles represent the health of Montanans and the coalition. The second survey questions reviewed the five-priority framework of the Coalition's prioritization work. Eight out of ten respondents agreed that the five-priorities captured the coalition's work, while two had other suggestions. Those suggestions included addressing health equity or eliminating health disparities as a separate priority and addressing oral health somewhere in the actual SHIP. The final survey question asked the coalition members if they had any other comments on the SHA/SHIP process. One member suggested in the comments, that a tribal consultation be considered during the drafting of the SHIP.

SHA/SHIP September Presentations

Todd Harwell reviewed the SHA/SHIP presentations from the month of September. There was a consensus from the presentations that unintentional injury was a priority based on the 2017 SHA data. From this data, audience members commented that unintentional injury should be represented in the SHIP. Oral health

and environmental air quality were also mentioned as concerns within Montanan communities. Todd Harwell and Joan Miles commented that in order to make improvements on the SHIP priorities, we need a document that is focused and specific. We also need priorities that are feasible in terms of State resources. As a result, we do not want to focus on more than five priorities. Todd Harwell proposed to the group that we remove Adverse Childhood Experiences (ACEs) as a priority area, and put Unintentional Injuries in its place. We will still address ACEs but it will be addressed as a strategy under Behavioral Health. Melanie Reynolds commented that suicide prevention should be specifically mentioned under Behavioral Health. Kristi Aklestad commented that access to care should also be mentioned under Behavioral Health.

Coalition Work Session

Joan Miles led the coalition work session and asked the group to comment on six questions for the following priority areas: Unintended Pregnancy, Cardiovascular Disease and Diabetes Prevention and Control, and Cancer Control: Tobacco Use Prevention and Screening.

Question	Unintended Pregnancy	Cancer Control	Cardiovascular Disease and Diabetes
<p>1. Are there specific goals/indicators you don't see that you think should be included?</p>	<ul style="list-style-type: none"> a. Use of birth control in adolescents b. Should we consider measuring abortion c. Include intended births indicator d. How we focus on Men YRBS data by sex (indicator #4) <ul style="list-style-type: none"> i. Look at by age ii. Of sexually active, percent using Birth Control e. Measure perinatal drug use. The DPHHS-MHCF SUD and Medicaid report documented a nearly 3-fold rise in drug-exposed newborns among Medicaid patients over the last 5 years (*this is by tox screen at birth, not NAS diagnosis—important distinction since meth may not lead to as much NAS), and we hear from hospitals around the state that this is a major issue. It is interesting to think about the relationship between drug use and unintended pregnancy: “The Problem” correctly states that women with unintended pregnancies are more likely to engage in risk behaviors like drinking, but if I’m not mistaken, the reverse is also true (that is, women with SUD are more likely to have unintended pregnancies. f. Do you want to mention AI disparities specifically, provided you have the data? 	<ul style="list-style-type: none"> 1. Second hand smoke indicator 2. Smoking while pregnant 3. E-cigarettes use among youth and adults 	<ul style="list-style-type: none"> a. Initiation 150 <ul style="list-style-type: none"> i. Possible strategy/partner ii. Contact is Karin Olsen Billings iii. 1yr. pilot with 10 schools b. Possibly include ACEs in Goal 3 c. Double check the 2022 target for #4 indicator d. Include specific health equity-related goals, such as reducing AI-specific rates

Question	Unintended Pregnancy	Cancer Control	Cardiovascular Disease and Diabetes
2. Are there goals/indicators listed that you think should not be included?	None	None	Revisit measuring those diagnosed with diabetes and death rate for diabetes. Are both necessary? Maybe just measure death rate for diabetes.
3. Are there strategies you don't see that you think should be added?	<ul style="list-style-type: none"> a. Add low income/ poverty to at risk population b. Add rural/frontier residents [telehealth] c. Use of social media to target youth d. Ensure that MT HELP act stays in place e. Any changes to ACA or healthcare reform keep access/coverage of family planning services f. Preconceptual counselling in primary care should be included here. (Clinical) g. SUD screening and early intervention in primary care (SBIRT) may also be relevant in view of my long-winded general question above. (Clinical) h. Examine Medicaid reimbursement of SBIRT and preconceptual counselling in primary care settings. (policy) 	<ul style="list-style-type: none"> a. AI (cultural specific) counselors in communities b. Increase tobacco tax (add e-cigarettes) c. Add e-cigarettes to Clean Indoor Air Act d. Difference between policy & practice changes e. Education for pregnant women who smoke— Prevention and Health Promotion f. Increase number of clinical referrals g. Clinic→ ACEs education and Behavioral Health screening h. Tobacco 21 i. Specify population (targets) under health equity j. This is a place where Medicaid expansion cannot be overlooked. Nearly 40% of new enrollees accessed a preventive service within the first year of coverage. Moreover, the expansion allowed IHS service units to begin referring people for cancer screenings not offered on site for the first time in more than a decade. Maintaining 	<ul style="list-style-type: none"> a. Add adults and youth to PHP #1 b. Identify and promote resources available that address food deserts/food preparation c. Karin will help re-word Policy #5 d. Include ACEs in Clinical #2 e. Include strategy on increasing opportunities/programs for year-round access to walking/PA (rural focus) f. More focus on youth (prevention) g. Any way to address cost of healthy foods? h. General thought: for media message-related strategies such as “educate employees via media messages” and “promote awareness of stroke risk factors,” if you haven’t done so already I just think it’s important to make sure you are choosing only those media-related strategies that have the strongest evidence for effectiveness. These are potentially costly, time-consuming, and not always, the most effective approaches. i. Clinical: under “Promote clinic-based systems of care...”, I would suggest adding “Promote team-based approaches to clinical care that integrate medical and behavioral health, increase the use of clinical pharmacists, and coordinate

Question	Unintended Pregnancy	Cancer Control	Cardiovascular Disease and Diabetes
		the expansion is essential for cancer control. (Policy)	patient care to ensure progress toward individual treatment targets.” This reflects the strong evidence for improved chronic disease outcomes in integrated behavioral health settings. j. Health Equity: add specific reference to the new MT Medicaid T-HIP program, which makes ~\$6-12 million per reservation per year available for prevention activities. This could read: Collaborate with tribal health departments to help identify and implement evidence-based chronic disease prevention programs that are appropriate for Montana’s new T-HIP program.
4. Are there strategies listed that you think should not be included?	Go to question 3—reproductive life planning should occur at multiple points—not just post-partum follow-up	a. Reword a few for clarity b. Is number of referrals measurable? Maybe instead measure number of calls followed through	a. More information on PHP #3 (BP in dental) b. Think of other health professions
5. What do you think is the most important strategy to address the priority?	a. Health Equity—focus on disparate populations→access to services b. Increase access to services among women in at risk populations	a. Marketing tactics (#1 on list)—Differences between vaping & smoking b. Kids in primary prevention c. Secondary prevention with cancer screening d. Advocate policy and practice changes	a. Policy #7 b. Worksite Strategies c. Clinical #4 d. Policy #2 e. Focus on the risk factor (obesity/PA) versus the disease f. Health Equity #5
6. Are there key stakeholders missing?	a. Title X providers b. AI leaders or health officials c. MMA d. AMP e. MPCA f. IHS g. BRFSS h. Resources: MHCF	a. Tribal health b. MMA c. IHS d. MHCF e. ACEs→ elevate Montana (Child wise) f. MSU extension g. Tribal Health	a. MMA b. Tribal Health Programs c. IHS d. MSU Extension e. Tribal Health Departments f. Urban Indian Health Centers

Question	Unintended Pregnancy	Cancer Control	Cardiovascular Disease and Diabetes
	i. Medicaid j. Tribal Health Departments k. Urban Indian Health Centers	Departments h. Urban Indian Health Centers	

Thank you and next steps

Todd Harwell thanked the group and reminded everyone that the next meeting will be a webinar on December 13th from 1:30 to 3:00pm.

