GALLATIN CITY-COUNTY HEALTH DEPARTMENT STRATEGIC PLAN

July 1, 2013 – June 30, 2016

EXECUTIVE SUMMARY

This document serves as an executive summary of progress made during the span of Gallatin City-County Health Department's Strategic Plan for fiscal year 2013 through fiscal year 2016.

CONTENTS

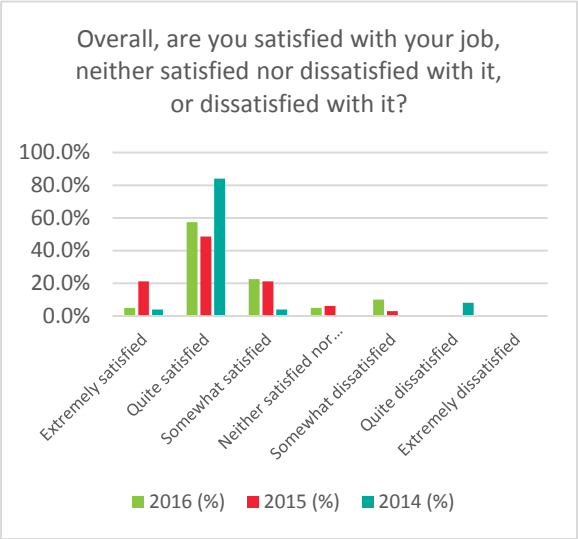
GALLATIN CITY-COUNTY HEALTH DEPARTMENT: STRATEGIC PRIORITIES, GOALS AND OBJECTIVES

PRIORITY AREA: ORGANIZATIONAL EXCELLENCE

Gallatin City-County Health Department will strive to achieve organizational excellence both to ensure the quality of services provided and to create a workplace that fosters well-trained, creative, and motivated staff. We will strive to build consistent, effective systems and policies that drive quality services and foster innovation that improve health outcomes.

GOAL 1: MAINTAIN AND IMPROVE ORGANIZATIONAL EXCELLENCE WITHIN THE HEALTH DEPARTMENT

Objectives:	**Progress Report:**
1.1 Gallatin City-County Health Department will submit all required documentation for national voluntary accreditation through the Public Health Accreditation Board (PHAB) by the end of 2014	GCCHD was awarded national accreditation in May 2015. Staff will work to submit PHAB annual reports on a timely basis. A QI team has been formed to work on preparing for re-accreditation in 2020.
1.1.1 Write and implement a Health Department Quality Improvement Plan by the end of 2013. This plan is guided by the Health Department's policies and strategic direction found in its mission and vision statements, in its strategic plan, and in its CHIP	A QI plan was created and implemented in 2013, and is being revised on an annual basis. This plan includes information on QI Committee governance structure, staff roles and responsibilities, and training needs. Current QI projects include: • Decreasing No-Shows in WIC • Improving EHS Customer Satisfaction Survey Response Rates • Increasing Quit Line Referrals & Enrollments • Using QI to Implement a new EHR • EHS Compliance Database • Immunization Travel Clinic Re-Vamp GCCHD staff are particularly excited about the new EMR system that was approved for purchase this past fall. This QI project began in January 2016 and gathered input from program areas regarding their needs for an updated and more user-friendly EMR database. GCCHD will be working closely with Patagonia EMR over the next few months as implementation of the new system begins.
1.1.2 Maintain, implement and assess the Health Department Workforce Development Plan by the end of 2013. This plan will address the training needs of the staff and the development of core competencies in order to perform their duties and carry out the Health Department's mission	GCCHD created a Workforce Development (WFD) plan in 2014. The WFD team revises the plan on an annual basis. We implemented Training Manager software to track and record trainings, continuing education requirements, certifications, etc. We also held a Diversity and Cultural Competency Training in May 2014 and had an AI/NA presentation from MSU in August 2014. An annual assessment helps identify priorities for workforce development efforts. The focus for FY16 was on financial planning & management, public health sciences, and policy development & program planning.

1.2 Create sustainable methods to measure and improve employee satisfaction within the Health Department by 2014	An annual employee satisfaction survey helps identify improvements and opportunities for continuing education. Results from this survey are incorporated into the WFD plan.  In 2015, a worksite wellbeing needs & interests survey was conducted. Based on the results, a committee was formed to work on implementing strategies and tactics to promote worksite wellbeing. The committee created a yearlong operating plan outlining goals and objectives. The annual employee satisfaction survey was modified to include questions related to worksite wellbeing; the committee will analyze these results and revise the operating plan on a yearly basis. Some examples of successful worksite wellbeing initiatives include: internal monthly wellness newsletter, two bikes (and helmets) were purchased and made available for staff to use, implementation of an employee immunization policy (recently recognized by the Immunization Action Coalition Honor Roll http://www.immunize.org/honor-roll/influenza-mandates/honorees.asp), monthly lunch and learn educational sessions, and more.
1.3 By August 2014, develop and implement a sustainable plan to increase awareness and recognition of services within Gallatin City-County Health Department and the community	The www.HealthyGallatin.org website & social media accounts are updated continuously with new and pertinent information. To help guide these efforts, the department created a Communications & Web Specialist position. In the past 3 years, GCCHD has implemented the use of a Healthy Gallatin letterhead and PowerPoint slides, a Public Communication Protocol and Procedure, and Healthy Gallatin jackets and vests were purchased for staff.
1.4 Reduce the amount of past due bills for immunization services by 50% by June 30, 2014	During the FY13 budget season, senior staff realized the IZ clinic had been operating in a deficit for at least 2 years. A QI project was started and the team created a fishbone diagram to analyze why IZ clinic was costing more money than it was generating. Potential solutions included: • Decrease nursing staff time

