HEALTHY
GALLATIN

2012 GALLATIN COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

ACKNOWLEDGEMENTS

The Healthy Gallatin initiative would like to thank the following organizations for participating in the planning sessions that led to the community health priorities outlined in this report:

Alcohol and Drug Services
Belgrade City Court
Belgrade School District
Bozeman City Commission
Bozeman Deaconess Health Services
Bozeman Job Services
Bozeman School District
Bridgercare
Cancer Support Community
City of West Yellowstone
Child Care Connections
Community Health Partners
Early Childhood Community Council
Gallatin City-County Health Department
Gallatin County Board of Health
Gallatin County Planning Office
Gallatin Mental Health Center
Gallatin Valley Farm to School
Gallatin Valley Food Bank
Gallatin Valley YMCA
Greater Gallatin United Way
HOPA Mountain
Human Resource Development Council
Montana Nutrition and Physical Activity
Montana Office of Rural Health
Montana Peer Network
Montana State University
Montana Tobacco Use Prevention Program
National Association of Mental Illness
Three Rivers Clinic
Thrive

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EXECUTIVE SUMMARY

What do you think of when you think of the word 'health'? Some people think about eating healthy, and some associate health with visiting a doctor's office. Every day we make choices that affect our health- small things like choosing to floss our teeth and big things like making the decision to seek medical care. Some health-related decisions are made for you, like the passage of the Affordable Care Act, or recommendations by national associations. Benjamin Franklin said, "an ounce of prevention is worth a pound of cure," we know that prevention is cheaper, more effective and better for the individual and society than addressing health conditions once they have been diagnosed. So, how can we, as a community, make a difference when it comes to health?

Health is a very large and multi-faceted topic. Measuring health and effectively addressing health challenges requires an effort on behalf of a community. Measuring the health of Gallatin County was a large undertaking, which is why this process was conducted through a collaborative effort. Gallatin City-County Health Department, in collaboration with Bozeman Deaconess Hospital, Community Heath Partners, and many additional organizations and stakeholders worked in partnership to conduct a comprehensive, county-wide health assessment utilizing the Mobilizing Action through Planning and Partnership process, the results of which were published in a Community Health Profile in 2012. In order to prioritize health issues and make sense of all of the data, stakeholders met to review the assessment results and prioritize issues that they felt were important to address, for the health of the community.

The strategic issues that Gallatin County communities are addressing include:

- How do we increase access to care?
- How do we increase strategic collaboration between service providers?
- How do we encourage healthy behaviors across the life span?

The following document outlines the strategies that community groups and stakeholders are working on together in order to improve the health of residents in Gallatin County.

DETERMINING HEALTH PRIORITIES

HOW DID WE GET HERE?

A community-driven health improvement framework called Mobilizing Action through Planning and Partnership (MAPP) was used to guide the health improvement process. The MAPP process began in July of 2011 and took 18 months to complete. The process was guided by a steering committee made up of community members and representatives of human service organizations.

The Community Health Profile is the document that was created from the first phase of the process in which the results and findings of four health assessments are detailed. The Community Health Improvement Plan was guided by MAPP as well, and this document will detail strategic issues that came out of the assessment process and outline goals and strategies to address these health issues.

The data related to the health of Gallatin County that is referenced throughout this document can be found in the Community Health Profile.

Both this report and the Community Health Profile can be found at **www.healthygallatin.org.**

PURPOSE

We recognize that by working together, we can accomplish more than we could alone. The purpose of the Community Health Improvement Plan is not to create more work for our partners, but to align and leverage the efforts of multiple organizations and to move toward improved health for the residents of Gallatin County in a strategic manner.

What follows is the result of the community's deliberation and planning to address health concerns in a strategic way that aligns resources and energy to make a measurable impact on health issues in Gallatin County. We recognize that there are many assets in Gallatin County that will help this process move toward accomplishing its goals.