MONTANA SHA/SHIP COALITION

Agenda

Wednesday, October 11, 12:30 – 4 pm

Cogswell Building, 1400 Broadway, Conference Room C205, Helena

Meeting Purpose

- To finalize the priority areas for the Montana State Health Improvement Plan
- To provide input on DRAFT goals, health indicators and evidence-based strategies to address SHIP priority areas

Welcome, Introductions 12:30-12:50

- Welcome, introductions, review of agenda and goals for the day
 - Todd Harwell, Public Health and Safety Division Administrator
- Review of SHA/SHIP process and communication plan
 - Jessica Miller, Plans Coordinator

Update on State Health Assessment 12:50-1

- Laura Williamson, MPH, State Epidemiologist

Coalition Work Session 1-3:45

- Review feedback from SHA/SHIP discussions, conference presentations and Coalition survey
- Finalize and adopt State Health Improvement Plan (SHIP) priority areas
- Discuss and provide feedback on DRAFT goals, health indicators and evidence based strategies to address SHIP priority areas
 - Jane Smilie and Joan Miles, Facilitators

Thank You and Next Steps 3:50-4

- Todd Harwell, Public Health and Safety Division Administrator



STATE HEALTH ASSESSMENT AND STATE HEALTH IMPROVEMENT PLAN

COALITION MEETING

WEDNESDAY, OCTOBER, 2017

NEW AGENCIES/MEMBERS

-Bonnie Lorang
-Bill Gallea & Tara Preston



-Katie Hawkins
-Autumn Cummings



COMMUNICATION PLAN-COMPLETED PRESENTATIONS

Montana Health Research Summit



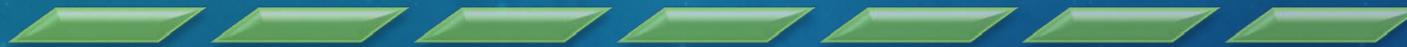
Montana Association of Counties Annual Conference



Montana Public Health Association Annual Conference



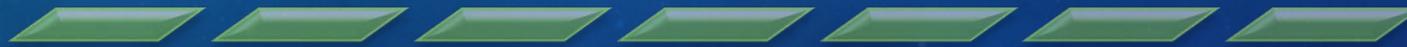
Montana Hospital Association Annual Conference



Montana Medical Association Board of Trustees



Montana AAP



UPCOMING SHA/SHIP PRESENTATIONS

Healthy Communities Conference

November 1, 2017

Pre-Conference Table-top
Discussion

Comment box on Healthier Montana Website:

<http://ahealthiermontana.mt.gov/shaship>

UPDATED SHA/SHIP TIMELINE—ACTIVITIES/TASKS

Completed

SWOT Analysis and Forces of Change

Draft SHA

Feedback and discussion sessions for SHA/SHIP (11 already completed)

Finalized Mission, Vision, and Guiding Principles

Proposed five priority areas

Future Tasks

Finalize priority areas

Objectives, Strategies, and Metrics

Priority Workgroups

UPDATED SHA/SHIP TIMELINE—SHA/SHIP COALITION MEETINGS

- Webinar
- 1:30-3:00pm

December 13th

February 28th

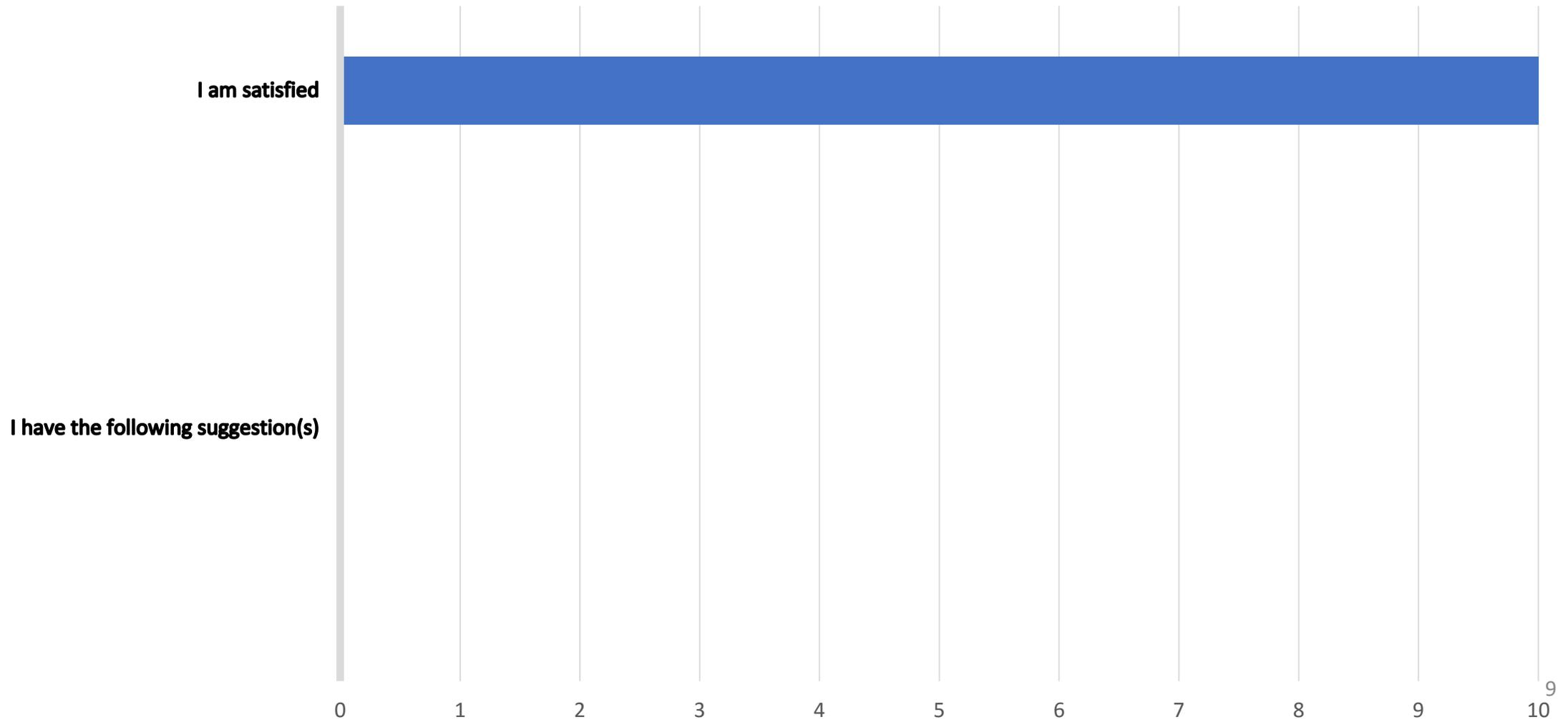
- Helena, MT.
- 10:00am-1:30pm

- New end goal for SHIP completion

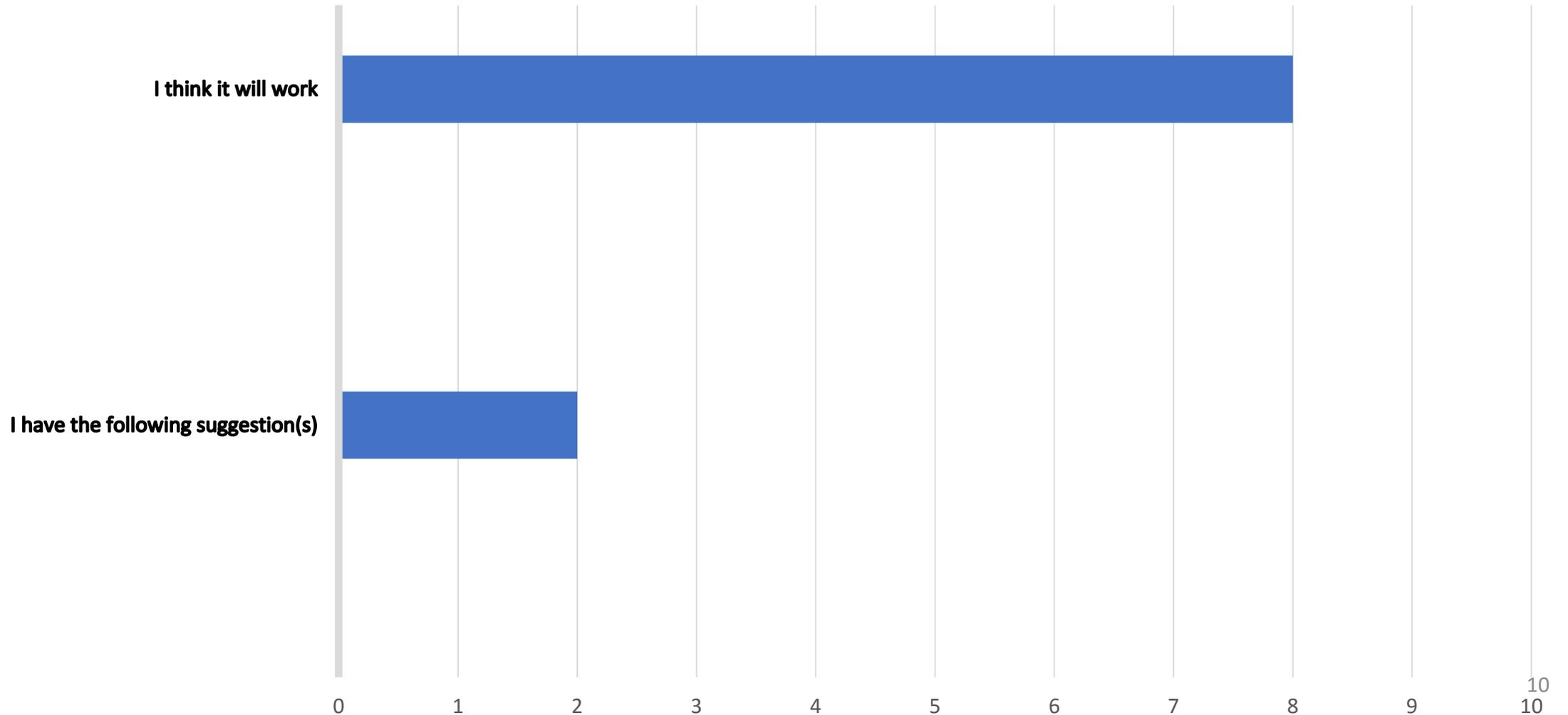
March 2018

SHA/SHIP Coalition September Survey Results

Q1. When you step back and review the vision for the health of Montanans, and the mission and guiding principles of the Coalition, are you satisfied with them?



