FLATHEAD COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

2023-2025

FLATHEAD CITY-COUNTY HEALTH DEPARTMENT

GREATER VALLEY HEALTH CENTER

Acknowledgements

Thank you to the following coalitions and organizations for participating in the development of the Flathead County Community Health Improvement Plan:

- Perinatal Mental Health Coalition
- Early Childhood Coalition
- Flathead County Behavioral Health Collaborative
- Flathead County Suicide Prevention Taskforce
- Safe Kids Safe Communities Coalition
- Summit of Coalitions
- Flathead City-County Health Department
- Greater Valley Health Center
- Logan Health
- Logan Health Whitefish
- Community Action Partnership of Northwest Montana
- Flathead County Agency on Aging
- Nurturing Center
- Postpartum Resource Group
- Child Development Center
- Evergreen Schools
- Flathead Association for the Education of Young Children (FAEYC)
- Flathead County Superintendent of Schools
- FVCC Early Childhood Education
- ImagineIf Libraries
- Columbia Falls School District
- Discovery Developmental Center
- Dept. of Children and Family Services (MT-DPHHS) Kalispell Office
- Northwest Montana Head Start
- Healthy Beginnings Pediatric Therapy
- Kalispell Schools – District 5
- Montana Legal Services Association
- Northwest Montana Educational Cooperative
- Tamarack Grief Resource Center
- Western Montana Mental Health Center
- Montana Healthcare Foundation
- Kalispell Police Department
- The Raleigh House
- Many Rivers Whole Health

Table of Contents

Overview

A Community Health Improvement Plan (CHIP) is a community-based systems approach to address public health issues or other health related challenges identified through a Community Health Needs Assessment and expanded through the development of the Community Health Improvement Plan. The Flathead County Community Health Needs Assessment (CHNA) was completed in 2021 as part of a collaborative effort between Flathead City-County Health Department, Greater Valley Health Center, Logan Health, and Logan Health Whitefish. This CHNA served as a tool toward reaching three goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life.
- To reduce the health disparities among residents.
- To increase accessibility to preventive services for all community residents.

For more detailed information regarding the Community Health Needs Assessment, please see the Flathead County Community Health Needs Assessment located on each of the participating agency websites or at flatheadhealth.org.

Process

The work for the 2023-2025 CHIP was accomplished through the Summit of Coalitions, a group comprised of representatives from coalitions and community groups spanning across all sectors in Flathead County. Members of the Summit of Coalitions group were given a copy of the draft CHNA and were provided with an explanation of the results. Then, a Summit of Coalitions meeting was held to present data from the CHNA and kickstart the CHIP process. After the review and finalization of the CHNA, Summit of Coalitions stakeholders were tasked with selecting priorities for the CHIP. Then, objectives and strategies were developed to address each of the priority goal areas.

Upon completion of the CHNA, the members of the Summit of Coalitions determined the most important health needs in our community by reviewing primary and secondary data, county demographics, and feedback from representatives who provided input on broad community interests. Once priorities were selected, the Flathead City-County Health Department worked closely with different coalitions and organizations throughout the county to brainstorm and draft collaborative strategies to address each priority. Prior to finalization, a Summit of Coalitions meeting was held to present a draft CHIP and provide an opportunity for feedback and revision. A timeline of the process is available below:

1) January – February 2022: CHNA process complete
2) March 2022: Community prioritization process occurs through the Summit of Coalitions
3) April – August 2022: Creation of objectives and strategies for each priority
4) September – October 2022: Strategies submitted through coalitions and organizations
5) November – December 2022: CHIP draft completed and presented to Summit of Coalitions
6) January 2023: CHIP implementation begins

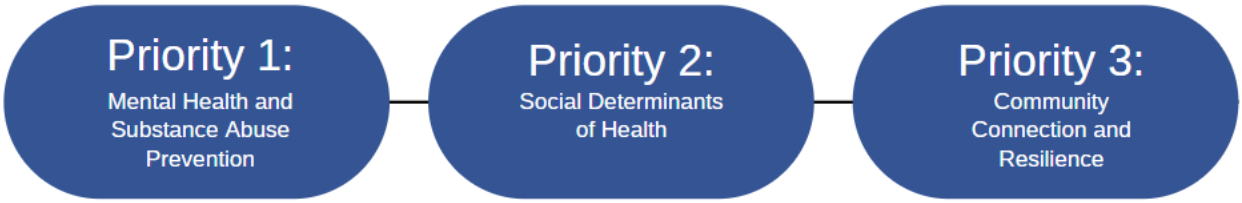
Connection to Other Plans

Several organizations involved in the CHIP process have their own strategic plans. Some components from these external plans tie into the Flathead County CHIP. For example, Logan Health and Logan Health Whitefish have a joint implementation plan which focuses specifically on work accomplished through

their organization. For more information about other community plans, please visit the respective organization's website.