<table>
<tr><td></td><td>

Ask for fees in lieu of donations
Bill all insurance companies
Implement sliding fee scale
Hire collection services for past-due invoices

Results:
<table>
<tr><th colspan="2">Clinic Profit Comparison</th></tr>
<tr><td>2011</td><td>($76,751.00)</td></tr>
<tr><td>2012</td><td>($103,279.00)</td></tr>
<tr><td>2013</td><td>($2,587.00)</td></tr>
</table>
<table>
<tr><th colspan="2">Total Nursing Costs</th></tr>
<tr><td>2012</td><td>$115,368.00</td></tr>
<tr><td>2013</td><td>$65,790.00</td></tr>
</table>
<table>
<tr><th colspan="3">Billing Revenue Per Client</th></tr>
<tr><th>Year</th><th># Clients</th><th>Revenue</th></tr>
<tr><td>2011</td><td>6047</td><td>$371,591</td></tr>
<tr><td>2012</td><td>5693</td><td>$378,214</td></tr>
<tr><td>2013</td><td>5517</td><td>$434,816</td></tr>
</table>
The clinic continues to operate under the above-mentioned solutions. At the end of FY16, the immunization team began another QI project looking at ways to improve travel clinic operations and increase revenue from that service. Data will continue to be collected to ensure that IZ billing revenue is maximized.
</td></tr>
<tr><td>1.5 Human Services will have Geographic Information System (GIS) capacity and training by the end of 2014</td><td>This objective was put on hold for various reasons. GCCHD is still interested in GIS capacity and plans to include it in the next strategic plan. The Access Committee of the CHIP is also interested in working collaboratively on GIS work. Additionally, EHS uses in-house GIS mapping capabilities for permitted on-site wastewater treatment systems.</td></tr>
<tr><td>1.6 Improve processes and technology used to manage large scale communicable disease outbreaks by 2014</td><td>Communicable Disease (CD), PHEP, and Admin staff completed a QI project that resulted in purchasing portable computers for the CD team, improved PDF fill-able forms, and enabling faxing from the portable computers. A second QI project determined texting helped facilitate disease investigation, especially among younger demographics. CD staff also improved technology use during Ebola surveillance by purchasing a Wi-Fi hot spot and creating a GCCHD Skype account. Each outbreak brought up new ideas and improvements. The CD team kept staff informed by providing regular updates at staff meetings.</td></tr>
<tr><td>1.7 Formalize and improve orientation to include information on Health Department programs and processes among new and current staff by 2014</td><td>An orientation process was implemented to introduce new hires to the entire department rather than just their program area. Admin staff created a program orientation checklist, and new hires are expected to set up time to meet with each program manager or identified staff member to get a more comprehensive overview of the department. Staff sign off on the checklist and the new hire orientation is tracked in Training Manager.</td></tr>
</table>

	EMPLOYEE NAME:_____ **Title:**_____ **Date of Hire:**_____ **Element** / **Program Mgr Sign-off** / **Date Completed** / **Comments** **A3. Department Overview (Matt or Tracy)** Mission / Vision Statement Organizational Chart Board of Health What is Public Health? Overview of State Government (DEQ & DPHHS) MSU City-County Relationship Strategic Plan Review Community Health Needs Assessment Community Health Improvement Plan Quality Improvement Projects Budget / Funding Sources PHN Orientation Manual Worksite Wellbeing—Operating Plan, and Team
1.8 Maximize staff resources by cross-training administrative/finance staff in selected human service programs by 2014	Front desk, billing, and payroll procedure manuals have been created and all Admin staff are cross-trained on front desk procedures. The Admin team has an on-going rotation through front desk duties to stay current on processes. Finance staff are working on cross training each other and writing procedures. Admin staff also participate in the quarterly program performance management meetings with managers and coordinators.