Q2. Do you think the five-priority framework captures the Coalition's prioritization work?



Q2. I have the following suggestion(s) for consideration.

I suggest that either improving health equity or reducing/eliminating health disparities may work best as a separate priority.

Not sure how, but would like to see oral health woven in as it affects cardiovascular, pregnancy and has consequences in tobacco and substance abuse

Q.3. Do you have any other comments on our SHA/SHIP process to date?

I suggest that you consider a tribal consultation as you draft the SHIP, given the marked health disparities observed in the SHA, and the need to ensure that ALL tribes have a strong voice in guiding the state's response.

I think it is a good plan.

I am really happy to see how this is coming together. I was a little nervous after our last meeting about the priorities, but I feel much better seeing them written above. These priorities capture what we should be focusing on. Thank you!

SHA/SHIP Presentations

Overview of:

- State Health Assessment
- SHA/SHIP Coalition
- Proposed priorities
- Feedback on four questions
 - What findings or priority areas surprised you?
 - Are these findings and priority areas consistent with your community or organization?
 - What is missing?
 - What do you think is the most important public health issue to take action on? Is your community or organization already working on this issue?

What did these partner organizations say?

- **MACO**
 - Need more focus on injury prevention-motor vehicle safety and seat belt use
- **MMA**
 - Unintentional injury prevention is missing and should be a priority
- **Montana AAP**
 - Injury prevention needs more focus
- **Montana Health Research Summit**
 - Priority areas might address oral health and the environment
- **MPHA**
 - Environment and air quality can affect physical activity and cardiovascular health
 - Oral health and access to care needs more focus
- **MHA**
 - Pediatric services needed for mental health

Proposal in light of this feedback

- Add unintentional injury
- ACEs - a strategy area under Behavioral Health

MONTANA STATE HEALTH IMPROVEMENT PLAN 2018- 2022

Healthy Living...Healthy Futures for Montana

SHA/SHIP Coalition

Our mission is to protect and improve the health of every Montanan through evidence-based action and community engagement. We commit to:

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

Priorities for Action

The SHA/SHIP Coalition used data and information about the health status of Montanans and community needs to develop its priorities for action. Strategies to address these priorities will focus on:

- prevention and health promotion
- clinical interventions and processes
- policy
- health equity

CARDIOVASCULAR DISEASE AND DIABETES PREVENTION AND CONTROL

Focus is on risk factors such as poor nutrition, physical inactivity, tobacco use, obesity, hypertension, and access to preventative healthcare.

CANCER CONTROL: TOBACCO USE PREVENTION AND SCREENING

Focus is on preventable cancers associated with tobacco use, poor nutrition and physical inactivity. As well as cancers that are treatable by early detection through cancer screening.

BEHAVIORAL HEALTH: MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Focus is on prevention of and treatment for alcohol, prescription and illicit drug use, ACEs.

UNINTENDED PREGNANCY

Focus is on access to family planning services with an emphasis on disproportionately affected populations.

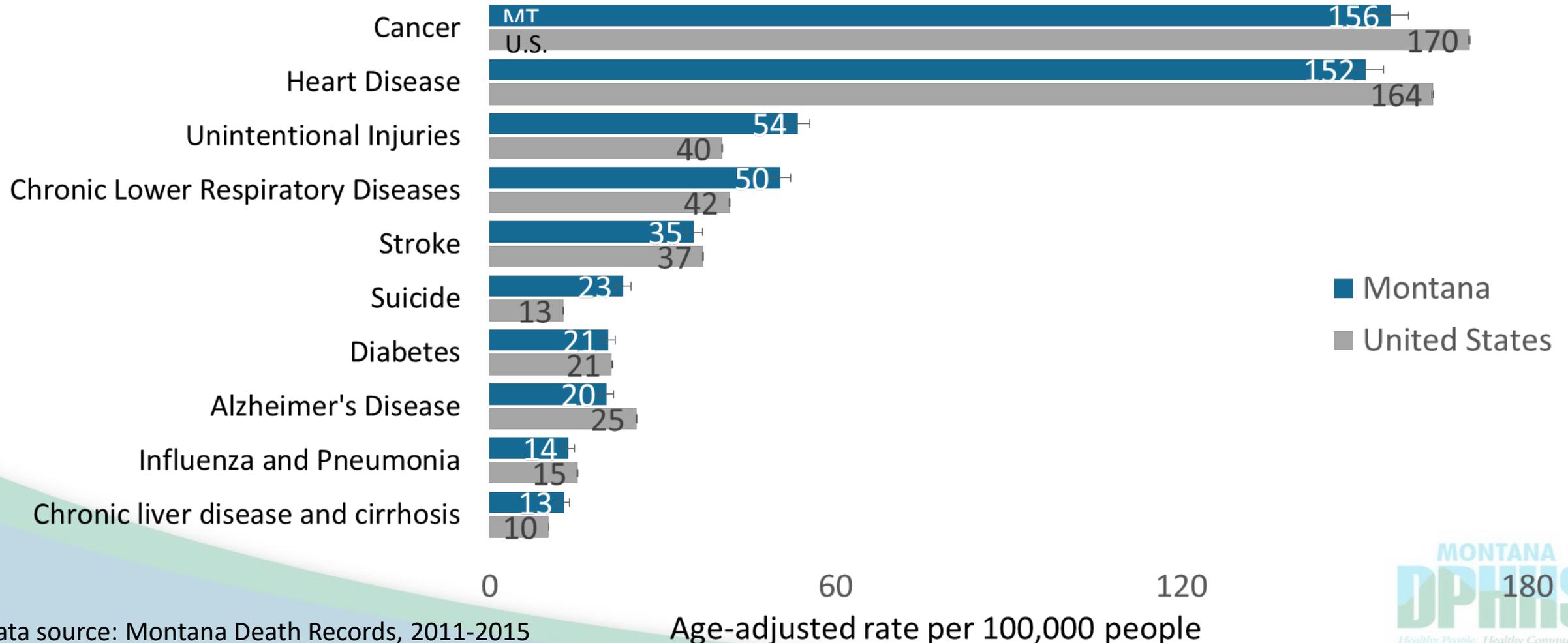
Unintentional Injury

Based on feedback received/ burden of mortality, YPLL...

INJURY

Top 10 leading causes of death in MT and U.S.

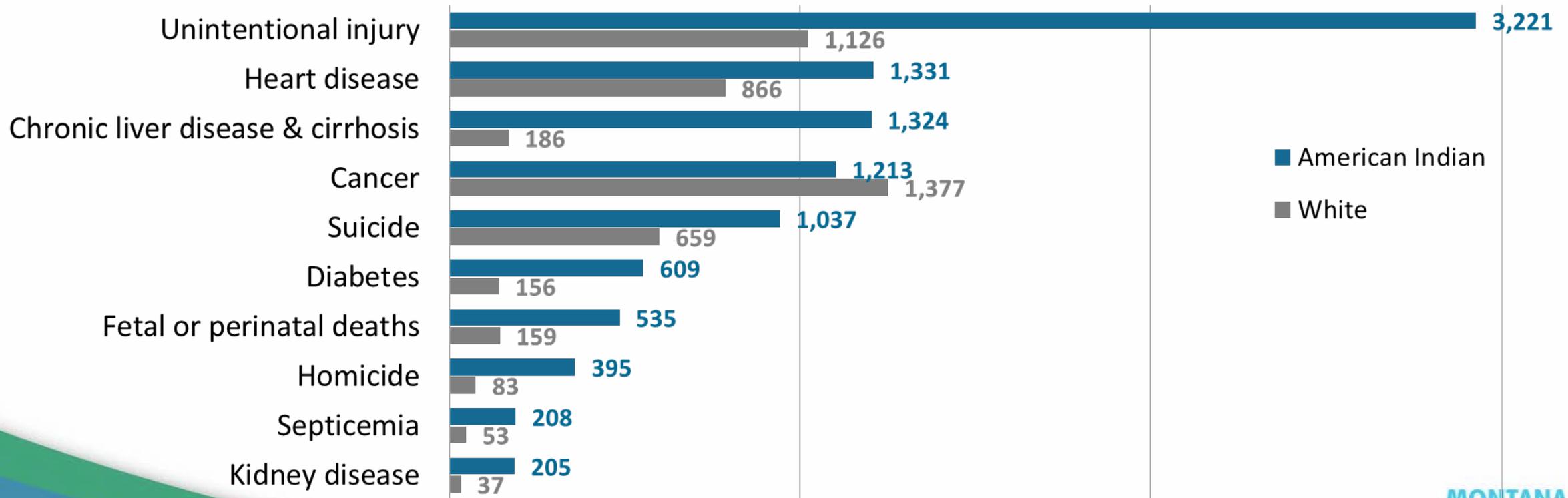
MT had **LOWER** mortality rate due to cancer & heart disease;
HIGHER mortality rate due to unintentional injury, CLRD, & suicide