PROCESS

At the community prioritization meeting, the results of the assessment were presented to the community and issues from each of the four assessments were highlighted. Each issue was a specific data point that was written out on sheets of paper and put on a wall for stakeholders to prioritize. During the community prioritization process the group created categories from the issues based on themes and relationships between and among issues. This process resulted in four theme areas: Access and Barriers to Health Care, Collaboration of Organizations, Healthy Behaviors and Social and Economic disparities. Stakeholders then used sticky dots to identify critical issues within the theme areas and also assigned their own name next to one or more strategic issues, thereby creating subcommittees for each theme area.

Following the community prioritization process, the subcommittees were convened to identify goals, strategies and tactics to address the strategic issues. During this meeting, each group was presented with promising practice strategies promoted by organizations that included The Community Guide, County Health Rankings and the National Prevention Strategy. Subcommittees met multiple times after the initial Goals and Objectives meeting in order to identify outcome indicators, strategies, tactics, and a lead for each strategy.

Each subcommittee will meet regularly to continue the work that has been outlined, and will do so by setting meetings that will be amenable to the members' schedules. The Health Department will assist in convening these meetings and measuring progress within each workplan.

ADDRESSING DETERMINANTS OF HEALTH

There was a fourth theme area identified at the prioritization process- one that included access to staple foods and affordable housing. This priority area was given the title "Social and Economic Disparities". The group felt that these issues were important enough to have their own priority, but participants also voiced concerns that it would be difficult to address these large, broad issues within the Community Health Improvement Plan. No subcommittee was formed around this issue, but it was decided that each priority area should address the social determinants of health in some way. The participants said that not addressing the social determinants of health would undermine the good work that is being undertaken in the other priority areas.

PRIORITY 1: ACCESS

STRATEGIC ISSUE 1: HOW DO WE INCREASE ACCESS TO CARE?

CURRENT SITUATION

Gallatin County is lucky to have a significant number of health care resources. Bozeman is home to Bozeman Deaconess Hospital and Montana State University which has a counseling program as well as a nursing program. Community Health Partners (Federally Qualified Health Center) serves populations on a sliding-fee scale throughout the county, with clinics in Belgrade, Bozeman and West Yellowstone. Gallatin County is lucky to have the health resources that are available, however, rural communities unanimously said that transportation was an issue, especially when it comes to accessing health services. With oil prices not likely to drop in the future, a larger percentage of income goes toward filling gas tanks. Transportation costs most significantly impact residents who are living below 200% of the Federal Poverty level.

Mental health is a significant issue in Gallatin County. According to the data collected, 8.7% of adults in Gallatin County have been diagnosed with major depression, compared with 11.7% of the United States. However, the suicide rate in Gallatin County is 17.3 per 100,000 compared to the national rate of 10.8 per 100,000. These numbers tell us that we have a lower rate of diagnosed major depression, and a high rate of suicide. Throughout the state of Montana, there have been efforts to reduce the stigma around seeking mental health services. Both of these numbers may have something to do with stigma and/or access. Mental health access was an issue that was discussed in all communities during the Community Health Assessment. Gallatin Mental Health Center provides a wide-range of services, including sliding-fee services for those who qualify. Gallatin Mental Health Center is in the process of expanding these services.

The Census estimates that nearly 30.2% of Gallatin County residents live below 200% of the Federal Poverty Level, which is equal to slightly more than 25,000 residents. Those individuals and families living below 200% of the Federal Poverty Level are less likely to have health insurance and less likely to receive lifesaving preventive health screenings. Furthermore, the Spanish-speaking population of Gallatin County has been growing in recent years, and is now the largest minority in Gallatin County with 2.9% as of the 2010 census. The medical community has responded to this new demographic slowly. Exact figures differ, but there are few primary care providers who speak Spanish and even fewer mental health professionals who do so. There have been community efforts to reach out to the Latino community.