Implementation and Tracking

The Community Health Needs Assessment (CHNA) and the Community Health Improvement Plan (CHIP) are completed every 3 years. The next Flathead County CHNA will be completed in 2024-2025, and the next Flathead County Community Health Improvement Plan will be implemented in 2026. During the three-year cycle, the Flathead County CHIP will be reviewed annually to assess progress towards improvement in each of the priority areas. Progress will be assessed through the measurement of short-term indicators of success for each strategy, as well as long-term health outcomes for each objective. Annual CHIP reports will outline specific progress, appropriative or necessary changes, and any other pertinent information. Reports will be sent out to stakeholders involved in the creation of the CHIP and will also be available publicly upon request. The Flathead CHIP will go into effect January 1st, 2023, with the goal to complete all strategies by December 31st, 2025.



Community Health Priorities

The CHIP outlines how partners in Flathead County plan to improve the health of all county residents during the three-year cycle (2023-2025). The document focuses on three priority areas. Within the three areas, there are measurable objectives which help to keep track of community progress. Each of the measurable objectives is broken down further into specific improvement strategies and action steps. We believe that implementing the strategies included in this CHIP will help us achieve our vision for a healthier community. The following priority health issues and objectives are listed below:

Priority 1: Mental Health and Substance Abuse Prevention

- Objective 1: Support suicide prevention efforts through effective partnerships, evidence-based training, and data evaluation.
    - Strategy 1: Implement a community suicide prevention taskforce.
    - Strategy 2: FICMMR gun lock project.
- Objective 2: Improve screening and referral processes for mental health services.
    - Strategy 1: Contact pediatric providers in Flathead County to share resource guide and explore the use of the MMH screening toolkit.
    - Strategy 2: Implement universal screening (eC-SSRS, PHQ-A, GAD-7, WSAS-Y, CRAFFT) for depression, anxiety, suicidality, resiliency, and substance abuse in Flathead County youth.
    - Strategy 3: Standardize depression screening in the hospital and clinic settings and expand patient population that is screened.
    - Strategy 4: Regularly update and distribute the Perinatal Mood and Anxiety Disorders (PMADs) "This is more than the Baby Blues" handout
- Objective 3: Decrease rates of tobacco use among behavioral health populations.

- Strategy 1: Conduct outreach to behavioral health facilities to help implement tobacco-free campus policies or integrate systems changes to increase tobacco cessation.

Priority 2: Social Determinants of Health

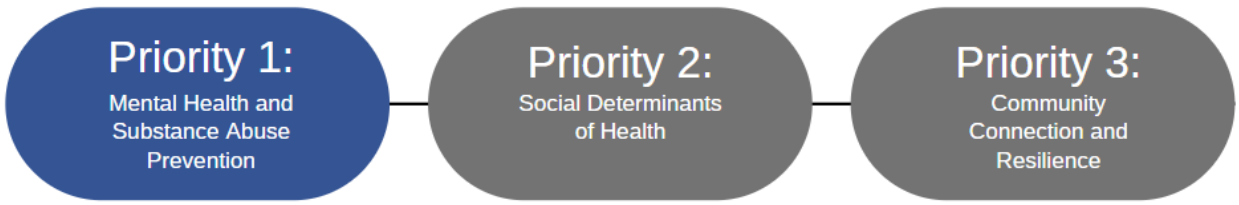
- Objective 1: Build capacity and increase access to healthcare services.
  - Strategy 1: Develop and implement the UM Health Extension Office Network.
  - Strategy 2: Breast and Cervical Cancer Screening.
- Objective 2: Eliminate low food security in children.
  - Strategy 1: WIC Nutrition Access Project
- Objective 3: Increase supportive housing opportunities to help vulnerable populations thrive.
  - Strategy 1: CAPNM Modular Unit Project

Priority 3: Community Connection and Resilience

1. Objective 1: Expand awareness of community resources and participation in community activities.
   - Strategy 1: Intergenerational Health Promotion Programming
   - Strategy 2: Annual review and update to the Linking Infants and Families to Services (LIFTs) guide.
   - Strategy 3: Support family caregivers and those living with or caring for someone with Alzheimer's or dementia.
   - Strategy 4: Expand CONNECT, a coordinated electronic referral system.
- Objective 2: Integrate resilience and trauma-informed care into the workplace.
  - Strategy 1: Reintroduce resilience and PACES training opportunities.
  - Strategy 2: Explore participation in Linking Systems of Care for Children and Youth in Montana (LSOC) Organization Trauma-Readiness Assessment

Priority Area 1: Mental Health and Substance Use Prevention

Mental Health and Substance Abuse were both identified as key areas of opportunity through the 2021 Flathead Community Health Needs Assessment (CHNA). Furthermore, behavioral health is included as a priority area in the most recent Montana State Health Improvement Plan (SHIP). The objectives and strategies included in this section of the plan focus on suicide prevention, building capacity, and improving screening and referral processes. Our goal is to create an environment in Flathead County in which mental health is supported and resources are available to all.