Data source: Montana Death Records, 2011-2015

10 leading causes of premature death among American Indian and White MT residents

Premature death described as Years of Potential Life Lost (YPLL) before age 75 per 100,000 people



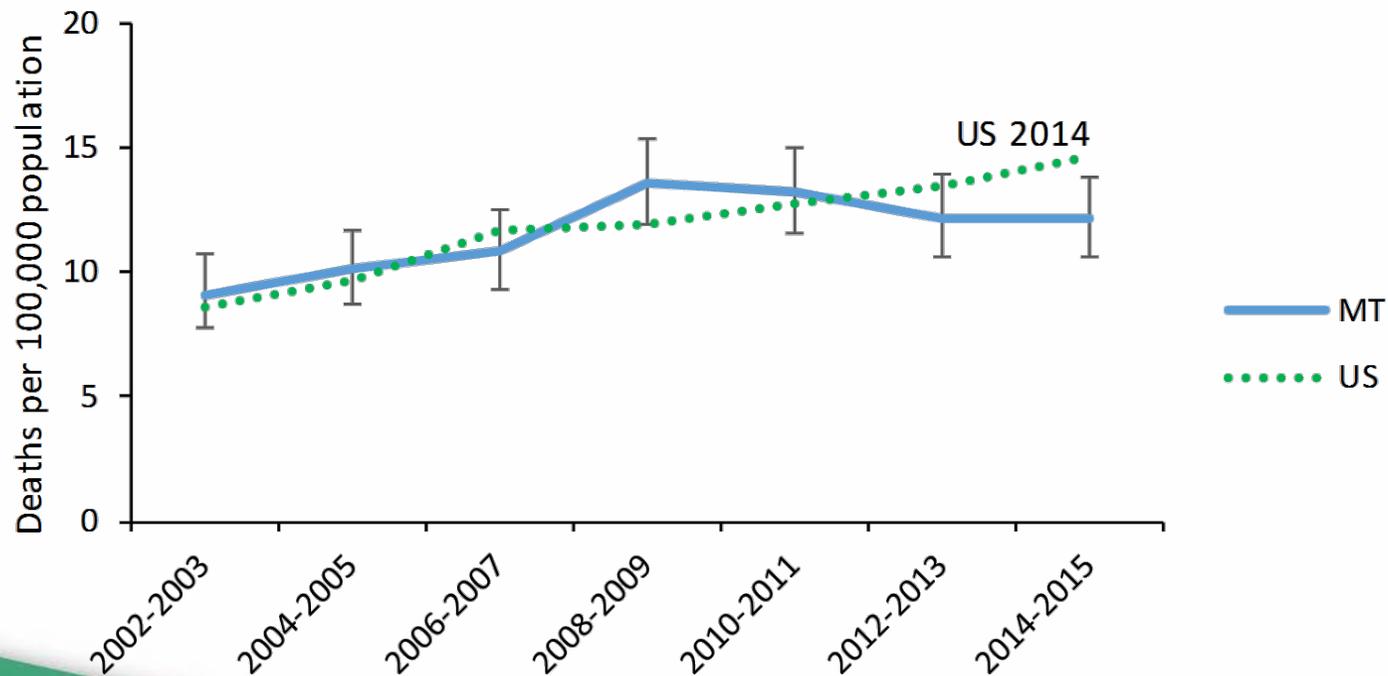
Data source: Montana Death Records, 2011-2015

Avg. annual YPLL per 100,000 persons

Fatalities for drug over dose **LOWER** in MT than U.S.

Hospital admissions for drug use have increased. **3,300 admissions** per year, on average, between 2010-2014

United States and Montana Drug Positioning
Age-adjusted Death Rates
US and Montana Resident Occurrences, 2002-2015

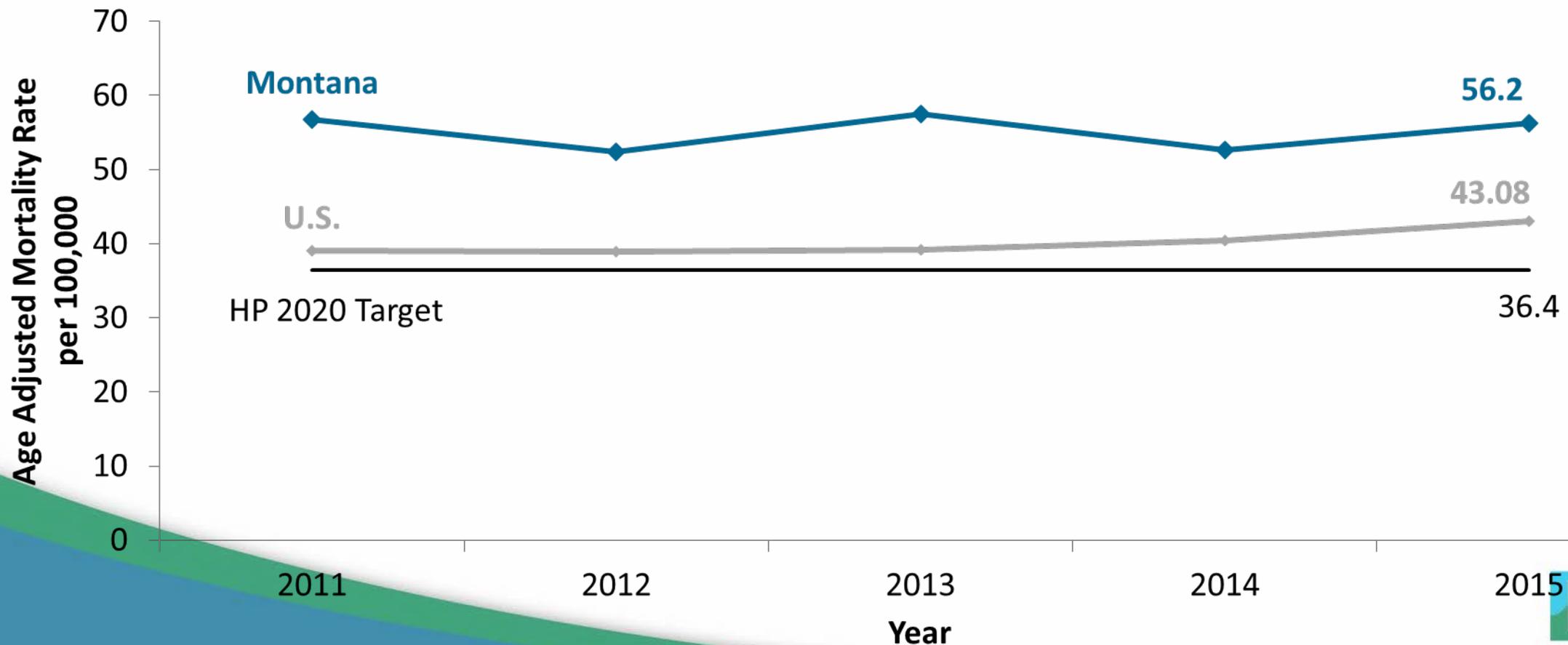


Data source: Montana death records, 2002-2015

600 deaths from unintentional injury each year in MT

Approx. 3,900 hospital admissions & 57,000 ED visits each year

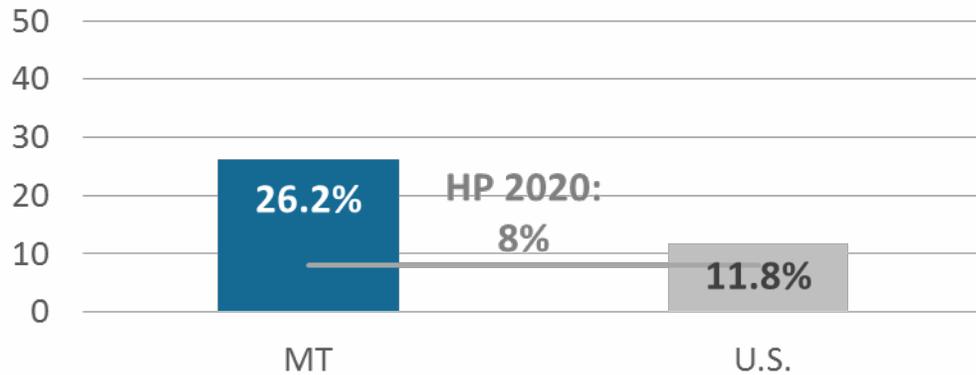
Mortality rate of unintentional injury, 2011-2015