ASSETS AND RESOURCES:

1. Physical
   - » Transportation
     - i. Streamline
     - ii. Galavan
     - iii. West Yellowstone Bus
2. Psychosocial and Health literacy
   - » Health literacy program at Bozeman School district
   - » MSU
     - i. College of Nursing
     - ii. Community Health Program
     - iii. Community Health workers
     - iv. Latino Immigrants services
   - » Bridgercare & Community Health Partners offers health education resources at a 4th/5th grade reading level
   - » National Alliance for Mental Illness
3. Availability of services
   - » Open access
     - i. Community Care Connect Bus
     - ii. Bridgercare
     - iii. Gallatin Mental Health Center
     - iv. Community Health Partners
   - » Western Montana Mental Health Center provides counseling services in Bozeman, West Yellowstone, Belgrade, Three Forks
   - » Community Health Partners and Bozeman Deaconess Health Group have implemented the Medical home model which requires a focus on internal medicine, forms medical pods to ensure clients receive service

PRIORITY 1: ACCESS

GOAL: IMPROVE ACCESS TO HEALTH SERVICES FOR THOSE LIVING BELOW 200% OF THE FEDERAL POVERTY LEVEL

OBJECTIVE 1

Expand HRDC transportation services (Galavan and Streamline) to encompass at least two trips per week to Three Forks and Manhattan by the end of 2013.

OUTCOME INDICATORS

- Number of communities served
- Number of days served
- Number of trips made
- Number of riders on Galavan and Streamline from Three Forks and Manhattan

STRATEGY	TACTIC	PERFORMANCE INDICATOR	TARGET DATE	OWNER
1.1 Determine feasibility and demand for expanded services	1.1.1 Survey residents of Three Forks and Manhattan to determine feasibility and demand for transportation services	Number of residents of Three Forks and Manhattan who completed the survey	7/31/2013	Human Resource Development Council- Lee Hazelbaker
1.2 Explore funding to offset costs of transportation route	1.2.1 Compile data to present to governing bodies of Three Forks, Manhattan, County Commission, and MSU to include the number of potential users (from GMHC, CHP, BridgerCare, and local businesses) and transportation information from Community Health Assessment	Number of outreach presentations given to governing bodies of Three Forks & Manhattan, County Commission and MSU	End of 2013	
	1.2.2 Investigate funding options to offset costs through MSU, state and county governments, local communities	Identification of feasible funding options		
	1.2.3 Explore Unified Transit District a policy and funding option and work on County Commissioners to place it on a ballot	Unified Transit District item on county ballot	11/1/2013	
	1.2.4 Include Three Forks and Manhattan in Streamline's five year transportation plan	Three Forks and Manhattan included in plan	1/1/2013	

ALIGNMENT

Streamline 5-year strategic plan

RECOMMENDED POLICY CHANGES

Expand Unified Transit District to increase funding for transportation services

GOAL: IMPROVE ACCESS TO HEALTH SERVICES FOR THOSE LIVING BELOW 200% OF THE FEDERAL POVERTY LEVEL

OBJECTIVE 2

Increase the number of people below 200% of the federal poverty level accessing mental health services from Gallatin Mental Health Center (GMHC) and Community Health Partners (CHP) by 10% by the end of 2014 (this would mean 503 active clients at GMHC on December 1, 2014 and 662 accessing services at CHP during the year 2014)

OUTCOME INDICATORS

- Number of people below 200% of FPL who are accessing mental health services from Gallatin Mental Health Center

Baseline: As of December 1, 2012, Gallatin Mental Health Center had 457 currently active clients below 200% of FPL. This number does not include those accessing sliding fee services or those accessing drop-in center or Hope House services.