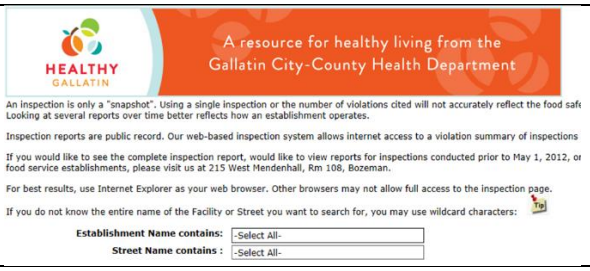
PRIORITY AREA: ENVIRONMENTAL QUALITY

The beauty, vast natural resources, and diverse economy of Gallatin County help make it an attractive place to live and visit. These assets, along with a recovering economy, are likely to spur population growth that will bring with it more construction, more wastewater, and more potential for pollution of our water, air and soil. Gallatin City-County Health Department will work to protect and improve the quality of those natural resources.

We will utilize our significant expertise in water quality to identify and improve wastewater systems of concern. We will work to educate and empower residents to keep our air clean and clear, both outside and inside our homes. Our staff will work with the Board of Health, when appropriate, to encourage the continued clean-up of sites where the soil and water has been contaminated. We will continue our work to ensure the health and safety of restaurants, hotels and motels, and other establishments, while empowering the public to access our work to make healthy decisions. We will perform this work both by enforcing state and local laws and by working collaboratively with the public to educate, empower, and collaborate.

GOAL 2: MONITOR AND ENFORCE ENVIRONMENTAL QUALITY THROUGHOUT GALLATIN COUNTY

Objectives:	**Progress Report:**
2.1 Increase EHS's capacity to review and issue septic permits by cross-training two additional sanitarians to conduct reviews by 2015	One additional Sanitarian has been trained to review septic permits increasing our capacity to conduct reviews in a timely and efficient manner. Currently there are two full time Sanitarian reviewing septic permits. However, staying within our 30-day regulatory timeline for septic reviews remains a central challenge for EHS. Workload has increased in volume and complexity and EHS needs more workforce capacity in this area in preparation for continued County growth and the reality of staff nearing retirement.
2.2 Ensure Local Regulations are compliant with State regulations, enforceable and protective of public health and the environment through revision of chapters 1-4 of the Gallatin County Health Code	This objective is in progress and an on-going effort. The Chapter 3 Revision was completed in the summer of 2015. A template is in place for Chapters 1, 2 & 4, and Chris Gray (county attorney) has reviewed with staff an initial draft of Chapters 2 & 4. This should be ready for Board consideration during first quarter of 2017.
2.3 Identify and bring public water systems (PWS) and public wastewater treatment systems (PWWTS) of concern within Gallatin County into compliance with State regulations	Also on going with significant achievements. EHS staff are updating the SPARC (Special Areas of Concern) list regularly to track progress and will update the BOH EH subcommittee regularly. There has been significant progress on several systems of concern in the past few years. Lagoon assessments are also continuing. The SPARC list will continue to be the main tool to identify systems and track progress.
2.4 Provide online access to restaurant inspection reports by July 2014	This was achieved in 2014. The database is easy to use and often the most frequented site on www.HealthyGallatin.org. This significantly helps boost website traffic. Below is a snapshot of what the page looks like:

	
2.5 Create an Air Quality Program that focuses on public education on indoor and outdoor air quality issues by July 2014	This is an on-going QI project. Staff have implemented a procedure to monitor daily air quality during the winter and the fire season. The website is updated daily and CAN alerts are issued as needed. With the addition of the Montana Tobacco Use and Prevention Program to GCCHD, EHS has played a more significant and collaborative role in the implementation and enforcement of the Clean Indoor Air Act (CIAA). EHS staff have been cross-trained in identifying CIAA complaints while in the field and have been provided signage should they see an establishment without the required materials. EHS sanitarians have assisted in following-up with establishments that have received a complaint.

PRIORITY AREA: CONNECTIONS THROUGH COLLABORATION

The American health system is poised to change rapidly and significantly in the coming years as the nation seeks to improve the quality of health care services while also making these services accessible and affordable, in part by providing access to health insurance for all Americans. Meeting this challenge with constrained economic resources will require us to work smarter. We will work to build more robust connections between health care providers and human service organizations that together can address the social determinants of health, such as economic security, education, strong families, and cohesive communities.

As the lead public health organization in Gallatin County, Gallatin City-County Health Department and the Board of Health will become a catalyst for creation of innovative and best practice solutions in the identified areas of our community health assessment, particularly where other agencies are not otherwise engaged. We will work with partners to convene community leaders to build true collaborations to identify health priorities, build capacity, and connect the people of Gallatin County to health resources and services they need to lead healthy, productive lives.

GOAL 3: CONNECT THE COMMUNITY TO RESOURCES, SERVICES AND INFORMATION.