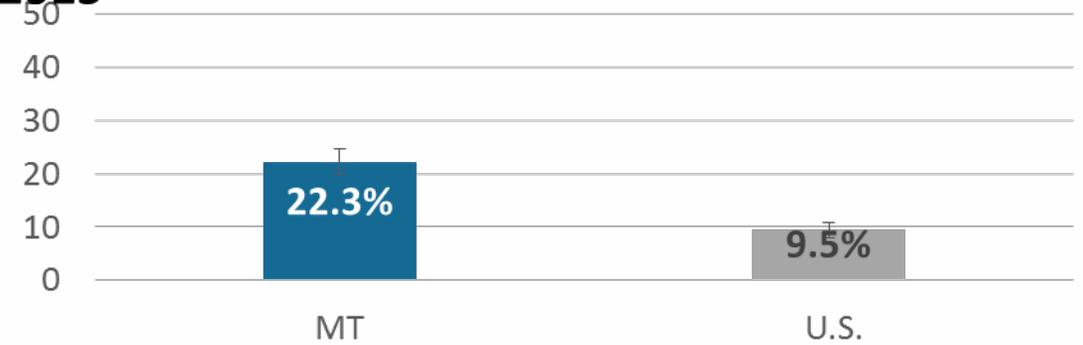
200 fatalities from motor vehicle accidents each year

Unsafe driving practices **HIGH** among Montanans. **1 in 4** do not wear a seat belt; **1 in 2** students text while driving

Adults that do NOT wear seatbelt, 2016



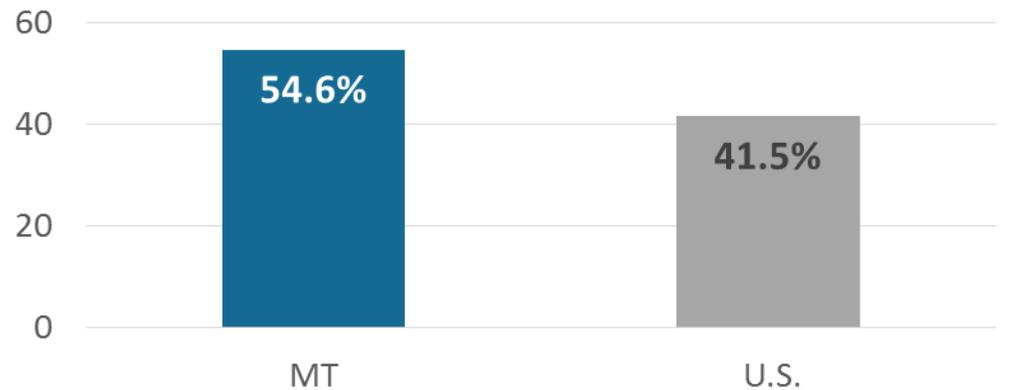
Students that do NOT wear seatbelt 2015



Adults that drink & drive, 2016



Students that text & drive, 2015



Falls are the most common non-fatal injury

Hospitalizations (N=15,610)	ED Visits (N=228,658)
1. Falls (57%)	1. Falls (36%)
2. Motor Vehicle (14%)	2. Struck by/against (13%)
3. Other Transport (7%)	3. Overexertion (10%)
4. Poisoning (7%)	4. Cut/Pierce (9%)
5. Struck by/against (3%)	4. Motor vehicle (9%)

MONTANA STATE HEALTH IMPROVEMENT PLAN 2018- 2022

Healthy Living...Healthy Futures for Montana

SHA/SHIP Coalition

Our mission is to protect and improve the health of every Montanan through evidence-based action and community engagement. We commit to:

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

Priorities for Action

The SHA/SHIP Coalition used data and information about the health status of Montanans and community needs to develop its priorities for action. Strategies to address these priorities will focus on:

- prevention and health promotion
- clinical interventions and processes
- policy
- health equity

CARDIOVASCULAR DISEASE AND DIABETES PREVENTION AND CONTROL

Focus is on risk factors such as poor nutrition, physical inactivity, tobacco use, obesity, hypertension, and access to preventative healthcare.

CANCER CONTROL: TOBACCO USE PREVENTION AND SCREENING

Focus is on preventable cancers associated with tobacco use, poor nutrition and physical inactivity. As well as cancers that are treatable by early detection through cancer screening.

BEHAVIORAL HEALTH: MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Focus is on prevention of and treatment for alcohol, prescription and illicit drug use, ACEs.

UNINTENDED PREGNANCY

Focus is on access to family planning services with an emphasis on disproportionately affected populations.

Unintentional Injury

Based on feedback received/ burden of mortality, YPLL...

Coalition work session – feedback on DRAFT goals, health indicators, strategies for each priority

- Weigh in on 3-4 priorities – you choose
- This is a first pass, you will have more opportunities
- Appoint a recorder/facilitator at each group discussion
- We will ask you to move to another priority ~ 15 minutes
- When you change groups, mix it up, sit with new people
- Appoint a new recorder/facilitator
- After the first round
 - Add new ideas - no need to repeat what has been written
 - Note when you disagree

Coalition work session

- Goals and Health Indicators
 - Are there specific goals/indicators you don't see that you think should be included?
 - Are there goals/indicators listed that you think should not be included? If so, why?
- Strategies
 - Are there strategies you don't see that you think should be added?
 - Are there strategies listed that you think should not be included? If so, why?
 - What do you think is the most important strategy to address the priority?
 - Are there key stakeholders missing?
- As drafted, is the content of this priority section consistent with the Coalition's mission, vision and guiding principles?

NEXT STEPS

- Finalize objectives and strategies for December Webinar
- Establish priority area workgroups
- Annual work-plan completed each year

UNINTENDED PREGNANCY

THE PROBLEM

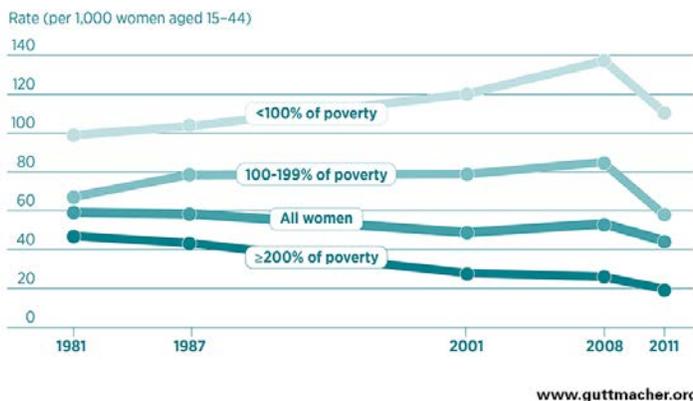
Unintended pregnancy is defined as a pregnancy that is either unwanted or mistimed. In 2015, half (31.8%) of Montana births were unintended (Health Survey of Montana’s Mothers and Babies, 2015). Of these births, 6.7% were the result of an unwanted pregnancy, with the mother having not wanted to become pregnant at that point in time or at any time in the future. A total of 25.1% of Montana births in 2015 were mistimed, with mothers not wanting to be pregnant at that point in time, but still wanting to be pregnant at some point in the future.

Unintended pregnancy is a public health concern because it can result in adverse maternal and child health outcomes, such as delayed and inadequate prenatal care, premature birth, low birthweight, and negative mental and physical health (1, 2, 3, 4, 5). Women with unintended pregnancies are more likely to engage in risk behaviors during pregnancy, such as smoking or drinking, and are less likely to use folic acid during pregnancy or breastfeed postpartum (6, 7). In addition, unintended pregnancy contributes to the incidence of abortion, with 42% of unintended pregnancies ending in abortion (8).

