St. James Healthcare

Community Health Improvement Implementation Plan

2014-2016

Sponsored by St. James Healthcare
In Cooperation With
Butte Silver Bow Health Department and Southwest Montana Community Health Center

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Acronyms and Abbreviations

Following is a list of acronyms and abbreviations that are used throughout the document.

BSB – Butte Silver Bow

CDC – Centers for Disease Control and Prevention

CHC – Southwest Montana Community Health Center

CHNA – Community Health Needs Assessment

PSA – Primary Service Area

PRC – Professional Research Consultants, Inc.

2014 Community Health Needs Assessment

In the spring of 2014, St. James Healthcare embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our community.

About St. James Healthcare

St. James Healthcare, based in Butte, Montana, is an acute care, not-for-profit, 98-bed hospital serving Butte-Silver Bow and six other counties in southwest Montana (Deer Lodge, Powell, Madison, Granite, Jefferson, and Beaverhead counties). Accredited by The Joint Commission, St. James Healthcare has 565 employees and a 65-member medical staff.

St. James Healthcare's mission is to improve the health of the people and communities we serve, especially the poor and vulnerable. To accomplish that mission, we provide access to more than 30 services, including, but not limited to: cancer care (both medical and radiation oncology), emergency services department which is ACS-accredited for Level III trauma services, cardiovascular services, radiology services, laboratory services, orthopedics, physical, occupational, speech and wound therapy, family medicine, internal medicine, pediatric medicine, surgical services, urology, and women's and children's services.

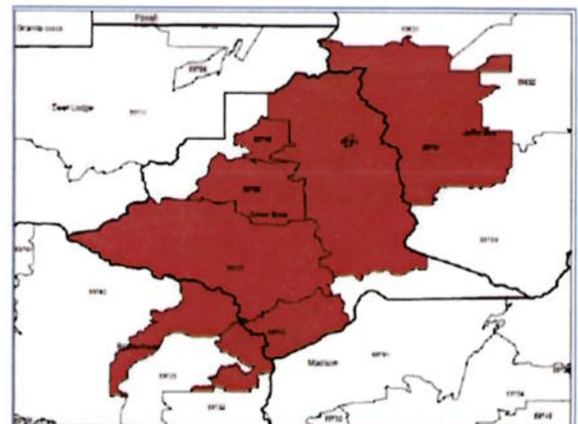
St. James Healthcare works closely with community partners to ensure it is serving the entire community, not only those who come through its doors. Building on a long tradition of service, St. James Healthcare utilizes hospital strengths alongside those of other well-established community partners. This strategy allows St. James Healthcare to better understand and reach the most vulnerable sectors of the community, while meeting pressing healthcare needs. The goal is to improve the community's health status by empowering citizens to make healthy life choices.

St. James Healthcare completed its last Community Health Needs Assessment in 2014.

Definition of the Community Served

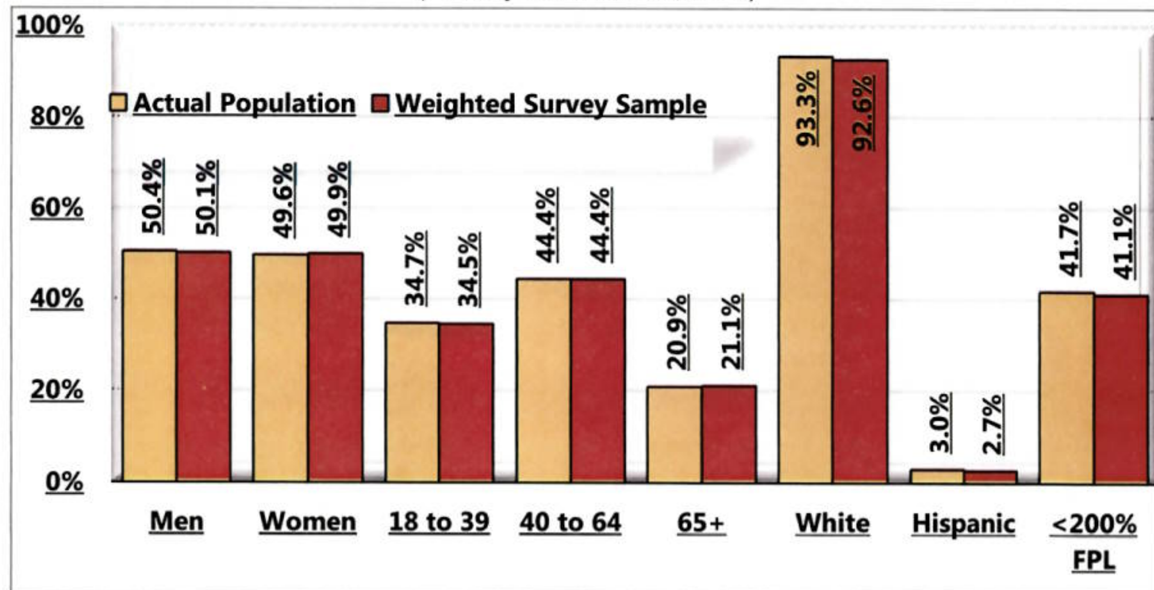
St. James Healthcare's community, as defined for the purposes of the Community Health Needs Assessment, included each of the residential Zip Codes that comprise the hospital's Primary Service Area (PSA), including: 59701, 59702, 59703, 59727, 59748 and 59750. A geographic description is illustrated in the following map.