Priority-Specific Objectives:

1. Support suicide prevention efforts through effective partnerships, evidence-based training, and data evaluation.
2. Improve screening and referral processes for mental health services.
3. Decrease rates of tobacco use among behavioral health populations.

Objective 1: Support suicide prevention efforts through effective partnerships, evidence-based training, and data evaluation.

Background:

Suicide is serious public health issue within the state of Montana. In 2021 in Flathead County, the crude suicide rate was 39.29 deaths per 100,000, nearly twice the national average. These rates fail to satisfy the Healthy People 2030 target of 12.8 suicides per 100,000 or lower. Suicide prevention was included as a priority objective in the previous Flathead County CHIP cycle. Additionally, preventing suicide is listed as a goal in the current 2019-2023 Montana State Health Improvement Plan (SHIP).

Measurable Long Term Health Outcomes:

We will assess the long-term progress of this objective by tracking the following measures:

- Suicide mortality rates
    - Sources: National Center for Health Statistics, Centers for Disease Control and Prevention, Montana Vital Statistics
- Nonfatal intentional self-harm emergency department visits and hospitalizations
    - Source: Montana DPHHS Hospital Discharge Data System

Strategy 1: Implement a community suicide prevention taskforce.	
Lead Organization:	Logan Health Behavioral Health & Nate Chute Foundation
Collaborating Organizations:	- Flathead City-County Health Department - Greater Valley Health Center - Flathead County Schools - Flathead County Sheriff's Office - Kalispell Police Department - Tamarack Grief Resource Center - Flathead AFSP - Kalispell Vet Center
Action Steps:	- Convene stakeholders on a monthly basis. - Create three working groups to address prevention, intervention, and postvention activities - Build workplans for each work group that align with the Montana State Suicide Strategic Plan - Implement a review and revision process to assess progress on work group activities annually
Timeline:	- Initial taskforce meeting Summer 2022 - Determine work group activities by April 2023 - Assess work group progress by April 2024
Indicators of Success (Short Term):	- Number of organizations represented in taskforce - Number of work group activities accomplished by April 2024
Baseline Data:	- NA

Strategy 2: FICMMR Gun Lock Project	
Lead Organization:	Flathead County FICMMR Team
Collaborating Organizations:	- Flathead County middle and high schools

	- Flathead County Suicide Prevention Taskforce - Flathead City-County Health Department
Action Steps:	- Establish partnerships with local middle and high schools to increase education and access to safe firearm storage in the home. - Provide schools with educational infographic and resources to provide to families - Distribute gun trigger locks to schools to be passed out to families free of charge - Partner with programs (i.e. Be Smart) to table with gun trigger locks and offer parent education during events such as school open houses/ parent teacher conferences, etc. - Develop consistent messaging to use amongst all organizations within Flathead County passing out gun trigger locks.
Timeline:	- Project began fall 2022 and will continue through the school year.
Indicators of Success (Short Term):	- Number of participating schools - Number of gun locks distributed
Baseline Data:	- NA

Objective 2: Improve screening and referral processes for mental health services.

Background:

In the 2021 Flathead County Community Health Needs Assessment, 82.4% of surveyed participants reported that mental health is a major problem in the community. Furthermore, there were reported disparities in accessing mental health services, particularly for women and adults aged 45 to 64. The 2019-2023 Montana State Health Improvement Plan (SHIP) has a goal to support the integration of physical and behavioral health care at the community level.

Measurable Long Term Health Outcomes:

We will assess the long-term progress of this objective by tracking the following measures:

- Percentage of individuals receiving treatment for mental health conditions.
    - Source: Flathead County Community Health Needs Assessment
- Percentage of individuals reporting difficulty accessing mental health services.
    - Source: Flathead County Community Health Needs Assessment

Strategy 1: Contact all pediatric providers in Flathead County to share resource guide and explore the use of maternal mental health screening toolkit.	
Lead Organization:	The Flathead Valley Perinatal Mental Health Coalition (PMHC)
Collaborating Organizations:	- Logan Health Maternal Care Coordinator - Flathead City-County Health Department Healthy Montana Families - Greater Valley Health Center - Nurturing Center - Flathead Postpartum Resource Group

Action Steps:	- The FICMMR (Flathead County Maternal and Child Fatality Review) Committee contacted these same providers in 2021 to disperse a maternal mental health toolkit to local clinics in an effort to expand awareness and screening of Perinatal Mood & Anxiety Disorders (PMADs) throughout Flathead County and surrounding areas. - The PMHC members will re-establish contact and meet with those same clinics to determine if screening has been adopted as a practice with mothers in the perinatal period, and to help address any barriers to using these tools.
Timeline:	- Screening toolkit reviewed by PMHC by end of 2022. - Contact and distribution efforts begin in January 2023. - Toolkit distributed to all clinics by December 31st, 2023. - PMHC will reach out to new providers/clinics with screening information on an ongoing basis.
Indicators of Success (Short Term):	- Number of pediatric providers contacted - Number of pediatric providers distributing resource guide - Number of pediatric providers utilizing resource guide
Baseline Data:	- Number of pediatric providers originally contacted in 2021 (12)