- Number of people below 200% of FPL accessing mental health services from CHP

Baseline: In 2011 CHP provided mental health services to 601 clients below 200% of FPL

STRATEGY	TACTIC	PERFORMANCE INDICATOR	TARGET DATE	OWNER
2.1 Reduce Stigma of seeking mental health issues	2.1.1 Engage Gallatin County schools to measure willingness to begin or expand mental health programs	Number of schools interested and willing to begin or expand mental health programs	end of 2014	Gallatin City-County Health Department and Early Childhood Community Council (ECC)
	2.1.2 Coordinate delivery of mental health programs to willing schools	Number of people who participate in the programs	end of 2014	
	2.1.3 Expand use of Health Teacher program for mental and emotional health	Number of lessons used from mental and emotional health of Health Teacher Program	end of 2014	Bozeman Deaconess Health Services
2.2 Expand counseling services in outlying communities as demand for services increases	2.2.1 Monitor demand for mental health services	Number of provider-hours serving the communities of: -West Yellowstone -Three Forks -Manhattan -Belgrade	End of 2015	Gallatin Mental Health Center
2.3 Provide access to telemedicine to benefit individuals in outlying communities	2.3.1 Implement telemedicine for outpatient therapy to serve outlying communities by 2014*	Number of telemedicine sites	End of 2014	
2.4 Support coalition of health organizations working to pass Medicaid Expansion *	2.4.1 Create and distribute talking points to local legislators	Number of legislators who receive talking points	end of 2013	Health Dept.

*** PROMISING STRATEGY:** Telemedicine There is some evidence that telemedicine increases access to care and improves health outcomes. It can increase access to care for individuals with chronic conditions and those in rural and other traditionally underserved areas. It can also improve health outcomes for long-term chronic conditions and mental illness.- County Health Rankings and Roadmaps

*** EVIDENCE BASED:** Mental Health Benefits legislation is "scientifically supported" by the County Health Rankings and Roadmaps. "There is strong evidence that mental health benefits legislation that include parity requirements improve access to mental health care."

ALIGNMENT

"Positive mental and emotional well-being depends on… the ability to access appropriate mental health services when needed." - Mental and Emotional Wellbeing, recommendation from National Prevention Strategy

Health Teacher lessons are aligned with National Health Education Standards

PRIORITY 1: ACCESS

GOAL: IMPROVE ACCESS TO HEALTH SERVICES FOR THOSE LIVING BELOW 200% OF THE FEDERAL POVERTY LEVEL

OBJECTIVE 3

By 2015, the proportion of people living below 200% FPL who are accessing the following preventive services will increase by the following:

OUTCOME INDICATORS:	ALL GALLATIN COUNTY RESIDENTS		
GALLATIN COUNTY	ALL INCOMES 2011	2015 TARGET	<200% FPL 2011
% Blood Pressure Checked in the Past 2 Years	87.3%	89.3%-92.3%	80.5%
% Cholesterol Checked in the Past 5 Years	80.2%	82.2%-85.2%	89.1%
% [Women 50-74] Mammogram in the Past 2 Years	74.3%	76.3%-79.3%	32.3%
% [Women 21-65] Pap smear in the Past 3 Years	89.8%	91.8%-94.8%	87.1%
% [Age 50-75] Colorectal Cancer Screening	61.8%	63.8%-66.8%	58.8%

NOTE ON TARGET: *The targets are a range calculated by a 2-5% increase of all Gallatin County residents. A range was chosen, because of the +/- 5% random sampling statistical error of the 2011 survey. The strategies and tactics target residents below 200% of the Federal Poverty level, because they are less likely to access many of the preventative screenings.*