This community definition was determined based on the zip codes of residence of recent patients of St. James Healthcare.



Demographics of the Community

The population of the hospital's service area is estimated at 34,000 people. It is predominantly White (93.3%) with 3.0% Hispanic. The population is made up of 50.4 percent men and 49.6% women. Approximately 41.7 percent of the population has an income level that falls below 200 percent of the federal poverty level.



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this CHNA.

Organizations and Facilities	Organizations and Facilities
A Plus Home Health Care	Department of Family Services
AA, NA, Al-Anon	Domestic Violence Hotline
Acadia Montana	DUI and Drug Courts
Adult Protective Services	Easter Seals- Highlands Hospice
Butte-Silver Bow Drug Task Force	Family Outreach
Butte-Silver Bow Parks and Recreation	Family Planning Clinic
Chamber of Commerce	Fit Kids Program
Chantix Hotline	Food Bank, Food Stamps
Children's Mental Health Committee	Assisted Living Centers
Chiropractors	Hayes Morris House
Churches	Head Start
City Parks	Health Clubs and Organized Sports Teams
Community, Counseling, and Correctional Services, Inc.(CCCS)	Healthy Montana Kids
Connections Corrections Program	Highland Hearing Center
Counselors	Law Enforcement
Crisis Line	Lewistown State Hospital
DARE	Life Management Associates LLC

Organizations and Facilities (continued)	Organizations and Facilities (continued)
Local Dentists and Eye Doctors	SMART Program
Local Counselors —Community and Schools	Southwest Montana Community Health Center — Dental Clinic, Nutritionist,
Local Pediatricians and Family Physicians	Suicide Prevention Community Committee
Local Pharmacies and State Prescription Registries	Southwest Montana Mental Health Services
Local School Districts	St. James Cancer Center
Local School-based Programs	St. James Emergency Department
Local Social Workers	St. James Healthcare
Local State Legislators	St. James Healthcare Foundation
Local Support Groups	St. James Healthcare Pain Center
Montana Chemical Dependency Center (MCDC)	St. Pete's Behavioral Health
Montana Department of Health and Human Services	Victims/Witness Advocate Program
Montana Independent Living	Walking/Biking Parks and Trail
Montana Mental Health Services	WATCH Program
Montana Quit Line	Western Montana Mental Health Center (WMMHC)
Montana State Hospital	WIC program
Montana Tech	YMCA
North American Indian Alliance	Youth Dynamics
Public Housing Education Programs	
REACT Group at Butte High	
Rocky Mountain Clinic	
Safe Space	
Salvation Army	
Shodair Children's Hospital	
Silver Bow Developmental Disabilities Council, Inc.	
Silver House	

How CHNA Data Were Obtained

Collaboration

The CHNA was sponsored by St. James Healthcare in collaboration with community partners, Butte-Silver Bow Health Department (BSB Health Department) and Southwest Montana Community Health Center (CHC). While St. James provided a significant portion of the funding, BSHD and CHC provided a share of funding and in-kind services.

CHNA Goals and Objectives

This CHNA is a systematic, data-driven approach to determining the health status, behaviors and needs and residents in the service area of St. James Healthcare in Butte, Montana. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A CHNA provides information so communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. It serves as a tool toward reaching these three basic goals:

1. **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little

from physical and mental illness, but also one where its residents enjoy a high quality of life.

2. **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.

3. **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted by PRC on behalf of St. James Healthcare, in cooperation with the BSB Health Department and Southwest Montana Community Health Center (CHC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

CHNA Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) which allows for comparison to benchmark data at the state and national levels.

Qualitative data input includes primary research gathered through an Online Key Informant Survey.

Community Health Survey

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by St. James Healthcare, BSB Health Department, CHC, and PRC.

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 400 individuals age 18 and older in the Primary Service Area (PSA). Once the interviews were completed, these were weighted in proportion to the actual population distribution to appropriately represent the Primary Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted PRC.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Community Stakeholder Input

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was implemented as part of this process. A list of recommended participates was provided by St. James Healthcare; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Participants included 59 key informants in the region.

Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. Participants included a representative of public health, as well as several individuals who work with low-income, minority populations (including Hispanic, African American, Native American, Middle Eastern), or other medically underserved populations (including those who are elderly, young, disabled, LGBT, veterans, uninsured/underinsured, Medicaid/Medicare, mentally ill, and/or homeless). Specific names/titles of those participating are available upon request.

Information Gaps

While this Community Health Needs Assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups, such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish, are not represented in the survey data. Other population groups, for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups. These might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In addition, this assessment does not include secondary data from existing sources which can provide relevant data collected through death certificates, birth certificates, or notifications of infectious disease cases in the community.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Vulnerable Populations

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs for our population. A distinct advantage of the primary quantitative (survey) research is the ability to segment findings by geographic, demographic and health characteristics to identify the primary and chronic disease needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, and racial/ethnic minority groups.

For additional statistics about uninsured, low-income, and minority health needs. Please refer to the complete PRC Community Health Needs Assessment report, which can be viewed online at: https://www.stjameshealthcare.org/~/media/stjames/stjamesfiles/2014chnabuttesilverbow031015.pdf .

Public Dissemination

This Community Health Needs Assessment is available to the public using the following URL: https://www.stjameshealthcare.org/~/media/stjames/stjamesfiles/2014chnabuttesilverbow031015.pdf .

St. James Healthcare will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. St. James Healthcare will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.

Health Needs of the Community

Prioritized Health Needs

Following are the "areas of opportunity" that represent the significant health needs of the community, based on the information gathered through this CHNA and the guidelines set forth in *Healthy People 2020.*

Areas of Opportunity Identified Through this Assessment		
1	**Access to Health Services**	• Routine Medical Checkups for Children • Ratings of Local Healthcare Services
2	**Cancer**	• Cancer Screenings: o Mammography o Pap Smear Testing o Colorectal Cancer Screening
3	**Disability and Conditions of Aging**	• "Fair/Poor" Physical Health • Activity Limitations • Arthritis/Rheumatism (Age 50+) • Sciatica/Chronic Back Pain • Deafness/Trouble Hearing
4	**Diabetes**	• Borderline/Pre-Diabetes o Education and Prevention o Diet and Exercise o Access to Care
5	**Heart Disease and Stroke**	• Hypertension • High Blood Cholesterol • Cardiovascular Risk Factors
6	**Injury and Violence Prevention**	• Use of Seatbelts • Firearms in the home (including homes with children)
7	**Mental Health and Mental Disorders**	• Inadequate Resources • Access to Care • Stigma • Dual Diagnosis • Housing and Homelessness
8	**Nutrition, Physical Activity, and Weight**	• Difficulty buying fresh produce • Overweight and Obesity o Lifestyle choices o Cost-Related Issues o Built Environment and Weather o Culture/Tradition o Education Awareness
9	**Respiratory Diseases**	• Chronic Obstructive Pulmonary Disease (COPD) Prevalence
10	**Tobacco Use**	• Current Smokers • Use of Smokeless Tobacco o High prevalence of Tobacco use o Youth o Addiction o Culture/Tradition
11	**Substance Abuse**	• High prevalence of Substance Abuse • Culture/Tradition • Inadequate Resources/Access • Barriers to Treatment: stigma, denial, education, awareness, motivation • At-Risk Groups: youth, low income, residents, mentally ill

On October 23, 2014, approximately 40 representatives of various community organizations met to evaluate, discuss and prioritize health issues for the community, based on findings of the 2014 CHNA. PRC began the meeting with a presentation of key findings from the CHNA, highlighting the significant

health issues identified from the research (see Areas of Opportunity above).

Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. Representatives of St. James Healthcare, BSB Health Department and CHC also provided guidance to the group, describing existing activities, initiatives, resources, etc., relating to the Areas of Opportunity. Finally, participants were provided an overview of the prioritization exercise that followed.

To assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- Scope & Severity — The first rating was to gauge the magnitude of the problem in consideration of the following:
    - How many people are affected?
    - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
    - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- Ability to Impact — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criterion were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

Priority	Health Issue	Scope & Severity Score	Ability to Impact Score	Average Score
1	Mental Health	8.73	6.73	**7.73**
2	Nutrition, Physical Activity, and Weight	7.39	7.37	**7.38**
3	Substance Abuse	8.29	6.34	**7.32**
4	Injury and Violence	7.29	6.66	**6.98**
5	Diabetes	6.88	7.02	**6.95**
6	Access to Healthcare services	6.69	6.83	**6.76**
7	Heart disease and stroke	6.85	6.53	**6.69**
8	Disability and conditions of aging	7.31	5.95	**6.63**
9	Tobacco Use	6.68	6.10	**6.39**
10	Cancer	6.10	5.44	**5.77**
11	Respiratory Diseases	5.95	5.23	**5.59**

Community representatives were asked to indicate whether they were interested in being a member of the Action Group for any of these areas of opportunity. In a separate session, the Steering Committee (St. James Healthcare, BSB Health Department and CHC) selected the top two from this group (Mental Health and Nutrition, Physical Activity and Weight), and for its third item, selected Tobacco Use, which was rated Number 3 in the telephone surveys.

Community representatives who indicated they would be interested in serving on the Action Group for these three areas were contacted and the teams were formed to work on the strategies, objectives and tactics for this Community Health Improvement Implementation Plan.

Community-Wide Community Benefit Planning

As individual organizations begin to parse out the information from the 2014 CHNA, it is St. James Healthcare's hope and intention that this will foster greater desire to embark on a community-wide community health improvement planning process. St. James Healthcare has expressed this intention to partnering organizations and is committed to being a productive member in this process as it evolves.

St. James Community Health Improvement Implementation Plan for FY2014-FY2016

The following outlines St. James Healthcare's plan (Implementation Plan) to address our community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and 3) promoting an understanding of these health needs among other community organizations and within the public itself.

Priority Health Issues To Be Addressed

In consideration of the top health priorities identified through the CHNA process, and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities, it was determined that St. James Healthcare would focus on developing and/or supporting strategies and initiatives to improve:

- **Mental Health & Mental Disorders**
- **Nutrition, Physical Activity & Weight Status**
- **Tobacco Use**

Priority Health Issues That Will Not Be Addressed

In acknowledging the wide range of priority health issues that emerged from the CHNA process, St. James Healthcare determined it could only effectively focus on those items it deemed most pressing, most under-addressed, and most within its ability to influence. Following are the items that will not be addressed along with a brief explanation on each.

Substance Abuse: St. James Healthcare has limited resources, services and expertise available to address alcohol and other drug issues. Other community organizations have infrastructure and programs in place to better meet this need. Limited resources and expertise excluded this as an area chosen for action.

Access to Health Services: St. James Healthcare felt that more pressing health needs exist in the Butte-Silver Bow community. St. James Healthcare has been able to fill gaps in regard to the number and types of healthcare providers available in the community to ensure a significant number of services are readily available in the community. In addition, through its Foundation, it also provides city bus passes to clinic social workers for patients who do not have transportation to get to appointments. Based on these and other community programs, this area had a lower priority and was excluded as an area chosen for action.

Cancer: St. James Healthcare believes existing programs within the community are having a positive impact on early detection of cancers and that a separate set of cancer-specific initiatives was not necessary.

Heart Disease and Stroke: St. James Healthcare believes more pressing health needs exist in the community; however, this item will be impacted indirectly by the Tobacco Use Action Plan outlined later in this document.

Injury & Violence Prevention: St. James Healthcare believes that this priority area falls more within the purview of BSB Law Enforcement Department as well as other community organizations. Limited resources and lower priority excluded this as an area chosen for action.

Disability and Conditions of Aging: St. James Healthcare believes that more pressing health needs exist. Limited resources and lower priority excluded this as an area chosen for action.

Diabetes: St. James Healthcare believes that existing programs offered at St. James Healthcare and throughout the community have been and will continue to address diabetes in the community and more pressing health needs exist in the Butte-Silver Bow community. Additionally, this item will be impacted indirectly by the action plans outlined later in this document.

Respiratory Diseases: St. James Healthcare believes that more pressing health needs exist in the BSB community. Additionally, this item will be impacted indirectly by the Tobacco Use Action Plan outlined later in this document.

Implementation Strategy and Action Plans

The following pages outline St. James Healthcare's plans to address those priority health issues chosen for action in the FY2014-FY2017 period.