Objectives:	**Progress Report:**
3.1 Build systems and collaboration necessary to connect clients who are not eligible for Montana Cancer Screening Program services to other resources in the community by June, 2014	Chronic Disease Prevention staff work closely with Bridgercare and CHP health care navigators to connect clients to services. Clients applying for cancer screening services are encouraged to indicate whether they have insurance or not – if they do, staff let them know that the ACA should cover preventive services. GCCHD has a Certified Application Counselor (CAC) on staff to assist clients wishing to enroll in Medicaid or during open enrollment periods. Staff also help explain the difference between preventative and diagnostic services, as well as terminology and definitions (deductible, co-pay, premium, etc.). Ongoing outreach efforts are being conducted in collaboration with Bozeman Health and the HealthCare Connections bus. Our on-staff CAC travels with the mobile health screening bus to various locations throughout the county to provide education on insurance options (Marketplace and Medicaid) as well as other health department services such as cancer screening, tobacco prevention, radon testing, lung cancer screening, skin cancer prevention, and more. When a client's needs fall outside the scope of health department services, Chronic Disease Prevention staff coordinate internally to get clients connected to other affordable resources and chronic disease programs in the region.
3.2 Create a network of Systems Navigators in major health and human service organizations throughout the county by the end of 2013 (CHIP Priority 2, Objective 1)	The Collaboration Team started initially as a priority of the CHIP and has been running for three years now. Different service navigators are nominated each year and meet monthly over the course of 12 months to hear presentations from different human service

	organizations in the community; this is a great way to learn about what other organizations are doing/what services they offer as well as facilitate warm handoffs between organizations serving the same clients Examples of presenting organizations: HRDC, CHP, Thrive, GMHC, Rural Dynamics Inc., OPA, Family Outreach, Love INC, AWARE, Youth Dynamics, plus others depending on the needs/wants of the group.
3.3 Increase the number of first trimester referrals from pre-natal care providers to the Public Health Home Visitation (PHHV) Program by 30% by 2016. (CHIP Priority 2, Objective 2)	Changes implemented through Project LAUNCH are resulting in earlier referrals. Prior to implementation in FY16, we received 328 total referrals from 19 different referral sources, 133 (40%) of which were referred prenatally. In the first two months of FY17, we received 107 referrals, 58 (54%) of which were referred prenatally. We will continue tracking the trimester of each prenatal referral when available. We will continue our outreach efforts with Women's Specialists in an effort to receive prenatal referrals in the first trimester. After recent feedback from the nurses at Women's Specialists, we revised the self-referral form that Women's Specialists includes in the introductory packet handed out to newly pregnant women in an effort to increase prenatal self-referrals.
3.4 By fall 2015, 75% of schools in Gallatin County will have a policy requiring parents to acknowledge that students who are under vaccinated may be excluded during a communicable disease outbreak	This was an on-going project that involved MSU nursing students and an INBRE intern. This project was prompted by a national trend of decreasing vaccination rates among young children and a rise in the number of vaccine preventable outbreaks (especially measles and pertussis/whooping cough). In 2015, the INBRE intern developed a risk assessment survey that was used to assess school immunization policies for all schools in Gallatin County. This was a phone interview given to school administrators. Results of the assessment found that private schools and smaller public schools were more likely to have higher proportions of unvaccinated or under-vaccinated students. Additionally, very few school districts require seating charts, which are integral during outbreak investigation and management. It was determined that 11 out of 16 school districts (69%) had an acknowledgment policy in place (4 districts did not participate in the survey). This translates to roughly 75% of Gallatin County schools having a policy in place. The school vaccination policy was critical during a mumps outbreak in two Belgrade schools in 2016. CD/IZ staff worked closely with the Belgrade school nurses to determine which students needed to be excluded from school to avoid putting them at risk of becoming ill. Parents were informed that if their child (or children) did not have an up-to-date MMR vaccine, they needed to be excluded from school or else

<table>
<tr><td></td><td>receive the vaccination. Mumps is highly contagious viral infection with a long incubation period, which caused this outbreak to last several months. Due to the school vaccination policy, a high rate of immunity in the affected Belgrade schools, and the collaborative relationship between health department staff and the Belgrade school nurses, this outbreak was contained and monitored in a way that minimized the risk of exposure and illness.</td></tr>
<tr><td>3.5 Organize, monitor and evaluate the progress of the Community Health Improvement Plan (CHIP), as needed, through the end of 2015</td><td>The first CHIP was created in 2012 with work plans lasting through 2015. A second Community Health Needs Assessment was conducted in 2014 in collaboration with BHDH and CHP. In August 2015, a group of stakeholders and community partners met to discuss the strategic priorities for the next CHIP (2016-2019). The following were areas of interest based on the data collection results:

<table><tr><th>Access</th><th>Healthy Behaviors</th><th>Nutrition & Physical Activity</th></tr><tr><td>• For seniors
• Transportation and mobility
• Insurance access (Medicaid)
• Mental health access
• Medical Home (Primary care physicians)</td><td>• Mental Health
• Substance use/abuse (current Healthy Behaviors group)
• Smoking in women of childbearing age</td><td>• Fruit and vegetable access
• Youth engagement
• Built environment</td></tr></table>
Work plans for the current CHIP have been finalized and subcommittees meet regularly to report progress.</td></tr>
</table>

PRIORITY AREA: PREVENTION

Prevention of disease is a bedrock principal of public health. In some cases, such as communicable disease surveillance and response, no other organization in Gallatin County can or will provide these services essential to public safety. In other areas, such as empowering people to eat healthy and lead physically active lives, Gallatin City-County Health Department can help residents prevent chronic diseases that are the leading causes of death and biggest drivers of the cost of health care. The Health Department can also play a pivotal role in gathering, analyzing, and using data to identify and address emerging health issues. Finally, the Department should continue to provide preventative services, such as immunizations, Public Health Home Visitation (PHHV) and the Women, Infants and Children (WIC) Supplemental Nutrition Program, to ensure that all residents have access regardless of their ability to pay.

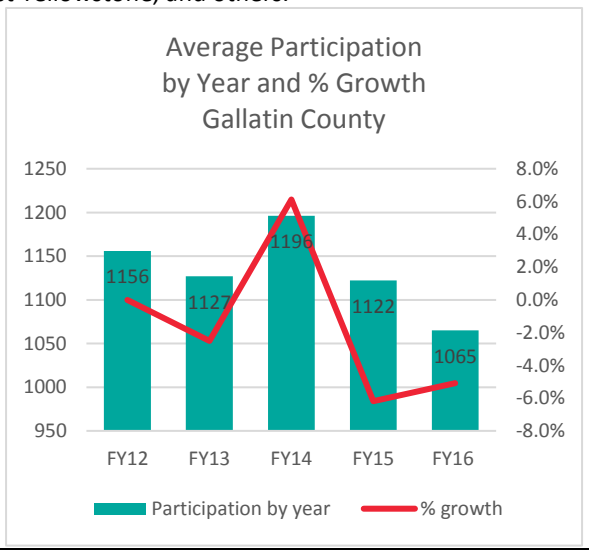
Whenever possible, the Department will utilize peer-reviewed scientific evidence and guidance from organizations such as the Centers for Disease Control (CDC) to address health issues.

GOAL 4: PROMOTE HEALTHY BEHAVIORS AND PREVENT DISEASE

Objectives:	Progress Report:
4.1 Increase provider compliance of the United States Preventative Services Task Force mammography guidelines to 20% by June 30, 2015	Chronic Disease Prevention program staff provide education and outreach materials to various healthcare providers in the community regarding cancer screening services and guidelines. This objective is difficult to measure because the language does not reflect work that can be done by the health department. However, providers that participate in the Montana Cancer Control Program (MCCP) must follow the USPSTF screening guidelines. There was no baseline data for this objective when it was written, so 20% was chosen as the goal. Since the program requires providers to follow the USPSTF mammography screening guidelines, we can say that 100% of providers are in compliance.
4.2 Decrease the rate of Chlamydia in Gallatin County by 10% by 2016	GCCHD staff decided to change the focus of this objective after comparing Gallatin County chlamydia rates to other counties and statewide data. It was determined that Gallatin County chlamydia rates were comparable to other Montana counties and that the focus should instead be on conducting specific, measurable, and achievable prevention activities regarding chlamydia. An example of this is a QI project that was completed in 2014 regarding the amount of time spent completing STD follow-up (project focused specifically on chlamydia) and how texting could be used in contact investigation. This QI project was published on PHQIX (Public Health Quality Improvement Exchange) in June 2015: https://www.phqix.org/content/using-texting-improve-std-follow-clients
4.3 By 2014 establish system of data collection to determine actual HCV screenings for Gallatin County residents born between 1945 and 1965	The number of newly diagnosed cases of Hepatitis C in Gallatin County for 2014 was 53, compared to 51 in 2013. The CD team has not seen a significant rise in the number of Hepatitis C cases, but they continue to follow the recommended guidelines for screening for Hepatitis C. The US Preventive Services Task Force recommends all people born between 1945 and 1965 be screened, regardless of