Strategy 2: Implement universal screening (eC-SSRS, PHQ-A, GAD-7, WSAS-Y, CRAFFT) for depression, anxiety, suicidality, resiliency, and substance abuse in Flathead County youth.	
Lead Organization:	Kalispell School District 5
Collaborating Organizations:	- Greater Valley Health Center - Flathead City-County Health Department - Logan Health Behavioral Health - Rural Behavioral Health Institute - Montana Healthcare Foundation
Action Steps:	- Use Screening Linked to Care plus CRAFFT tool to conduct screenings of a sample of students in School District 5 in the Fall and Spring. - Assess data to determine if indicators of success have been achieved. - Develop and disperse wallet-sized resource cards to all students.
Timeline:	- CRAFFT screening pilot project began in January of 2022. - All students at initial pilot school will be screened by Dec 31, 2023. - Project data will be collected and assessed by Dec 31, 2024. - Discussions to expand project to other schools within the district will continue (ongoing).
Indicators of Success (Short Term):	- Number of students connected to resources - Increased resiliency scores among students between fall and spring screenings - Decrease in functional impairment scores among students between fall and spring screenings

Baseline Data:	- NA

Strategy 3: Standardize depression screening in the hospital and clinic settings and expand patient population that is screened.	
Lead Organization:	Logan Health
Collaborating Organizations:	- Logan Health Whitefish - Logan Health - Logan Health Behavioral Health
Action Steps:	- Increase identification of needs for support and treatment of depression and suicide - Develop, introduce, and implement suicide risk screening policy within Logan Health primary care, walk-in care, emergency department, all specialties, and inpatient care - Implement policy to screen all patients 12 and older - Utilize policy algorithms to connect patients with positive screens to appropriate resources
Timeline:	- Utilize PHQ screening for every patient 12 and older by Dec 31, 2025.
Indicators of Success (Short Term):	- Number of patients screened - Number of patients referred to additional resources
Baseline Data:	- NA

Strategy 4: Regularly update and distribute the Perinatal Mood and Anxiety Disorders (PMADs) "This is more than the Baby Blues" handout	
Lead Organization:	The Flathead Valley Perinatal Mental Health Coalition (PMHC)
Collaborating Organizations:	- Logan Health Maternal Care Coordinator - Flathead City-County Health Department Healthy Montana Families - Greater Valley Health Center - Nurturing Center - Flathead Postpartum Resource Group
Action Steps:	- Ensure resources and information in handout is up to date - Distribute handout to organizations serving PMADs populations - Create a plan to update the resource regularly
Timeline:	- Initial handout created July 2020 - Review and update handout by January 2023 - Distribute handout to PMADs organizations by January 2024 - Implement ongoing process to review and revise handout as resources change
Indicators of Success (Short Term):	- Number of resources updated and added - Number of organizations receiving the handout during distribution
Baseline Data:	- Baseline numbers of resources and organization contact list comes from the original version of the resource created in 2020.

Objective 3: Decrease rates of tobacco use among behavioral health populations.

Background:

Diseases caused by tobacco place a disproportionate burden on behavioral health populations. Nearly 25% of adults in the US have a behavioral health condition and these adults consume 40% of all cigarettes smoked by adults in the US. On average, people with behavioral health conditions die 5 years earlier than people without these conditions, and more than 50% die from tobacco-attributable diseases. According to a recent Montana Behavioral Risk Factor Surveillance System report, the smoking rate for Montanans with poor mental health is two times higher than for those without poor mental health. Behavioral health treatment settings continue to allow tobacco use among clients because of misconceptions that cessation could interfere with treatment. However, research has shown that smoking can worsen symptoms and outcomes.

Measurable Long Term Health Outcomes:

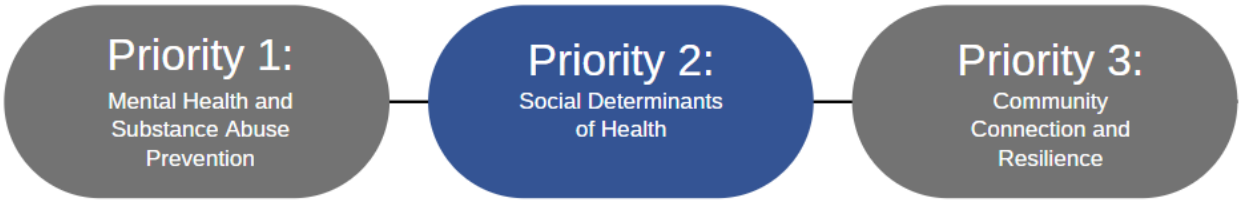
We will assess the long-term progress of this objective by tracking the following measures:

- Smoking rate among people who report having poor mental health
    - Source: Montana Behavioral Risk Factor Surveillance System
- Smoking attributable mortality rate
    - Source: CDC Smoking-Attributable Mortality, Morbidity, and Economic Costs