Tobacco Use Action Plan

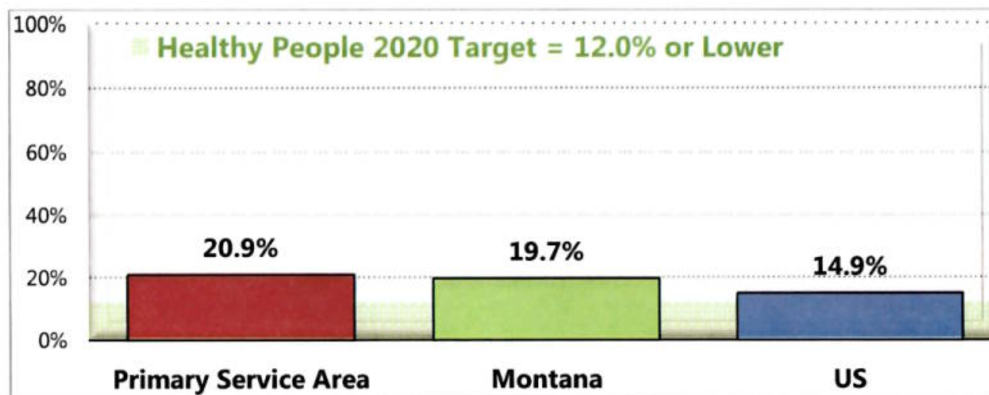
Overview

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 American die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco-related illness such as cancer, heart disease, and respiratory disease.

A total of 20.9% of adults in our PSA currently smoke which is above the average for Montana and the U.S. as shown in the following graph.

Current Smokers

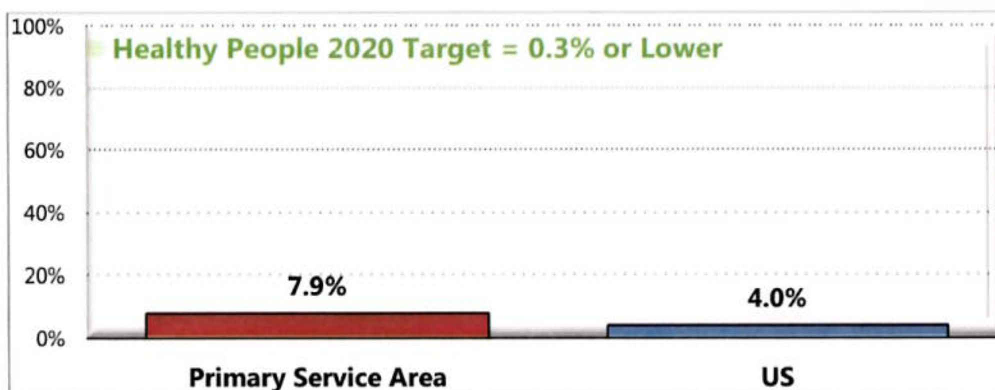
(Primary Service Area -- 2014)



Of that percentage, 17.9% smoke in the home when children are present. This compares to 9.7% in the U.S. Another 7.9% use some type of smokeless tobacco compared to the national average of 4.0%. As shown in the following graph, the Healthy People 2020 target is 0.3% or lower.

Use of Smokeless Tobacco

(Primary Service Area, 2014)



Our goal for this area of opportunity is to reduce the number of adolescents and adults from ages 18 to 35 who use tobacco by providing them with more information and encouraging them to try the Montana Quit Line.

Action Group Members

The Action Group for Tobacco Use included representatives from the following agencies/organizations:

- BSB Tobacco Prevention Department
- SW Montana Community Health Center
- BSB Health Department
- Butte Cares
- Montana Orthopedics
- St. James Healthcare

Goals for This Action Plan

1. Reduce the percentage of smokers in Butte Silver Bow by 2017 from 20.9% to less than 18% and reduce the percentage of smokeless tobacco users from 7.9% to 5%.

2. Reduce the number of adolescents who start using tobacco.

Strategies, Objectives and Tactics

1. **Continue to educate all patients admitted to St. James Healthcare who smoke or use tobacco products.**

   The main objective of this strategy is to renew emphasis on the health risks associated with tobacco use and provide assistance to quit tobacco. The primary audience is patients admitted to St. James Healthcare.

   The tactics are to:

   - Provide each patient with St. James tobacco cessation materials, continue to educate patients and refer them to the Montana Quit Line for help to give up tobacco products.

   - Expand the program to include all our ambulatory areas and clinics.

2. **Develop a community ambassadors' network to spread the message to give up tobacco.**

   The main objective of this strategy is to renew emphasis on the health risks associated with tobacco use and provide assistance to quit tobacco. Primary audience is adolescents and people between the ages of 18 and 35.

   The tactics are as follows:

   - Using St. James tobacco cessation materials as a guide develop simplified and easy-to-read tobacco cessation handouts with the phone number for the Montana Quit Line.

   - Recruit ambassadors to include physicians, military recruiters, high school coaches and counselors, Big Brothers and Big Sisters volunteers, and other well-respected members of the community who interact with youth and young adults.

- In a classroom setting or one-on-one, train the ambassadors on using the materials.
- Encourage the ambassadors to reach out to 10 or more people each month.
- Conduct semi-annual meeting with ambassadors to get their feedback and input for any changes that could be helpful in reaching the target population.