STRATEGY	TACTIC	PERFORMANCE INDICATOR	TARGET DATE	OWNER
3.1 Improve the Local Public Health System's ability to deliver recommended preventive services to target population	3.1.1 Create and make available a master list of community-based preventive programs/services available serving the target population	Master list created	Dec. 2013	Gallatin City-County Health Dept. and Community Health Partners
	3.1.2 Educate systems navigators to identify community based preventive services and understand importance of screenings	Number of people served by community-based preventive programs	End of 2014	
	3.1.3 Explore new technology, including GIS Mapping, that would facilitate identifying underserved populations.	Number of new technologies identified	end of 2014	Health Dept.
	3.1.4 Inform/re-educate providers of legal responsibilities of providing services in languages and options for expanding languages offered	The number of providers offering language services, determined through pre and post surveys	end of 2014	MIJA and MT Legal Services
3.2 Increase target population's understanding of the benefits of preventive care and increase motivation to access preventive care while reducing cultural and health literacy barriers.	3.2.1 Identify community events that reach out to target population and seek ways to integrate recommended preventive care services.	Number of community events where populations were engaged	end of 2013	Health Dept. Bozeman Deaconess, and Community Health Partners
	3.2.2 Use the Promatoras program model to reach at risk/vulnerable populations*	Number of Promotores/as	end of 2014	
	3.2.3 Update and make available the list of human service organizations and contacts who provide services in Spanish	Number of referrals from Promotoros program	End of 2013	

*** SCIENTIFICALLY SUPPORTED:** Expand use of Community Health Workers (CHW)- " There is strong evidence that CHW interventions improve a variety of health outcomes and behaviors, and increase access to care. CHW models are a suggested strategy to promote healthy behaviors and connect underserved populations."- County Health Rankings & Roadmaps

ALIGNMENT

- "Increasing the use of preventive services depends on the health care system's ability to deliver appropriate preventive services as well as people's understanding of the benefits of preventive care and their motivation and ability to access services"
  - Clinical and Community Preventive Services, Recommendation from the National Prevention Strategy"
- Emphasizing primary and preventive care linked with community prevention services is an objective of the US Department of Health and Human Services Strategic Plan
- Emphasizing primary and preventive care linked with community prevention services is an objective of the US Department of Health and Human Services Strategic Plan

RECOMMENDED POLICY CHANGES

Advocate for medical provider policy changes to include language options

PARTNERS AND COMMUNITY MEMBERS WHO HAVE AGREED TO SUPPORT CHIP ACTION:

These organizations helped develop the Access workplan and are committed to the goals and strategies outlined above.

Board of Health
Bozeman Deaconess Health Services
Bozeman Job Services
BridgerCare
Community Health Partners
Gallatin City-County Health Department
Gallatin Mental Health Center
Montana State University Nursing Program
National Alliance for Mental Illness
Tobacco Use Prevention Program
West Yellowstone City Council

PRIORITY 2: COLLABORATION

STRATEGIC ISSUE 2: HOW DO WE INCREASE STRATEGIC COLLABORATION BETWEEN SERVICE PROVIDERS?

CURRENT SITUATION

As with the health care infrastructure in Gallatin County, many social and human service organizations are located in the city of Bozeman. These social and human service organizations provide numerous services to individuals throughout the county, which include, but are not limited to heating, childcare, and food assistance, pregnancy and early childhood education and nutrition, and family support. The Local Public Health System is comprised of organizations that have a stake in the health of the community. From city governments to schools, non-profits, faith institutions and emergency responders, this definition, applied broadly, encompasses a large number of organizations throughout the county. Many programs that used to be directly funded through the federal government have been cut, so people are relying on non-profits for services that used to be provided through the government.

Similarly, many communities said that they have a lack of knowledge about services that are available for them to utilize. When people are unaware that services are available within their communities, these services are unlikely to remain in the community.

The Local Public Health System assessment informed Healthy Gallatin that there is a lack of coordination between organizations that provided personal health and social services. With a move toward Medical Home Models and Electronic Health Records, coordination between organizations can be easier and part of organizational policy.

ASSETS AND RESOURCES:

- Small community
- Organizations that want to collaborate
- Knowledge of partners and potential partnerships
- Many organizations that provide healthcare assistance for low-income people
- Successful fundraisers
- Involved and generous community

GOAL: TO INCREASE AWARENESS AND USE OF HEALTH SERVICES AND RESOURCES THROUGH IMPROVED COMMUNICATION AND COORDINATION AMONG HUMAN SERVICE PROVIDERS.