Strategy 1: Conduct outreach to behavioral health facilities to help implement tobacco-free campus policies or integrate systems changes to increase tobacco cessation.	
Lead Organization:	Flathead City-County Health Department
Collaborating Organizations:	- Logan Health Behavioral Health - Greater Valley Health Center - Other behavioral health clinics
Action Steps:	- Attempt to establish relationships with behavioral health providers through phone calls, in-person meetings, or virtual meetings. - Offer recommendations for the implementation of tobacco-free campus policies or tobacco dependence screening policies in behavioral health settings. - Educate providers on the health inequities caused by tobacco use among behavioral health populations. - Educate providers on the 5 A's of smoking cessation - Provide cessation resources and supports for patients.
Timeline:	- Begin outreach in October of 2022. Reach out to three behavioral health clinics by Dec 31, 2023, and seven total clinics by Dec 31, 2024. - Continue communication with established providers and continue to make connections with new providers and clinics (ongoing annually)
Indicators of Success (Short Term):	- Number of clinics provided tobacco prevention education materials. - Number of clinics adopting tobacco-free campus policies - Number of patients referred to the Montana Tobacco Quitline
Baseline Data:	- NA

Priority Area 2: Social Determinants of Health

The social determinants of health (SDOH) are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health and quality-of-life outcomes (HP2030). Examples of SDOHs include healthcare access and quality, educational attainment, neighborhood safety, and social and community context. SDOH were included as a priority area in the 2020-2022 Flathead County Community Health Improvement Plan, and many aspects of SDOH were highlighted as areas of opportunity in the most recent 2021 Flathead County Community Health Needs Assessment. Needs that stem from SDOH are the root causes of poor health for many of our community members. By addressing these root causes, we can effectively reduce poor health outcomes across many different areas.



Priority-Specific Objectives:

1. Build capacity and increase access to healthcare services.
2. Eliminate low food security in children.
3. Increase supportive housing opportunities to help vulnerable populations thrive.

Objective 1: Build capacity and increase access to healthcare services.

Background:

In the 2021 Flathead County Community Health Needs Assessment, 22.2% and 38.9% of informants listed access to healthcare as a major or moderate problem in our county, respectively. Furthermore, "healthcare access and quality" is included as a social determinant of health (SDOH) domain in Healthy People 2030 (HP 2030). More specifically, our included strategies align with the HP2030 objectives AHS-08, C-05, and ECBP-D07 (See Appendix 1). We believe that building capacity and improving collaboration within our current systems will help more people get the care that they need.

Measurable Long Term Health Outcomes:

We will assess the long-term progress of this objective by tracking the following measures:

- Percentage of individuals reporting difficulty accessing healthcare services.
    - Source: Flathead County Community Health Needs Assessment
- Mental health providers per 100,000 population.
    - Source: Flathead County Community Health Needs Assessment

Strategy 1: Implementation of the UM Health Extension Office Network	
Lead Organization:	- University of Montana – Health and Medicine

Collaborating Organizations:	- Logan Health - Flathead City-County Health Department - Lake County Public Health - Rural Behavioral Health Institute
Action Steps:	- Develop and implement the UM Health Extension Office Network in Flathead and Lake Counties through the use of the Health Extension Toolkit and Model - Participate in planning grant for the development and implementation of the UM Health Extension Office Network in Flathead and Lake Counties.
Timeline:	- Pilot planning project began in July 2022 - Develop a strategic plan for the implementation project by June 2023 - Continue to work with involved stakeholders to implement HERO model in Flathead County (ongoing through 2025).
Indicators of Success (Short Term):	- Completed Needs Assessment - Completed Strategic Plan - Secured funding for continuation of pilot project
Baseline Data:	- NA

Strategy 2: Increase coordinated breast and cervical cancer screening	
Lead Organization:	Flathead City-County Health Department
Collaborating Organizations:	- Logan Health - Logan Health Whitefish - Greater Valley Health Center - Save-a-Sister
Action Steps:	- Increase coordination of cancer services to reduce cancer prevalence and death within the community. - Offer multiple mobile mammography events in areas across the county. - Increase awareness of the Montana Cancer Screening Program and its resources for eligible women. - Develop care pathways for newly diagnosed patients. - Provide supports for patients and families with cancer diagnosis.
Timeline:	- Host three mobile mammography events in partnership with Logan Health and Save-a-Sister by Dec 31st, 2023. - Strengthen partnership between agencies to implement annual co-hosted screening events in 2024 and 2025. - Make connections with providers and clinics in surrounding counties to strengthen awareness of the program (ongoing)
Indicators of Success (Short Term):	- % of women who have completed breast and cervical cancer screenings - Number of women enrolled in the Montana Cancer Screening Program - Number of women utilizing Save a Sister

Baseline Data:	- 448 enrolled in the MCSP program in FY22.