Plan to Evaluate Impact

To evaluate the impact of these tactics, the Action Group will obtain baseline data (number of referrals from each quarter in 2014) from the Montana Quit Line, and using quarterly data from 2015, compare with Montana Quit Line data for same quarters of 2015 and 2016 to validate that the referral numbers are increasing.

Mental Health and Mental Disorders Action Plan

Overview

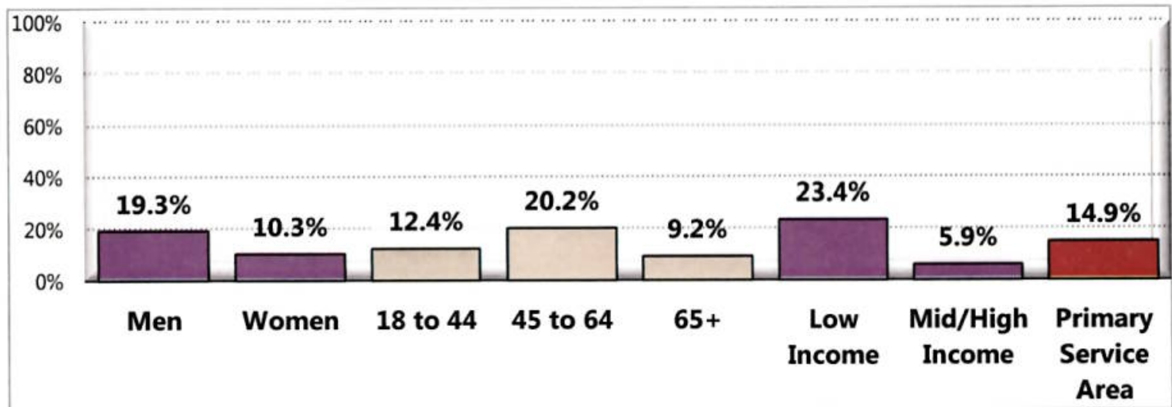
Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders.

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. According to the national Institute of Mental Health (NIMH), in any given year, an estimated 13 million American adults (approximately 1 in 17) have a seriously debilitating mental illness. Mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25% of all years of life lost to disability and premature mortality. Moreover, suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

Mental health issues in Butte Silver Bow are significant and numerous programs are currently in place to help the mentally ill. In our Primary Service Area 14.9% of adults experience fair to poor mental health compared to 11.9% nationally. The breakdown is shown in the following graph.

Experience "Fair" or "Poor" Mental Health
(Primary Service Area, 2014)



Our goal is to improve mental health in the community through earlier diagnosis and to ensure referrals are completed.

Action Group Members

The Action Group for Mental Health included representatives from the following agencies/organizations:
Acadia Montana

- SW Montana Community Health Department
- Western Montana Mental Health
- Butte-Silver Bow School District
- Montana Soars Program
- Montana Tech
- Butte Cares
- Frontier Hospice
- 4 C's
- St. James Healthcare

Goals for This Action Plan

1. Reduce the number of persons who report Fair or Poor Mental Health from 14.9% to 12%.

2. By 2017, 50% of mental health agencies and providers in Butte Silver Bow County will be using the NOBLE referral system.

Strategies, Objectives and Tactics

1. **Engage Primary Care Providers to Help Identify and Manage Mental Health Issues in their Patients**

   The main objective of this strategy is to ensure that all providers (especially Primary Care providers) have access to education and tools that will help them identify and manage patients with mental health issues.

   The tactics are to:

   - Offer a course (possibly with CMEs) to all providers that will help them learn how to recognize

depression in their patients.

- Incorporate standard Patient Health Questionnaire (PHQ-2) questions in new patient health information forms and PHQ-9 questions into the medical record for each patient, and continue to work toward adding the questions to the EMR on the ambulatory side. An affirmative response to either of the two questions in the PHQ-2 may indicate mental health issues. Additional questions in the PHQ-9 would then be asked.

- Expand current list into a comprehensive list of all mental health services/therapists available in the county for providers to give to patients based on the outcome of the PHQ questions. (This step will be replaced by the NOBLE System when it is available late in 2016).

2. **Implement the NOBLE Referral System in All Agencies Throughout the County**

   The main objective of this strategy is to have a county-wide system used by all agencies so that patients referred for mental health services can be easily followed from agency to agency. This will ensure that all referrals get completed; if the referral is not completed, the patient is flagged in the system to alert the referring provider. The system should be up by November 2016. Montana Soars High School program has a grant to pay for the initial system installation and also a coordinator to get it set up and train providers.

   The tactics are to:

   - Install the NOBLE System by end of 2016 – Montana Soars
   - Provide training for all agencies – Montana Soars
   - Activate the NOBLE System -- St. James Healthcare and Medical Group social workers and providers will use the system to track all mental health referrals.