	participation in risky activities. Additionally, all individuals with past or current injection drug use, those with certain medical conditions, and those with known exposure, should be screened for Hepatitis C. The Communicable Disease team has worked to improve the way that Hepatitis C cases are counted and assessed, even though there has not been a significant rise in the number of cases.
4.4 Increase rate of fully-immunized children ages 18-35 months in GCCHD clinic from 49.1% to 55% by 2016	Our CoCASA report from 11/1/2015 showed that 37 of 52 (71%) children between the ages of 19-35 months reported as fully vaccinated. The CoCASA report from 11/29/2016 showed that 47 of 84 (56%) children between the ages of 24-35 months reported fully vaccinated. (Note on the CoCASA report: since the adoption of this objective, the reporting schedule for CoCASA has changed from annually to every two years. Additionally, CD/IZ staff have found that the report contains some errors and needs reviewing for patients that are not part of our clinic. Also the age range changed from 19-35 to 24-35 months.) Additionally, the IZ team is using Call 'Em All phone reminders and recalls for missed appointments. Admin is also working with clients to schedule next appointment before leaving the office (this ensures a reminder phone call and recall postcard). All clients are mailed a recall postcard within 2 weeks of when the next shot was due. Reminder phone calls go out one day before the scheduled appointment.
4.5 Improve cost effectiveness of public outreach to raise awareness of immunization events, special clinics and regular clinics by 2016	In order to improve cost effectiveness, GCCHD curtailed almost all paid advertising for flu clinics and tracked the impact on attendance. The data showed that attendance at flu walk-in or special clinics that had paid advertising was less or no different from the clinics that had no paid advertising. Based on this, GCCHD has decided to spend minimal funds to advertise flu clinics. The health department utilizes free advertising sources, such as the Healthy Gallatin website and social media accounts to spread the word about immunization events and clinics.
4.6 Convene alcohol, tobacco and other drug (ATOD) prevention stakeholders to create a county-wide strategy to address ATOD use and abuse by the end of 2014 (CHIP Priority 3, Objective 1)	This objective was not accomplished by the end of 2014; however, this work has been part of the CHIP since 2012. In 2015, a core group of organizations came together to develop a Healthy Behaviors work plan, with the focus being on alcohol misuse (underage population). The core team consists of representatives from ADSGC, C-CODA, GCCHD, GMHC, and MSU. The core team meets on a regular basis and coordinates efforts to address underage drinking in Gallatin County. One area of success for this work was the completion of a Community Readiness Assessment by an MSU INBRE intern (Nolan Clark). The CRA was an insightful process that brought in the perspective of community partners. The resulting CRA score indicated that alcohol misuse is indeed a problem in the Gallatin Valley; however, the community is resistant or unsure of how to begin addressing the problem. The Healthy Behaviors core group will continue to focus efforts on this work through 2018, at which point the work plan will be reassessed and revised as needed.

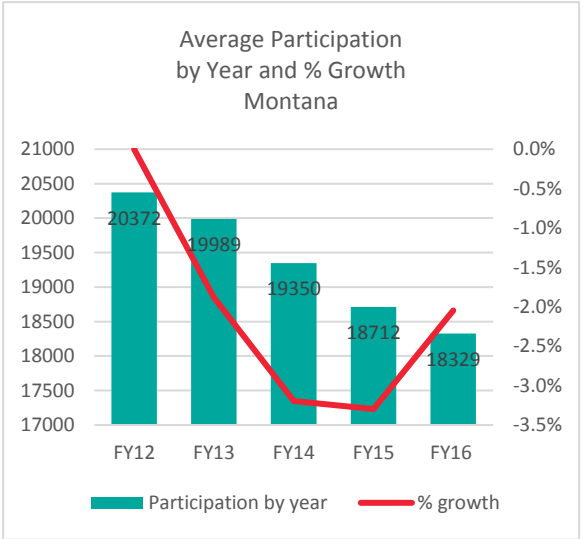
	Additionally, GCCHD acquired the Montana Tobacco Prevention Program (MTUPP) grant in 2014. This grant focuses on collaboration with community partners on topics such as addressing second-hand smoke exposure in multifamily housing units, engaging youth in projects intended to reduce tobacco initiation amongst their peers, and connecting current tobacco users, especially vulnerable populations (pregnant women and those with mental illness), to resources like the MT Quit Line to help them quit tobacco.
4.7 Decrease the percentage of PHHV women reporting current tobacco use from 30% to 20% by 2016	This was monitored on the PHHV annual performance plans from FY13 through FY16. At the end of FY16, 21% of PHHV women reported current tobacco use (this number has fluctuated over the years as it reflects the current home visiting caseload). The home visitors currently assess tobacco use within the first few home visits using the 5 A's Tobacco Use assessment tool. If a client is currently smoking or if the baby is exposed to second hand smoke, the home visitor provides education and refers the client to a tobacco cessation program. The home visitor then follows-up on subsequent visits to reassess, advise the client, and provide further education. The home visitors are using new brochures highlighting a new incentive program for pregnant woman through the Montana Quit Line, as well as new brochures addressing the risks of using smokeless tobacco. We attribute the success of this objective in part to the home visiting social worker's involvement on the Quit Line Referral/Enrollment QI project. From this QI project, a process map was developed, as well as a list of frequently asked questions that home visitors may be asked on home visits regarding the Quit Line process. A recording of an actual Quit Line call was obtained and made available to the HV team to increase their understanding of this process. We plan to continue our collaboration with the Tobacco Prevention Program in an effort to maintain our success on this goal.
4.8 Develop and establish a system for tracking the immunization status of PHHV children by 2015	At the end of FY16, 84% of PHHV children were up to date on their immunizations. We have not reached the goal of 90% yet this year. Home visitors address immunizations with all home visiting clients. They assess the parent's plan and values in regards to immunizing their children. Home visitors provide immunization education to all families and regularly follow-up with the children's immunization status on subsequent home visits. Home visitors are updating the children's immunization status at regular age intervals per the Advisory Committee on Immunization Practices standards and Montana State law requirements for school entry. All home visiting families sign a release of information so immunization records can be entered into imMTrax. We find it difficult to improve on this goal because almost all of the families who are not up to date have objections to immunizing their children. One home visitor reported that through education, she was able to change the minds of one family that had previously refused immunizations and the child is now up to date. We will continue to provide education to all HV families on the importance of immunizations.