OBJECTIVE 1

Create a network of systems navigators in major health and human service organizations throughout the county by the end of 2013.

OUTCOME INDICATORS

- Establishment of systems navigator network
- Development of a systems navigator workplan that identifies the priorities for the group
- Number of systems navigator referrals to WIC and Community Health Partners

** a systems navigator or resource coordinator is any individual in an organization who refers clients to existing community resources that would benefit the individual.*

STRATEGY	TACTIC	PERFORMANCE INDICATOR	TARGET DATE	OWNER
1.1 Identify systems navigators in major health and human service organizations*	1.1.1 Survey services providers to see if they have a systems navigator (Note: if many people within the organization act as a systems navigator, organizations are encouraged to designate one to attend meetings and report back) 1.1.2 Establish MOUs for participating agencies to formalize the network	• Number of organizations who have responded to the survey • Number of systems navigators identified • Number of organizations who have signed the MOU	Dec. 2013	Health Dept
1.2 Create regular meetings to educate systems navigators of the issues in each agency for connecting clients to additional services	1.2.1 Identify educational priorities to determine what would be most beneficial for system navigators through a survey of navigators and organizational leaders 1.2.2 Hold regular meetings that address the issues prioritized by the systems navigators 1.2.3 Survey systems navigators after initial meetings to determine the effectiveness of the trainings	• Number of systems navigator meetings • Completed surveys measuring effectiveness • Number of systems navigators who believe the meetings are helping them connect clients	end of 2014	Health Dept
1.3 Connect clients to services	1.3.1 Generate referral success stories from within Systems Navigator Network to promote more referrals	• Number of referrals made by participating systems navigators • Number of success stories	end of 2014	Health Dept but passed on to Systems Nav. Network
	1.3.2 Survey clients to determine if needs are being met	• Number of surveys completed by clients • Number of clients who say their needs are being met		

*** EVIDENCE BASED OR PROMISING STRATEGY:** Systems navigators and integration is a "scientifically supported" strategy from County Health Rankings and Roadmaps

RECOMMENDED POLICY CHANGES

Memorandums of Understanding for participating agencies to formalize systems navigator network

PRIORITY 2: COLLABORATION

GOAL: TO INCREASE AWARENESS AND USE OF HEALTH SERVICES AND RESOURCES THROUGH IMPROVED COMMUNICATION AND COORDINATION AMONG HUMAN SERVICE PROVIDERS.

OBJECTIVE 2

Increase the number of first trimester referrals from pre-natal care providers to the Health Department Home Visitation Program by 30% by 2015 (20 women referred by providers)

*** BASELINE:** Between December 2011 and November 2012 providers referred 15 women prenatally to the home visitation program

Note: Increasing referrals to the Home Visitation program is a pilot program, designed to understand and eliminate barriers to referrals to an evidence-based program which is already measured. Expanding provider referrals to other programs and services is a long-term goal.

OUTCOME INDICATORS

- Number of referrals
- Percent of referrals to home visiting program occurring before the first trimester
- Number of providers who refer

STRATEGY	TACTIC	PERFORMANCE INDICATOR	TARGET DATE	OWNER
2.1 Make the system easier for providers to refer to the health department's Public Health Home Visitation Program	2.1.1 Engage providers to determine barriers to timely referrals	Number of providers who have been engaged in process	End of 2014	Health Dept.
	2.1.2 Explore potential provider-based electronic systems solutions (e.g., EMR, EHR, etc.) that can facilitate referrals and potential integration into work flow. *			
2.2 Identify and engage champions within pre-natal care who make referrals	2.2.1 Identify one champion willing to endorse the Health Department Home Visitation program	Number of champions identified	Jun-13	Health Dept.
	2.2.2 Work with champion to develop outreach plan to other providers which may include success stories, education, and formal presentations	Creation of outreach workplan	end of 2013	
	2.2.3 Provide feedback to providers about the benefits the client receives due to their referral	Number of providers who have been engaged in process	end of 2014	

* Studies show better patient outcomes with electronic health records. HealthIT.gov recommends, "EHRs can improve the ability to diagnose diseases and reduce- even prevent-medical errors, improving patient outcomes."