3. **Participate in the New Mental Health Advisory Council (formed by Butte-Silver Bow and Support Other Community Programs**

   The main objective of this strategy is to have a group with a bigger voice regarding mental health issues facing the county that can make recommendations on how best to deal with these issues. This advisory council was formalized in November 2015. It consists of members from all the pertinent agencies and healthcare facilities including St. James Healthcare as well as a number of members who have been clinically diagnosed with mental health issues.

   Another objective is to continue to provide support to existing programs and groups such as the Montana Soars program (for teens) and the Suicide Prevention Committee.

Plan to Evaluate Impact

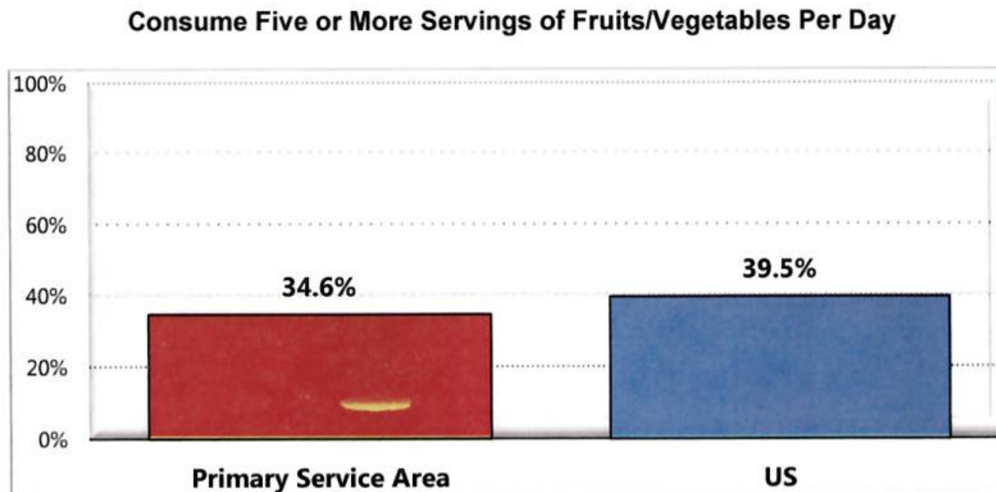
To evaluate these tactics, baseline data from existing mental health facilities will be obtained for 2015 and compared throughout 2016 to determine whether the number of referrals from providers has increased. That comparison will also occur when the NOBLE system is activated.

Nutrition, Physical Activity & Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities. The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

As shown in the graph, in the Primary Service Area, only 34.6% of adults consume five or more servings of fruits/vegetables per day compared to 39.5% nationally.

Consume Five or More Servings of Fruits/Vegetables Per Day



Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

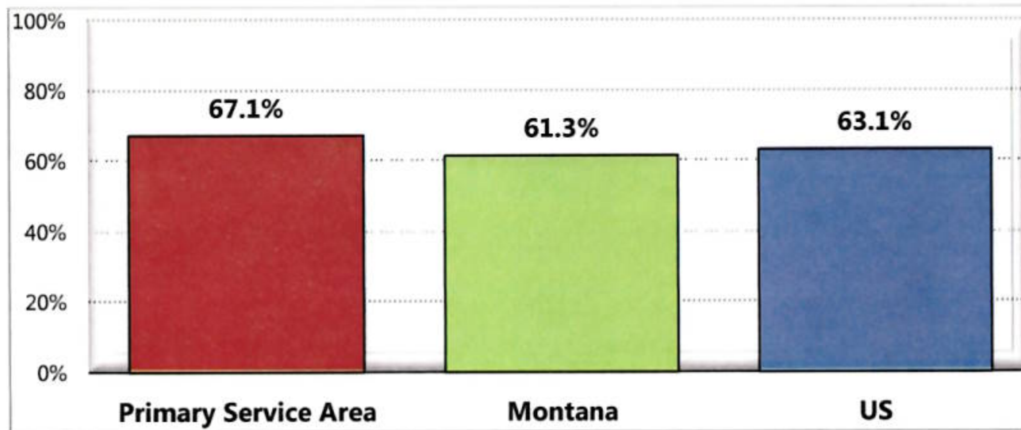
Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors positively associated with adult physical activity include postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