Objective 2: Eliminate low food security in children.

Background:

In the 2021 Flathead County Community Health Needs Assessment, 9.6% of community residents are determined to be food insecure. In addition, 11.7% of the population report it to be very or somewhat difficult to buy fresh produce. Healthy eating during childhood is important for growth and development, and we believe it is important to strive for access to nutritious foods for all Flathead County children. This objective coincides with Healthy People 2030, fitting within the "Nutrition and Health Eating" goal. Furthermore, our objective aligns with HP2030 objectives NWS-07, NWS-09, NWS-13, NWS-01, NWS-06, and NWS-02 (See Appendix 1).

Measurable Long Term Health Outcomes:

We will assess the long-term progress of this objective by tracking the following measures:

- Percentage of individuals determined to be food insecure.
    - Flathead County Community Health Needs Assessment
- Percentage of middle school and high school students reporting going hungry because of lack of food in the home.
    - Flathead County Youth Risk Behavior Survey

Strategy 1: WIC Nutrition Access Project	
Lead Organization:	Flathead City-County Health Department
Collaborating Organizations:	- OBGYN clinics - Food banks (Whitefish, Kalispell, Columbia Falls) - Head Start
Action Steps:	- Standardize WIC referral form and establish an effective referral process. - Conduct outreach to partners with focus on OBGYN clinics, food banks, head start program. - Works towards a co-location model between WIC and clinics to increase participant access.
Timeline:	- Project begins 2022 - Goal of implementing co-location model by end of year 2025.
Indicators of Success (Short Term):	- Number of WIC participants - Number of clinics utilizing WIC referrals
Baseline Data:	- No (0) co-locations in effect end of year 2022.

Objective 3: Increase supportive housing opportunities to help vulnerable populations thrive.

Background:

In the 2021 Flathead County Community Health Needs Assessment, 5.7% of individuals lived in unhealthy or unsafe housing conditions. Additionally, recent information from the 2021 Point in Time Survey determined that homelessness in Montana increased by 16% in 2021 when compared to the previous year. The goal of this objective is to connect people with needed resources and create more sustainable housing solutions for those who are unable to access traditional housing.

Measurable Long Term Health Outcomes:

We will assess the long-term progress of this objective by tracking the following measures:

- Percentage of individuals living in unhealthy or unsafe housing conditions.
    - Source: Flathead County Community Health Needs Assessment
- Number of individuals experiencing homelessness.
    - Source: Point in Time Survey

Strategy 1: Implement a modular unit project serving individuals who are homeless with the highest intersections with emergency systems (medical, justice, homeless, etc.) to integrate behavioral health strategies and place-based care.	
Lead Organization:	Community Action Partnership of Northwest Montana
Collaborating Organizations:	- Local behavioral health providers - Local social service organizations

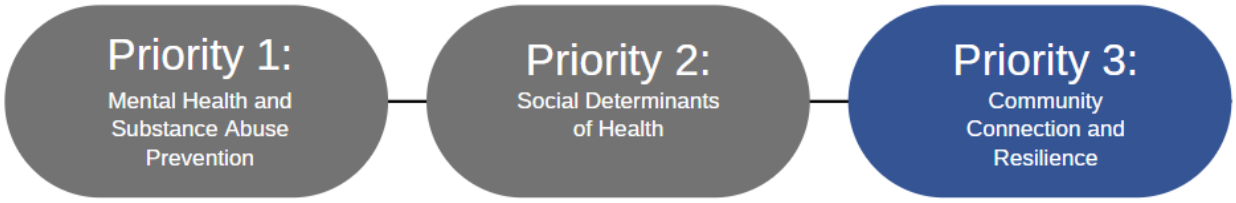
Action Steps:	- Utilize 17 purchased studio units to provide housing and care for individuals at highest intersections with emergency systems.
	- Work with local providers to integrate behavioral health and place-based care strategies:
	  o Provide onsite immediate care counseling for those in crisis and help to coordinate ongoing comprehensive services to help reduce wait time between referral and enrollment.
	  o Provide onsite case management to provide light touch supports and reduce barriers to help clients continue using needed services.

Timeline:	- CAPNM has purchased 17 studio units for this project. - CAPNM is working with a donor to purchase property in Evergreen to house this project in 2022 and 2023. - CAPNM is hoping to launch the project in Summer of 2023. - Evaluation of the project's success will be ongoing 2023-2025.
Indicators of Success	- Number of individuals successfully enrolled and utilizing services - Time between referral and enrollment

(Short Term):	
Baseline Data:	- NA

Priority Area 3: Community Connection and Resilience

The benefits of social and community connection span widely, including things such as improved physical and emotional health. As we move out of the COVID-19 pandemic, our stakeholders identified the need to rebuild community connections. Additionally, this priority area relates to the "Partnership and Capacity Building" and "Resilience" priority areas recognized in the 2020-2022 CHIP. For our CHIP work to be successful, we must foster partnerships and continue collaboration across multiple sectors in our community.