4.9 Decrease the percentage of repeat births to PHHV mothers ages 15-21 from 20% to 15% by 2016	In 2013, 20% of PHHV mothers ages 15-21 had a repeat birth. In 2014, 7% of PHHV mothers had a repeat birth. These percentages represent the mothers receiving services at that point in time, so it is difficult to compare the data year over year. Due to the inconsistencies in the data and the fact that some PHHV mothers were intentionally getting pregnant, the home visiting team shifted the focus on this objective to providing education to PHHV clients on family planning methods. At the end of FY16, 78% of the PHHV mothers ages 15-21 reported current use of a family planning method. All home visitors assess clients on their plans and values regarding family planning methods and desired pregnancies. They also receive education on birth control options. The home visitor then follows up on subsequent visits to reassess family planning use and continues to provide support and education as appropriate. We implemented a new tool in HDIS to track if a PHHV mother is using a family planning method and to identify which method they are using.
4.10 Increase the percentage of PHHV infants who were ever breastfed from 80% to 94% by 2016	At the end of FY16, 96% of PHHV infants were ever breastfed. Through videos, discussion, and brochures, all home visiting parents interested in breastfeeding are provided education on the benefits of breastfeeding. Home visiting clients are also referred to more specialized support services depending on baby's medical needs, such as cleft palette, tongue-tie, and more severe feeding issues that go beyond the home visitors' expertise. These specialized services include the lactation education program at the health department and the breastfeeding peer-counseling program at WIC. We will continue to partner and refer to lactation programs when appropriate.
4.11 Increase WIC participation by at least 7%, annually, through 2016	WIC participation peaked in FY14; however, it has been on a downward trend, both locally and at the state level, since FY14. Some factors that may contribute to this are staff retention, clinic location, lack of WIC participating grocery in West Yellowstone, and others. 

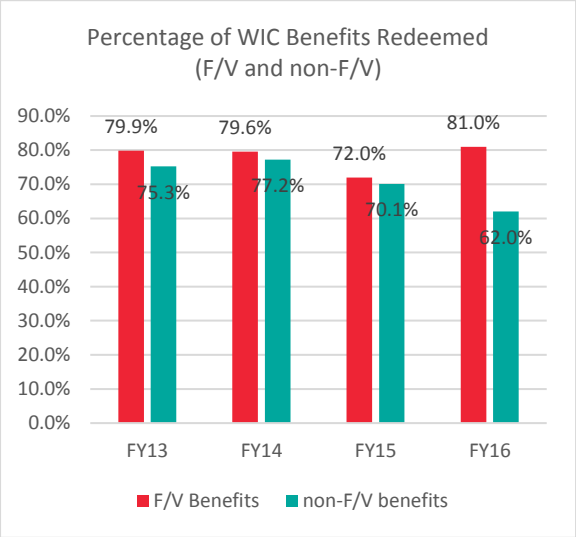
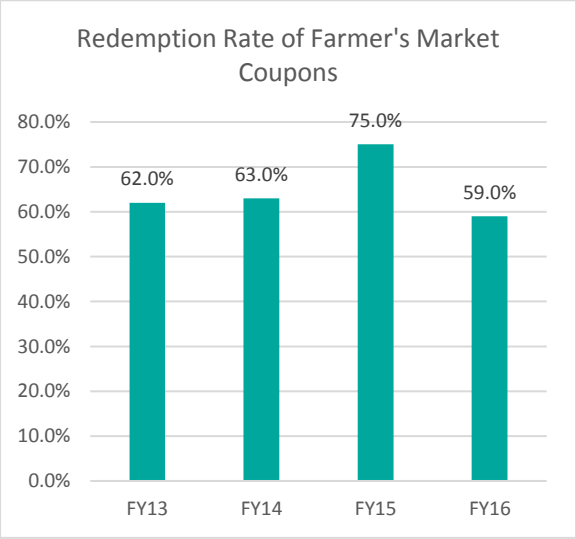
Some interventions that WIC has implemented over the past few years include creating Facebook and Pinterest accounts to help with social media outreach. Staff also write weekly blog posts that feature grocery store specials that are posted on the Healthy Gallatin website and shared on social media. "Willow Comes to WIC" is another strategy that staff have incorporated into WIC operations to help increase participation and retention. "Willow" is a bunny puppet that helps kids explore fresh produce from her magic garden. This is a hands-on activity to help kids try new foods and gives parents ideas for new recipes to try. Feedback from parents has been extremely positive; with some saying, "I never thought my kid would try that!" Healthy Gallatin WIC received the most innovative education award in April 2016 for work being done with the "Willow" program.