Rates of unintended pregnancy are highest among poor and low-income women, women without a high school degree, women aged 15-24, and women of color (8, 9). Since 1981, rates of unintended pregnancy have decreased, with women living at or above 200% of the federal poverty line seeing the sharpest decrease (10).

UNINTENDED PREGNANCY RATES

Between 1981 and 2011, unintended pregnancy has become increasingly concentrated among poor and low-income women.



References:

1. Sonfield A et al., The Social and Economic Benefits of Women’s Ability To Determine Whether and When to Have Children, New York: Guttmacher Institute, 2013.
2. Lawrence III HC, Testimony Before the Institute of Medicine Committee on Preventative Services for Women, Washington, DC: American Congress of Obstetricians and Gynecologists, 2011.

3. Herd P et al., The implications of unintended pregnancies for mental health in later life, *American Journal of Public Health*, 2016, 106(3):421–429.
4. Wendt A et al., Impact of increasing inter-pregnancy interval on maternal and infant health, *Paediatric and Perinatal Epidemiology*, 2012, 26(Suppl. 1):239–258.
5. Kavanaugh ML and Anderson R, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*, New York: Guttmacher Institute, 2013. Finer LB, Unintended pregnancy among U.S. adolescents: accounting for sexual activity, *Journal of Adolescent Health*, 2010, 47(3):312–314.
6. Rosenberg, Kenneth D., Jill M. Gelow, Alfredo P. Sandoval. Pregnancy Intendedness and the Use of Periconceptional Folic Acid, *Pediatrics*, 2003, 111(1): 1142-1145. Finer LB, Unintended pregnancy among U.S. adolescents: accounting for sexual activity, *Journal of Adolescent Health*, 2010, 47(3):312–314.
7. Cheng, D., EB Schwarz, E. Douglasb, and I. Horon, Unintended pregnancy and associated maternal preconception, prenatal and postpartum behaviors, *Contraception*, 2009, 79(3): 194-198.
8. Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, *New England Journal of Medicine*, 2016, 374(9):843–852).
9. Finer LB, Unintended pregnancy among U.S. adolescents: accounting for sexual activity, *Journal of Adolescent Health*, 2010, 47(3):312–314.
10. Guttmacher Institute. Unintended Pregnancy in the United States, September 2016. <https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states>.

GOALS

1. Increase the use of moderate and highly effective methods of contraception.
2. Reduce the rate of teen pregnancy.
3. Reduce the rate of births with an 18 month or less interbirth interval.

HEALTH INDICATORS by 2022	HP 2020 [check if indicator aligns with HP]
1. Decrease the proportion of pregnancies that are unintended from 31.8 percent to 26.8 percent (Baseline: Health Survey of Montana Mothers and Babies, 2015).	√
2. Reduce the proportion of pregnancies conceived within 18 months of a previous birth from 33.2 percent to 30.0 percent (Baseline: Montana Department of Public Health and Human Services, Office of Vital Statistics, 2016).	√
3. Reduce pregnancies among adolescent females aged 15 to 17 from 12.5 per 1,000 to 9.5 per 1,000 (Baseline: Montana Department of Public Health and Human Services, Office of Vital Statistics, 2016).	√
4. Increase the proportion of adolescents grades 9 - 12 who have never had sexual intercourse from 43.2 percent to 48.0 percent (Baseline: Montana Youth Risk Behavior Survey, 2017).	√
5. Increase the percentage of women aged 18 to 49 years that adopt or continue use of the most effective or moderately effective methods of contraception from XX	√

percent to XX percent (Baseline: Montana Behavioral Risk Factor Surveillance System, 2018).	
---	--

Action Area	Strategy [for each strategy, please indicate the goal(s) # and indicator(s) # to which it links]
Prevention and Health Promotion	
Clinical	•
Policy	•
Health Equity	•

Key Partnerships

[List groups, coalitions, councils already working, plus other key constituencies needed]

The template above will help us create the high-level 5-year SHIP document. After we reach agreement on the content of the barebones 5-year plan, we will create and populate an annual workplan for each priority area that details the following.

1. What specific actions, activities and tasks need to be completed to make progress toward implementing each strategy outlined in the plan?

By what date will each specific action, activity and task be completed?

How will we know if we accomplished these actions and if they were completed on time? What will be our process measures?

2. Who will primarily be responsible for implementing each strategy?
 - Role of state health department?
 - Role of local health departments?
 - Role/s of other partners?

3. Can we make and measure progress on the indicators for this priority area in one year? If so, what will be the annual target?

If not, how will progress be measured and tracked for the year?

Chronic Disease Prevention and Control:

Cancer Control: Tobacco Use Prevention and Screening

THE PROBLEM – Tobacco Use

Tobacco use remains the leading cause of preventable death and disability, with **1,600** tobacco-related deaths occurring in Montana each year.¹ Cigarette smoking harms nearly every organ of the body, causes many diseases, and reduces the health of smokers in general.^{2,3 4,5}

Figure X: In 2016, more than one quarter of adults were current tobacco users, however, usage was significantly higher among certain demographic groups.⁴

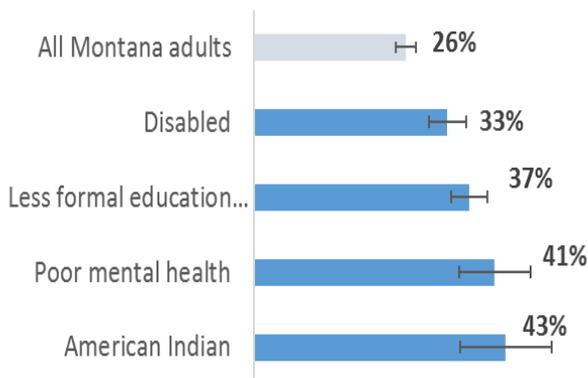
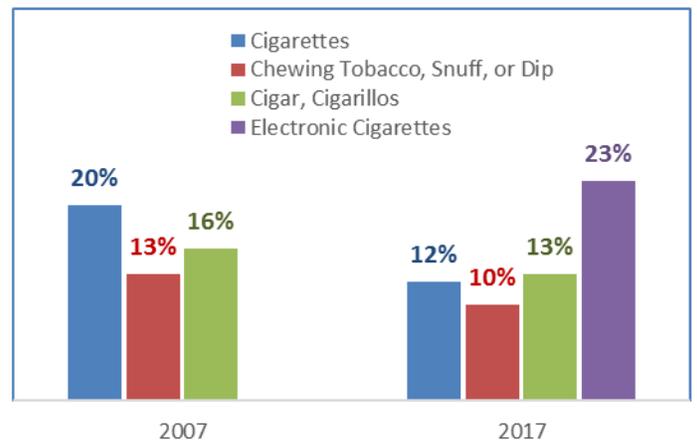


Figure X: Combustible cigarettes are no longer the preferred tobacco product among Montana youth.



While we have seen a significant decrease in cigarette consumption over the last decade, the use of other tobacco products remains high. Smokeless tobacco use is twice as high in Montana compared to the United States. Among the male population, youth use smokeless tobacco almost as much as adults, (**14%** and **15%**, respectively), showing how effective tobacco companies are in getting new users addicted to their products.⁶ The tobacco industry spends almost **\$30 million** each year on marketing in Montana and their strategies specifically target youth by focusing on sports, celebrities, and tempting flavors.⁷ The popularity of e-cigarettes among youth is also a concern. Almost **half** of all Montana youth have tried e-cigarettes and **one in four** report currently using them. Youth use of nicotine in any form, from cigars to smokeless tobacco to e-cigarettes, is addictive and unsafe.

THE CONSEQUENCE OF THE PROBLEM – Chronic Disease

People who use TOBACCO increase their risk for

- Heart disease
- Stroke
- Cancers (numerous)
- Diabetes
- Rheumatoid arthritis
- Preterm births
- Low birth weight babies
- Reduced fertility
- Asthma Exacerbations

Cancer

In Montana, there are about 5,600 new cases of cancer each year. The most common types of cancer are female breast cancer, prostate cancer, lung cancer, and colorectal cancer. Cancer incidence is significantly higher among American Indians in Montana compared to Whites. The largest disparities between American Indians and Whites were for lung and liver cancer incidence, which were two and three times higher respectively.

GOALS

1. Prevent tobacco use among young people;
2. Promote tobacco cessation among adults and young people
3. Increase cancer screening using nationally recognized guidelines.