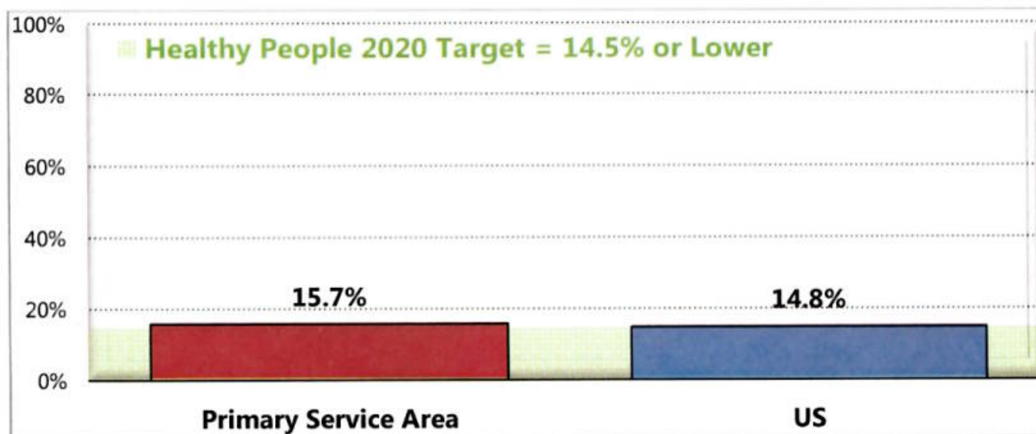
Factors negatively associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Both nutrition and physical activity have an impact on body weight. In the Primary Service Area, 27.4%

of adults performed moderate physical activity compared to 30.6% nationally, but only 31.6% had a healthy body weight compared to 37.5% for the state, and 67.1% had a Body Mass Index of 25.0 or higher as shown in the following graph.



The percentage of children, ages 5 to 17, which are considered obese is 15.7% in the Primary Service Area compared to 14.8% nationally and a Healthy People 2020 target of 14.5% or lower.



Our goal for is to reduce the number of health-related issues for both children and adults caused by poor nutrition, low levels of physical activity, or excess weight.

Action Group Members

The Action Group for Nutrition, Physical Activity and Weight included representatives from the following agencies/organizations:

- Fit Kids Program Team
- Butte School District
- Butte Silver Bow Health Department

- Butte Silver Bow Planning Department
- SW Montana Community Health Center
- Belmont Senior Center
- St. James Healthcare

Goals for This Action Plan

1. Reduce the number of obese children in the community to 14.5%.

2. Enhance the overall wellness of the community and reduce the number of overweight adults from 67.1% to 65%.

3. Increase awareness of programs and activities available for both children and adults.

Strategies, Objectives and Tactics

1. **Continue FitKids360 program and Cross Country Ski Program**

   The primary objective of this strategy is to provide a program for overweight children and their families to teach them the importance of eating right and exercising. A secondary objective is to get children involved in physical activity.

   The tactics are to:

   - Continue to offer FitKids360, a 7-week St. James Healthcare-sponsored program for provider-referred children up to the age of 18 and their families twice a year.

   - Continue to work with community partners to offer a cross country ski day for 3-grade students.

2. **Develop a process to provide information to parents about programs and activities available in Butte to keep their children active.**

   The main objective of this strategy is to keep children active by ensuring their parents are aware of all the opportunities available for school age children to keep them active.

   The tactics are to:

   - Establish a community-wide committee, made up of leaders from organized activities within the community that will work together to produce a regularly scheduled (quarterly or bi-yearly) calendar of events and information on organizations, activities, etc., for children to be distributed to school children during the school year.

   - Establish a scholarship program to give low-income children an opportunity to participate in camps and other activities that may be out of reach to them because of costs or lack of appropriate gear or apparel.

3. **Support the BSB Chronic Disease Management Program**

   The primary objective of this strategy is to provide educational programs for adults on all aspects of wellness from chronic disease management to fitness and workplace wellness programs.

The tactics are to:

- Inform providers about the programs and encourage patient referrals.

- Coordinate St. James programs and other programs in the community with the BSB programs, such as Diabetes Education.

Plan to Evaluate Impact

To evaluate these tactics, the Action Group will track the number of children involved in programs such as FitKids360 program and Cross Country Ski Day. Also it will determine a baseline 2015 participation level in elementary children's activities and organizations and measure again at the end of each year that the calendar of events is produced.

For the BSB Chronic Disease program, the respondent rate for the programs offered will be tracked.

Adoption of Implementation Plan

On November 12, 2015, the St. James Healthcare Community Board of Directors, which includes representatives from throughout Butte-Silver Bow, met to discuss this plan for addressing the community health priorities identified through our Community Health Needs Assessment. Upon review, the Board approved this Implementation Plan and the related budget items to undertake these measures to meet the health needs of the community.

St. James Healthcare Board Approval & Adoption:

Bernard F. McCarthy Chair

By Name & Title

November 11, 2015

Date