ALIGNMENT

- " Clinical and community prevention efforts should be mutually reinforcing-- people should receive appropriate preventive care in clinical settings and also be supported by community-based resources. Clinicians can refer patients to community-based prevention resources such as programs for blood pressure and cholesterol control or home-based interventions to control asthma triggers." Clinical and Community Preventive Services, Recommendation National Prevention Strategy
- " Integrated health care describes a coordinated system in which health care professionals are educated about each other's work and collaborate with one another and with their patients to achieve optimal patient well-being. Implementing effective care coordination models (e.g., medical homes, community health teams, integrated workplace health protection and health promotion programs can result in delivery of better quality care and lower costs." - Clinical and Community Preventive Services, Recommendation from the National Prevention Strategy
- Promoting early entry into primary care, education, and coordinated services for pregnant women and infants is a part of the US Department of Health and Human Services Strategic Plan
- "By 2017, increase the percentage of women who reported entering prenatal care in the first trimester to 78% (HP2020 target)" - Montana State Health Improvement Plan outcome indicator

RECOMMENDED POLICY CHANGES Memorandums of Understanding for participating agencies to formalize systems navigator network

PARTNERS AND COMMUNITY MEMBERS WHO HAVE AGREED TO SUPPORT CHIP ACTION:

These organizations helped develop the Collaboration workplan and are committed to the goals and strategies outlined above.

Bozeman Deaconess Health Services
Bozeman Job Services
BridgerCare
Cancer Support Community
Child Care Connections
Community Health Partners
Early Childhood Community Council
Gallatin City-County Health Department
Gallatin County Planning and Development
Human Resource Development Council
Montana State University
Montana Tobacco Use Prevention Program
Three Rivers Health Clinic
Thrive

PRIORITY 3: HEALTHY BEHAVIORS

STRATEGIC ISSUE 3: HOW DO WE ENCOURAGE HEALTHY BEHAVIORS ACROSS THE LIFE SPAN?

CURRENT SITUATION

Risky behaviors have a significant impact on health. Alcohol use leads to impaired judgment, tobacco use can lead to cancer, and seatbelts have been proven effective as life-savers in the event of a motor vehicle accident. In Gallatin County, 9.5% of residents report using smokeless tobacco, significantly higher than the national average of 2.8%.

One fifth of Gallatin County Residents report binge drinking (5+ drinks in one sitting for men, 4+ drinks for women). This rate is higher than Montana binge drinking rates. Alcohol impairs judgment and excessive consumption can have many consequences, which can include (but is not limited to): injury, death, assault, sexual assault, unsafe sex, drunk driving and property damage.

Throughout the county, residents voiced concern for the children and adolescents living in their communities. While it could be said that the, 'there's nothing to do/I'm bored' argument posed by adolescents is heard everywhere you go, many communities spoke of a lack of healthy and affordable opportunities for youth and adolescents. This was especially true for youth whose parents cannot afford, either monetarily or temporally, to have their children participate in activities that may be enjoyed by others. Communities are concerned that this lack of activities may have an effect on the decision to experiment with alcohol, tobacco and other drugs.