Priority-Specific Objectives:

1. Expand awareness of community resources and participation in community activities.
2. Integrate trauma-informed care and resilience into the workplace.

Objective 1: Expand awareness of community resources and participation in community activities.

Background:

This objective is aimed towards linking necessary services with the groups of people who need them. We know that ensuring equitable access helps community members lead healthier lives. Strategies included in Objective 1 strive to rebuild a sense of community and increase awareness of local resources. These strategies relate to several of the overarching goals of Healthy People 2030, and are directly linked to a few HP2030 objectives, including DH-D01 and HC/HIT-04 (See Appendix 1).

Measurable Long Term Health Outcomes:

We will assess the long-term progress of this objective by tracking the following measures:

- Overall health status of the community
  - Source: Flathead County Community Health Needs Assessment
- Livability score for Flathead County seniors
  - Source: Montana Area IX Community Assessment Survey for Older Adults

Strategy 1: Introduce intergenerational evidence-based programming focused on health-promotion and disease prevention.	
Lead Organization:	Agency on Aging

Collaborating Organizations:	- MSU Rural Extension Office - Kalispell Senior Center - FVCC - Flathead City-County Health Department
Action Steps:	- Work with partnering community organization to determine evidence-based health promotion activity. (Examples of potential activities include Strong People, QPR, or FVCC Continuing Education) - Schedule and promote activity to individuals across generations with the help of other organizations (4-H, Senior Centers, etc) - Track attendance numbers and evaluate success of program.
Timeline:	- Select evidence-based program in 2023. - Schedule and promote first activity by end of year 2023. - Continue to expand and offer programming 2023-2025.
Indicators of Success (Short Term):	- Number of program participants - Number of events held
Baseline Data:	- NA

Strategy 2: Review and update the Linking Infants and Families to Services (LIFTS) guide.	
Lead Organization:	Perinatal Mental Health Coalition
Collaborating Organizations:	- Flathead City-County Health Department - Logan Health - Logan Health Whitefish - Greater Valley Health Center
Action Steps:	- PMHC will review resources listed in database and update or remove resources as needed annually. - PMHC will promote LIFTS guide to organizations and individuals who work with infants and families.
Timeline:	- Initial population of resources into the LIFTS database occurred in 2022 by the Maternal Health Coordinator - Resources will be reviewed and updated annually 2023-2025 - Annual review will occur by May 15th of each year
Indicators of Success (Short Term):	- Number of resource listings updated - Number of event listings updated
Baseline Data:	- Resources available in LIFTS guide as of 2022.

Strategy 3: Support families, caregivers, and those living with or caring for someone with Alzheimer's or dementia.	
Lead Organization:	Agency on Aging
Collaborating Organizations:	- Alzheimer's Association - Kalispell Senior Center - Local churches
Action Steps:	- Offer educational workshops and events to resource and connect caregivers.

	- Continue to develop partnership with the hope of offering additional resources such as day services, respite, zoom access for events. - Expand partnerships (i.e. local churches or other organizations) to host events in different locations around the valley.
Timeline:	- 2 events offered in 2022 (listening session and educational workshop) - Schedule and promote additional activities in 2023. - Continue to expand and offer programming 2023-2025.
Indicators of Success (Short Term):	- Number of workshops held - Number of program participants
Baseline Data:	- Two (2) program activities offered in 2022.

Strategy 4: Expand CONNECT, a coordinated electronic referral system	
Lead Organization:	Flathead City-County Health Department
Collaborating Organizations:	- Flathead City-County Health Department - Logan Health - Logan Health Whitefish - Additional social service providers
Action Steps:	- Reach out to existing CONNECT users with updates and information about the new system. - Present to new organizations and coalitions to increase CONNECT user-base. - Update and sign MOUs with enrolled organizations.
Timeline:	- CONNECT recently underwent a DPHHS state review and is slated to resume functioning in fall of 2022. - Outreach for CONNECT will resume January of 2023 and continue annually.
Indicators of Success (Short Term):	- Number of agencies enrolled in CONNECT. - % of CONNECT referrals that are successful.
Baseline Data:	- 61 enrolled organizations in 2020.

Objective 2: Integrate resilience and trauma-informed care into the workplace.

Background:

The 2019-2023 Montana State Health Improvement Plan selected Adverse Child Experiences (ACEs) as a priority area. While our objective is not a direct overlay, ACEs are the foundation behind our understanding of cumulative stressors in childhood which may lead to lifelong risks for poor health outcomes. Increasing knowledge and skills regarding ACEs, trauma-informed care, and resilience will lead to a healthier and more connected community.

Measurable Long Term Health Outcomes:

Although ACEs cannot be directly assessed through current data sets, there are other long term health measures that are closely related to ACEs that we can evaluate to measure long-term progress within this objective.

- Percent of children in poverty.