HEALTH INDICATORS by 2022	HP 2020
1. Decrease the percent of Montana adults who currently use tobacco from 26.0 to 23.5 (Baseline: Montana BRFSS, 2016)	✓
2. Decrease the percent of Montana youth who currently use tobacco from 32.7 to 29.7 (Baseline: Montana YRBS, 2017)	✓
3. Increase the proportion of Montana men and women aged 50 to 74 who report being up to date with colorectal cancer screening from 62% to 80%. (Baseline: Montana BRFSS, 2016)	✓
4. Increase the proportion of Montana women aged 50 to 74 who report having had a mammogram in the past 2 years from 72% to 80%. (Baseline: 2016 Montana Behavioral Risk Factor Surveillance System)	
5. Increase the proportion of Montana women aged 21 to 65 who report having had a Pap test in the past three years from 81% to 86%. (Baseline: 2016 Montana Behavioral Risk Factor Surveillance System)	

Action Area	Strategy
Prevention and Health Promotion	<ul style="list-style-type: none"> • Increase awareness of tobacco marketing tactics through educational materials, presentations, and media campaigns (Goals 1 and 2; Indicators 1 and 2) • Educate Montana employees through worksite wellness small media messages supportive of healthy lifestyle behaviors and early detection of cancer. (Goal 3; Indicators 3, 4, and 5)
Clinical	<ul style="list-style-type: none"> • Increase referrals to evidence based chronic disease prevention and management programs (e.g. Montana Tobacco Quit Line, DPP, DSMES, WWE, CDSMP) (Goal 2; and Indicator 1) • Advocate for policy and practice changes within healthcare systems to increase cancer screening, tobacco cessation counseling, and high quality care for CVD and diabetes. (Goals 2 and 3; Indicators 1, 3, 4, and 5). • Provide technical assistance to clinics on electronic

	continuous quality improvement (eCQI) to improve chronic disease care and clinical preventive services in primary care settings. (Goals 2 and 3; Indicators 1, 3, 4, and 5)
Policy	<ul style="list-style-type: none"> Promote implementation of smoke-free and tobacco-free environments (e.g., K-12 schools, colleges, hospitals, multi-unit housing, parks, and local Clean Indoor Air Policies). (Goals 1 and 2; Indicators 1 and 2)
Health Equity	<ul style="list-style-type: none"> Develop and disseminate culturally appropriate chronic disease prevention and control materials and media for American Indians. (Goals 1 and 2; Indicators 1, 2, 3, 4, and 5) Increase referral's to the American Indian Commercial Tobacco Quit Line (Goal 2; Indicator 1) Promote cancer screening through culturally appropriate education with target populations. (Goal 3; Indicator 3, 4, and 5) Educate providers, Indian Health Service and Tribal Health on screening guidelines, insurance coverage, referrals, state programs and access barriers. (Goal 3; Indicator 3, 4, and 5) Increase the number of American Indians in Montana navigated to insurance coverage through the Affordable Care Act marketplace or Medicaid. (Goal 3; Indicator 3, 4, and 5)

Key Partnerships

[List groups, coalitions, councils already working, plus other key constituencies needed]

- Stroke Workgroup
- Mission: *Lifeline* Montana
- Million Hearts Workgroup
- Healthcare providers at hospitals and primary care clinics
- Quality Improvement Network-Quality Improvement Organization
- Montana Community Pharmacies
- Montana Dental Offices

- The American Cancer Society
- Montana Tobacco Prevention Advisory Board
- Montana Office of Public Instruction
- Healthcare providers
- Montana Tobacco Prevention Specialists
- National Jewish Health
- NASPA (Student Affairs Administrators in Higher Education) Bike Walk Montana
- Montana State University Office of Rural Health
- Western Transportation Institute
- America Walks
- The Sonoran Institute
- National Center for Appropriate Technology
- Montana Cancer Coalition
- Montana American Indian Women's Health Coalition
- Montana Primary Care Association
- Mountain Pacific Quality Health Foundation
- Local public health departments
- Schools
- Worksites
- Montana Diabetes Advisory Coalition
- Montana Medicaid
- State of Montana Health Care & Benefits Division
- Montana Diabetes Educators Network
- Montana Kids with Diabetes School Collaborative
- Billings Area Indian Health Service
- University of Montana Rural Institute Disability & Health Program
- University of Montana Office of Rural Health and Area Health Education Center
- University of Montana School of Extended and Lifelong Learning
- University of North Dakota Energy & Environmental Research Center
- American Association of Diabetes Educators
- American Diabetes Association

¹ CDC, <https://www.cdc.gov/tobacco/about/osh/program-funding/pdfs/montana-508.pdf>

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 July, 2017].

³ U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: What It Means to You. 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, 2010 [accessed July, 2017].

⁴ Montana Behavioral Risk Factor Surveillance System, 2016.

⁵ Cigarette, smokeless tobacco, and Montana e-cigarette estimates are from BRFSS, 2015. National e-cigarette estimate is from the National Health Interview Survey, 2014. Cigar estimate is from Montana Adult Tobacco Survey, 2016.

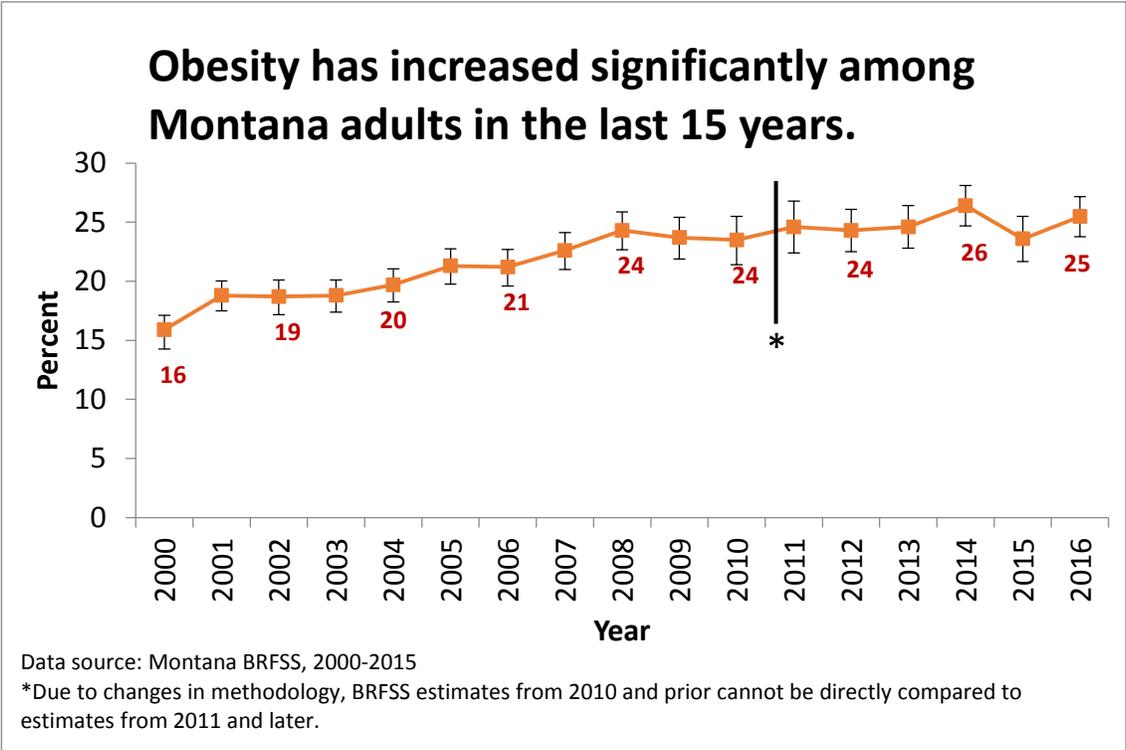
⁶ Montana BRFSS, 2016 and Montana YRBS, 2017

⁷ Campaign for Tobacco-Free Kids, http://www.tobaccofreekids.org/facts_issues/toll_us/montana

Chronic Disease Prevention and Control: *Cardiovascular Disease and Diabetes Prevention and Control*

THE PROBLEM – Obesity

Obesity is a serious health concern that results from a combination of poor dietary patterns and physical inactivity. More than **1 in 10** Montana youth and **1 in 4** Montana adults are currently obese.¹ American Indians and persons with a disability are significantly higher, with **38%** and **33%** being obese, respectively.



Regular physical activity is one of the most important things people can do for their health. People who are physically active live longer and have lower risks for heart disease, stroke, type 2 diabetes, depression, and some cancers.² Physical **inactivity** is a risk factor for multiple causes of death and chronic morbidity.³ **75%** of Montana adults and **72%** Montana youth do not meet physical activity recommendations.⁴

THE CONSEQUENCE OF THE PROBLEM – Chronic Disease

People who are OBESE increase their risk for:

- Heart disease
- Stroke
- Some cancers
- Diabetes
- Arthritis
- High blood pressure
- High cholesterol
- Gallbladder disease
- Mental illness
- Asthma Exacerbations

Diabetes

The prevalence of diabetes in Montana has increased from 2.8% in 1990 to 8.0% in 2016; however, it is significantly lower compared to the US. About 65,000 people have diagnosed diabetes. Health disparities exist in diabetes prevalence by race, income, education, residence, disability status, and Veteran status. For instance, in 2015, 19.2% of American Indians/Alaska Native adults had diabetes compared to 7.3% of White non-Hispanic adults.