ASSETS AND RESOURCES:

Numerous formal and informal organizations are addressing issues related to alcohol, tobacco, and other drugs. The following organizations are just some of the most prominent organizations:

- Alcohol & Drug Services of Gallatin County
- Belgrade Youth forum
- Bozeman Deaconess Health Services
- Clean Indoor Air Act
- Community Health Partners
- Environment (opportunities)
- Faith community
- Family Promise
- Food Bank
- Gallatin City-County Health Dept.
- Gallatin Valley Farm to school
- Gallatin Valley Land Trust
- Gallatin Valley YMCA
- Health care providers
- Human Resource Development Council (HRDC)
- Law enforcement (SRO/DARE officer)
- Montana Tobacco Use Prevention Program
- Senior center
- Team Nutrition
- Thrive
- Many non-profits
- Mental health center
- MSU Extension Service
- WIC
- United Way KidsLINK program
- 4-H Club

PRIORITY 3: HEALTHY BEHAVIORS

GOAL: DECREASE SUBSTANCE ABUSE ACROSS THE LIFESPAN IN GALLATIN COUNTY

OBJECTIVE 1
Convene alcohol, tobacco, and drug prevention stakeholders to create a county-wide strategy to address alcohol, tobacco and other drugs by the end of 2014.

OUTCOME INDICATORS	
• Existence of group with true collaborative agreement	• Number of organizations represented in group
• Number of people and organizations represented in group	• Creation of county wide strategy with buy in

STRATEGY	TACTIC	PERFORMANCE INDICATOR	TARGET DATE	OWNER
1.1 Convene formal and informal groups to form a unified coalition that aligns goals and strategies and ensures consistent messaging*	1.1.1 Research effective models of Prevention coalitions and determine a model that would be most beneficial and sustainable in Gallatin County	• Number of models researched • Identification of the most beneficial model	end of 2013	Becky Franks, YMCA
	1.1.2 Identify partners and assets from across the county who are already involved, or may have vested interest in the coalition	• Number of partners identified		YMCA & School Districts- Laura St. John, Connie Bengtson
	1.1.3 Ensure that youth and concerned community members are included in the coalition	• Number of youth involved		
1.2 Integrate goals of organizations in county-wide strategy	1.2.1 Convene partnership to identify what is already going on and identify priorities	• A list of current ATOD prevention strategies being done by partners that are best practice, proven effective and fit into the county-wide strategy • Number of coalition PSAs created • Number of other projects completed with the coalition • Number of resources analyzed	6/1/2014	Becky Franks, YMCA
	1.2.2 Support initiatives already occurring, that fit into the best practice strategy.			
1.3 Identify available financial resources and analyze and ensure effectiveness	1.3.1 Create an asset map of available resources		end of 2013	Becky Franks

*** PROMISING PRACTICE:** Community-based process- The Center for Substance Abuse Prevention recommends community partnerships to elicit change both at the systems level and at the individual behavior level. "Multi-agency activities can increase coordination of efforts between public and private agencies, and between law enforcement and service providers.

ALIGNMENT	
"Effective public participation can help ensure that health equity and sustainability are considered in decision making. Community coalitions can be effective in raising awareness and attention to a broad range of issues (e.g., alcohol and other substance abuse, teen pregnancy) and implementing effective policies and programs" - Empowered People,	recommendation from National Prevention Strategy The Montana State Health Improvement Plan will be addressing chronic disease through policies and prevention and health promotion efforts.

PARTNERS AND COMMUNITY MEMBERS WHO HAVE AGREED TO SUPPORT CHIP ACTION:

These organizations helped develop the Healthy Behaviors workplan and are committed to the goals and strategies outlined above.

Alcohol and Drug Services
Belgrade School District
Bozeman Deaconess Health Services
Bozeman School District
Child Care Connections
Gallatin City-County Health Department
Gallatin Valley Farm to School
Gallatin Valley Food Bank
Gallatin Valley YMCA
Greater Gallatin United Way
Health Matters
HOPA Mountain
Local prevention specialists
Montana Office of Rural Health
Montana's Peer Network
MSU Nutrition and Physical Activity Program
Tobacco Use Prevention Program