    - Source: Flathead County Community Health Needs Assessment
- High school graduation rates.
    - Source: US Census Bureau
- Tobacco use and marijuana use among youth.
    - Source: Youth Risk Behavior Survey

Strategy 1: Reintroduce resilience and PACES training opportunities	
Lead Organization:	Early Childhood Coalition
Collaborating Organizations:	- ECC Steering Committee members and facilitator
Action Steps:	- Reengage with the Resilient Flathead Workgroup - Explore opportunities for educational presentations (MHFA, de-escalation, motivational interviewing, etc). - Presentations to be initially held at monthly ECC meetings with the potential of expanding to community.
Timeline:	- Reach out to potential presenters beginning July 2022 - Schedule one initial training opportunity to occur by end of June 2023 - Look to schedule additional trainings throughout 2024
Indicators of Success (Short Term):	- Number of trainings held - Number of individuals trained
Baseline Data:	- Two potential presenters have been contacted by November 2022.

Strategy 2: Promote the use of trauma-informed organizational assessments	
Lead Organization:	Early Childhood Coalition
Collaborating Organizations:	- ECC Steering Committee members and facilitator
Action Steps:	- Explore participation in the Linking Systems of Care for Children and Youth in Montana (LSOC) Organization Trauma-Readiness Self-Assessment - Explore templates for trauma-informed policy and practice. - Implement trauma-informed organizational practices, beginning with organizations involved in ECC. - Invite outside organizations to utilize the templates and implement trauma-informed practices in the workplace.
Timeline:	- Discuss opportunities and models beginning January 2023. - Implement trauma-informed practices within the coalition by June 2023. - Look for opportunities to expand participation with trauma-informed practices in other organizations 2024-2025.
Indicators of Success (Short Term):	- Number of organizations implementing trauma-informed policies and practices.
Baseline Data:	- No data regarding trauma-informed organizations has been collected as of 2022.

Appendix 1:

Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade. The following HP2030 objectives align with the strategies included in our 2023-2025 Community Health Improvement Plan.

Healthy People 2030 Objectives:

- AHS-08: Increase the proportion of adults who get recommended evidence-based preventive healthcare.
- C-05: Increase the proportion of females who get screened for breast cancer.
- DH-D01: Reduce anxiety and depression in family caregivers of people with disabilities.
- ECBP-D07: Increase the number of community organizations that provide prevention services.
- HC/HIT-04: Increase the proportion of adults who talk to friends or family about their health.
- NWS-01: Reduce household food insecurity and hunger.
- NWS-02: Eliminate very low food security in children.
- NWS-06: Increase fruit consumption by people aged 2 years and over.
- NWS-07: Increase vegetable consumption by people aged 2 years and older.
- NWS-09: Increase whole grain consumption by people aged 2 years and over.
- NWS-13: Increase calcium consumption by people aged 2 years and over.

Appendix 2:

Baseline data for long-term health outcomes mentioned in this 2023-2025 Community Health Improvement Plan.

Priority and Objective	Long Term Outcome (Flathead County Specific)	Baseline	Source
1.1	Suicide Mortality Rates	Crude rate 39.23 deaths per 100,000 in 2021.	Flathead County Suicide Report
1.1	Nonfatal intentional self-harm emergency department visits	Age-adjusted rate 99.23 per 100,000 in 2020.	DPHHS
1.2	Individuals receiving treatment for mental health conditions	16.4% of adults, 2021	CHNA
1.2	Individuals reporting difficulty accessing mental health services	4.7% of adults, 2021	CHNA
1.3	Smoking rates among people who report having poor mental health	30%* of individuals reporting poor mental health report being a current smoker, 2020	Montana BRFSS
1.3	Smoking attributable mortality rate	25.8%* of cancer deaths attributable to smoking, 2021	CDC BRFSS
2.1	Individuals reporting difficulty accessing healthcare services	36.8% of adults reported difficulty accessing healthcare, 2021	CHNA
2.1	Mental health providers per 100,000 population	65.9 mental health providers per 100,000, 2021	CHNA
2.2	Individuals determined to be food insecure	9.6% of residents considered food insecure, 2021	CHNA
2.2	Middle school and high school students reporting going hungry because of lack of food in home	Highschool) 5.38% Middle school) 5.1% reported sometimes, most of the time, or always, 2021	Flathead County YRBS
2.2	Individuals living in unhealthy or unsafe housing conditions	5.7% of residents, 2021	CHNA
3.1	Overall health status of the community	12.6% of adults report health status as “fair” or “poor”, 2021	CHNA
3.1	Livability score for Flathead County seniors	Community inclusivity) 53/100, Equity) 47/100	Area IX Community Assessment
3.2	Children in poverty	15.7% of children, 2021	CHNA
3.2	High school graduate or higher, percent persons aged 25 or older	94.2%, 2021	US Census
3.2	Tobacco/e-cigarette use, and marijuana use among high school students	Ever tried cigarette) 27.25% Ever tried e-cigarette) 46.44% Ever tried marijuana) 36.01%	Flathead County YRBS

*Data point for Montana, not specific to Flathead County