During 2016, an INBRE intern helped conduct a survey of family & graduate housing students at MSU to see how many knew about WIC services, how many were potentially eligible for services, had children under age 5, etc. Based on the outcomes of this research project, WIC is looking at holding a clinic at MSU to try to reach those students who are not currently receiving WIC but meet eligibility requirements.

A QI project is also looking to reduce the number of no-shows at WIC appointments: participants currently receive an automated phone call reminder 2 days before their appointment; sometimes these calls cause confusion, so WIC staff call clients the day before their appointments as well to confirm or reschedule if necessary. Participants who attend their scheduled appointments are also entered into a quarterly drawing for a prize. In 2016, Town & County donated several grocery store gift cards, which went to WIC participants selected from the raffle.



The graph above demonstrates that participation across the state has dropped. This could potentially be due to improved economy, families don't feel they need WIC services, etc.

4.12 Increase redemption of WIC benefits to 85% at grocery stores by 2016	The following graph depicts the percentage of WIC benefits redeemed by fiscal year from FY13 to FY16. This measure is broken down by fruit and vegetable benefits redeemed and non-fruit and vegetable benefits redeemed. From FY13 to FY16, the average percent of F/V benefits redeemed was 78.1%. From FY13 to FY16, the average percent of non-F/V benefits redeemed was 71.1%. 
4.13 Increase redemption rate of WIC Farmer's Market Coupons to 75% by 2016	The following graph depicts the percent of WIC Farmer's Market coupons redeemed by fiscal year. The average percent of coupons redeemed from FY13 through FY16 is 64.8%.  WIC has a CPA working on the Farmer's Market program to implement various strategies to increase participation and usage of farmer's market coupons. During summer 2016, WIC had a CPA and administrative aid attend several of the farmer's markets in Bozeman to issue coupons and help participants use them.
4.14 Increase breastfeeding of WIC mothers to the following by 2016: • Initiation 86% to 91%	This objective proved to be more difficult to measure than originally anticipated. Similar to some of the PHHV metrics, these numbers represent a snapshot in time. The

• Duration 59% • Any breastfeeding at 12 months 45% • Exclusively breastfeeding at 6 months 45%	breastfeeding 'initiation' rate and the percent of infants 'exclusively breastfeeding at 6 months' were the two metrics consistently reported on. The other two metrics, 'duration' and 'any breastfeeding at 12 months', did not have consistent data, and unfortunately cannot be reported on at this time. We will consider this for the next strategic plan. FY16: Initiation rate at end of FY16: 92.4% Ex BF at 3 months, end of FY16: 32.6% Ex BF at 6 months, end of FY16: 29.5% FY15: Initiation rate at end of FY15: 92.2% Ex BF at 3 months, end of FY15: 41.0% Ex BF at 6 months, end of FY15: 31.9% FY14: Initiation rate at end of FY14: 89.9% Ex BF at 3 months, end of FY14: 41.3% Ex BF at 6 months, end of FY14: 33.5% Overall, this data shows that WIC does a great job promoting and supporting the initiation of breastfeeding. One major challenge WIC staff hear about from participants is the difficulty of returning to work and continuing to breastfeed. WIC staff have identified a need to work with employers to be supportive of breastfeeding mothers and their needs when returning to work. This is something that the Gallatin Breastfeeding Coalition and the Lactation Education Program are also working collaboratively on. For more info, see: http://www.gallatinbreastfeedingcoalition.org/breastfeeding-friendly-businesses.html It should also be noted that Gallatin WIC breastfeeding initiation rates were recognized in 2015 as the highest rate among the large counties in the state. WIC staff provides support and education to all WIC participants on the importance of breastfeeding. WIC has a part-time Breastfeeding Peer Counselor that is available to help clients with their breastfeeding needs. WIC also has a number of pumps available for clients to rent. The majority of WIC staff are Certified Lactation Consultants (CLCs). Outside of WIC, the Lactation Education Program serves to promote and support breastfeeding mothers in the community. The program is funded through the Kellogg Foundation and focuses on rural communities in Gallatin, Madison, and Park Counties. LEP staff conduct home visits to mothers wanting breastfeeding support, as well as setting up support groups and teaching classes in rural communities. This program also has pumps available for rent.