Cardiovascular Disease

More Montanans die from cardiovascular disease (CVD), which includes heart disease and stroke, than any other chronic disease. High blood pressure, cigarette smoking, sedentary life-style, obesity, high cholesterol and diabetes all contribute to the development of CVD. In 2015, the percentage of Montana adults with CVD was over three times higher for those with high blood pressure than those without this risk factor.

GOALS

1. Make active living and healthy eating easy, safe, and accessible everywhere Montanans live, work, learn, and play
2. Improve high blood pressure control.
3. Increase awareness of modifiable risk factors for heart disease and stroke (i.e., high blood pressure, high blood cholesterol, cigarette smoking, physical inactivity, diabetes, obesity, and overweight).
4. Fewer Montanans develop type 2 diabetes.
5. Fewer Montanans die from diabetes and its complications.

HEALTH INDICATORS by 2022	HP 2020
<ol style="list-style-type: none"> 1. Decrease the percent of Montana adults who are currently obese from 25.5 to 22.5 (Baseline: Montana BRFSS, 2016) 2. Decrease the percent of Montana youth who are currently obese from 11.7 to 8.5 (Baseline: Montana YRBS, 2017) 3. Increase the percent of Montana adults 18-85 years with diagnosed high blood pressure who achieved blood pressure control (documented as BP < 140/90 mmHg) from 64.2% to 61.2% (Baseline: Patient Centered Medical Home annual data submitted to Commissioner of Securities and Insurance). 4. Decrease the age-adjusted stroke mortality of Montanans from 33.8 to 33.5 stroke deaths per 100,000 population. (Baseline: Montana Vital Statistics from calendar year 2015) 5. Decrease the percent of Montana adults with diagnosed diabetes from 8.0% in 2016 to 7.4% by 2022. (Baseline: BRFSS) 6. Decrease the age-adjusted death rate for diabetes reported as the underlying or multiple cause of death per 100,000 persons with diabetes from 68.1 in 2015 to 66.6 in 2022. (Baseline: Montana Vital Statistics Death Records) 	<p style="text-align: center;">√</p> <p style="text-align: center;">√</p> <p style="text-align: center;">√</p>

Action Area	Strategy
<p>Prevention and Health Promotion</p>	<ul style="list-style-type: none"> • Implement evidence-based programs that facilitate chronic disease prevention and chronic disease self-management (e.g. Walk with Ease, Worksite Wellness Programs, Rx Trails, Diabetes Prevention Program (DPP), Diabetes Self-Management Education and Support (DSMES) programs, etc.) (Goals 1, 2, 4, and 5; Indicators 1, 2, 3, 5, and 6) • Educate Montana employees through worksite wellness small media messages supportive of healthy lifestyle behaviors and early detection of cancer. (Goal 1; Indicators 1 and 2) • In dental offices, promote blood pressure screenings and referrals to primary care providers. (Goal 2;

	<p>Indicator 3)</p> <ul style="list-style-type: none"> • Promote awareness of stroke risk factors through the stroke media campaigns on American Indian reservations and in communities. (Goal 3; Indicator 4) • Engage community pharmacies in improving blood pressure medication adherence with pharmacy patients, which may affect blood pressure control. (Goal 2; Indicator 3) • Improve awareness of stroke signs and symptoms through the stroke media campaigns. (Goal 3; Indicator 4) • Promote awareness of pre-diabetes among people at high risk for type 2 diabetes (Goal 4; Indicator 5).
Clinical	<ul style="list-style-type: none"> • Increase referrals to evidence based chronic disease prevention and management programs (e.g. Montana Tobacco Quit Line, DPP, DSMES, WWE, CDSMP) (Goal 3 and 4; and Indicator 4) • Advocate for policy and practice changes within healthcare systems to increase cancer screening, tobacco cessation counseling, and high quality care for CVD and diabetes. (Goals 2 and 3; Indicators 3, 4, and 5). • Promote clinic-based systems of care for chronic disease self-management of patients seen at primary care clinics and community pharmacies. (Goals 2 and 4; Indicators 3 and 4) • Provide technical assistance to clinics on electronic continuous quality improvement (eCQI) to improve chronic disease care and clinical preventive services in primary care settings. (Goals 2 and 3; Indicators 3, 4, and 5)
Policy	<ul style="list-style-type: none"> • Promote implementation of smoke-free and tobacco-free environments (e.g., K-12 schools, colleges, hospitals, multi-unit housing, parks, and local Clean Indoor Air Policies). (Goal 1; Indicators 1 and 2) • Promote and support the implementation of local Active Transportation policies (Goal 1; Indicators 1 and 2)

	<ul style="list-style-type: none"> • Support worksite snack bars and cafeterias in creating policies that encourage healthy nutrition standards for food and beverages provided at meetings, trainings and/or conferences. (Goal 1; Indicator 1) • Support worksites in creating policies that establish guidelines to promote a work environment that increases opportunities for employees to engage in physical activity. (Goal 1; Indicator 1) • Work with the Office of Public Instruction (OPI) and school districts to strengthen school wellness policies and chronic disease management protocols.(e.g. access to nutritious food, active transportation, physical education, recreation facilities open to the community, reduce screen-time usage (Goals 1 and 5; Indicator 1, 2 and 6) • Encourage creation and implementation of blood pressure and tobacco use screening and referral protocols in dental offices. (Goal 3; Indicator 3) • Increase reimbursement for evidence-based programs that facilitate chronic disease prevention and chronic disease self-management (Goals 3 and 4; Indicators 5 and 6).
<p>Health Equity</p>	<ul style="list-style-type: none"> • Develop and disseminate culturally appropriate chronic disease prevention and control materials and media for American Indians. (Goals 3 and 4; Indicators 4 and 5) • Deliver resources and technical assistance to Farmers Market Masters to initiate or expand Electronic Benefit Transfer in their markets (Goal 1; Indicators 1 and 2). • Educate providers, Indian Health Service and Tribal Health on screening guidelines, insurance coverage, referrals, state programs and access barriers. (Goal 3; Indicators 1, 3, 4, and 5) • Increase the number of American Indians in Montana navigated to insurance coverage through the Affordable Care Act marketplace or Medicaid. (Goals 2 and 4; Indicators 3, 4, and 5)

	<ul style="list-style-type: none"> • Increase access to services (including telehealth to rural/frontier areas, accessibility adaptations for people with disability, locations on American Indian reservations, and support for Medicaid members) (Goals 4 and 5; Indicators 5 and 6). • Increase engagement of community health workers (CHWs) in the provision of self-management programs and on-going support (Goal 5; Indicator 6).
--	---

Key Partnerships

[List groups, coalitions, councils already working, plus other key constituencies needed]

- Stroke Workgroup
- Mission: *Lifeline* Montana
- Million Hearts Workgroup
- Healthcare providers at hospitals and primary care clinics
- Quality Improvement Network-Quality Improvement Organization
- Montana Community Pharmacies
- Montana Dental Offices
- The American Cancer Society
- Montana Tobacco Prevention Advisory Board
- Montana Office of Public Instruction
- Healthcare providers
- Montana Tobacco Prevention Specialists
- National Jewish Health
- NASPA (Student Affairs Administrators in Higher Education) Bike Walk Montana
- Montana State University Office of Rural Health
- Western Transportation Institute
- America Walks
- The Sonoran Institute
- National Center for Appropriate Technology
- Montana Cancer Coalition
- Montana American Indian Women’s Health Coalition
- Montana Primary Care Association
- Mountain Pacific Quality Health Foundation

- Local public health departments
- Schools
- Worksites
- Montana Diabetes Advisory Coalition
- Montana Medicaid
- State of Montana Health Care & Benefits Division
- Montana Diabetes Educators Network
- Montana Kids with Diabetes School Collaborative
- Billings Area Indian Health Service
- University of Montana Rural Institute Disability & Health Program
- University of Montana Office of Rural Health and Area Health Education Center
- University of Montana School of Extended and Lifelong Learning
- University of North Dakota Energy & Environmental Research Center
- American Association of Diabetes Educators
- American Diabetes Association

¹ YRBS, 2017 and BRFSS, 2016

² <https://www.cdc.gov/healthyplaces/healthtopics/physactivity.htm>

³ <http://www.who.int/publications/cra/chapters/volume1/0729-0882.pdf>

⁴ BRFSS, 2015 and YRBS, 2017