Meeting Minutes: March 4, 2019  
Lewis and Clark Community Health Improvement Plan Meeting #3

Meeting Purpose: Outline a path for Collective Impact in each of the key areas for action for the Community Health Improvement Plan

Opening and Overview from Meetings 1-2

<table>
<thead>
<tr>
<th>Introductions</th>
<th>Introductions of group members and Healthy Together Steering Committee</th>
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</table>
| Overview of Meetings 1-2 | • Katie reviewed results from meetings 1-2 (presentation)  
• Outlines two health priority areas that will structure the CHIP and how we arrived at those areas and the focus areas for action under each priority area  
• The purpose of today’s meeting is to begin to develop a path forward for collective impact in each of the priority areas  
• Review of collective impact |

<table>
<thead>
<tr>
<th>Explanation of groups</th>
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|                        | • Early Childhood  
  o Childcare and school readiness (Lead facilitator=Zero to Five and Early Childhood Coalition)  
  o Adverse Childhood Experiences (ACEs) (Lead Facilitator=Childwise and Elevate Montana)  
  o Behavioral Health  
    o Prevention and stigma reduction (Lead facilitator=Suicide Prevention Coalition)  
    o Screening and Access to Care (Lead facilitator=Local Advisory Council)  
  o Systems coordination and referral (Lead facilitator=CONNECT Referral System) |

Website Demo  
Gayle provided a short demo of the Healthy Together website to help the group know how to access information about this process

Set up for meeting  
• Group members self-selected into one of the groups and introduced themselves

Early Childhood: Early Childcare and Education

<table>
<thead>
<tr>
<th>Attributes of the Current System</th>
<th>Current work</th>
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</table>
|                                  | • Early Childhood Coalition  
  o Early care and education  
  o Home visiting task force  
  o Maternal mental health |
| **Zero to Five Initiatives** | **Early Childhood Services Bureau**  
<table>
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<td></td>
<td>o Federal grant (planning)</td>
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<td>o Parent education/provider education</td>
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<td>o Funding coalitions</td>
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<td><strong>90 Licensed Facilities-7 Head Start</strong></td>
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**Attributes of the current system**
- Ages 0-2 -- challenge to find care
- Ages 0-5 - care available during traditional work hours; those who need it most often don’t work traditional hours
- Have to get on a waiting list before pregnant
- No care available outside of Helena/East Helena
- Lack of awareness of scholarships
- Unlicensed childcare
- Need or not to be licensed

**Envisioning the Ideal System**
- Education about childcare options and scholarships at birth, through St. Peter’s and pediatricians’ offices
- Universal application
- Navigator system-open door, office pediatricians
- Increased employer-sponsored childcare

**Critical Shifts Needed to Move from Current to Ideal System**
- Community education about options
- Employers understand the value of childcare
- Childcare co-op model
  - o Shared costs (benefits, training)
  - o One application
  - o Universal standards
- Childcare facilities getting/providing data to indicate need

**Draft “Shared Vision for Change”/Common Agenda**
A community that values childcare and fosters an environment where high-quality childcare exists and provides options to all.
Connect all early care to kinder

**Current multi-sector/lead facilitator group development stage**
We have existing groups in place-ECC and 0-5
Need to recruit to the ‘right’ meeting
ECC-current workgroups will have coordinator funded soon, increased focus on Week of the Young Child and coordination/connection
Community-wide work related to early childhood, working with school district to focus on transitions/readiness to kindergarten
0-5-very early: still developing government/decision-making structure

**Action steps on group development**
- Align 0-5 w/ ECC-define relationship

**Current communication**

**Action steps for developing continuous communication**
- Educate community on quality early care
| Current and proposed mutually reinforcing activities | • Survey/educate employers about employer-sponsored care  
• Research/survey/explore co-op  
• Identify needed/missing data to indicate need  
• Survey community needs |
<table>
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<tbody>
<tr>
<td>Shared measurement</td>
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### Early Childhood: ACEs and Trauma Informed

#### Attributes of the Current System
- 11 affiliates of Elevate Montana
  - One in Lewis and Clark County
  - Cross-sectional members/network
  - Master trainers/community presenters
- “Buy-in” to trauma-informed trainings
  - Shodair
  - Lewis and Clark Public Health
  - St. Peter’s Health
  - McDonald’s Restaurants

#### Envisioning the Ideal System
- Policy for NEO (what does that mean?)
  - Practices of organizations to operate trauma-informed
- Screening and appropriate referrals
- Introduction and understanding for all major/minor employers-chamber members
- Systems of EAP to address high ACE scores
- Awareness of resilience efforts
  - Creating positive experiences HOPE (Health Outcomes from Positive Experiences)
- MT BRFSS information on HOPE available in 2020

#### Critical Shifts Needed to Move from Current to Ideal System
- Engagement/understanding of critical windows of opportunity for brain development
  - Gestation-growing neural structures of next generations
  - Early parenting-growing caregiver capacity
  - Engage men and support their important role with mother and baby
- Buy-in from those who don’t yet understand the importance of a trauma-informed system
  - Supervisors and addiction science-use positive community norming and buy-in
  - Decide on language and terms-trauma and toxic stress
- Breaking down barriers/stigma
  - Educating kids (similar to sex education in health class)
  - Educating young parents
  - Educating communities: public health, business, health, education systems, military, faith
  - Engage adults to “be the one”
  - Storytelling
- Some system to identify when more support is needed and a plan as to how to get it
  - Protective factors screen or resilience screens with resources in areas of need (i.e. sports, Blue Cross Blue Shield, tutor, volunteer opportunities to find a job etc.)
<table>
<thead>
<tr>
<th>Draft “Shared Vision for Change”/Common Agenda</th>
<th>To create a safe and compassionate community where we share our stories and support each other-strengthen relationships, in it together</th>
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<tbody>
<tr>
<td>Current multi-sector/lead facilitator group development stage</td>
<td>Backbone=Elevate Montana, Helena,</td>
</tr>
</tbody>
</table>
| Action steps on group development | Set executive-level meeting to education/advocate  
Collaborative work; engage members and keep members engaged |
| Current communication | Need to make sure that groups with mutually reinforcing activities communicate |
| Action steps for developing continuous communication | Need a communications strategy  
Increase awareness  
  - Elevate Montana work  
  - Talking points/fact sheet about how ACEs effect x, y, z |
| Current and proposed mutually reinforcing activities | Target largest employers: state of MT, hospital, school district, county government, VA, City of Helena, BCBS-MT, CareHere, EAP, Diamond, Dick Anderson  
Access legislators  
Advocate/engage peer-to-peer conversations to answer-how does this help my X=i.e. summer g (?)  
Create a snapshot of what is happening now; need an inventory  
Need a plan to decide who has capacity to do an inventory and who is doing what  
  - Create survey  
  - Recruit survey participants to E.H.  
Create cross-sharing/peer-learning plan; how/where does this happen?  
Create 5-10 year plan with stakeholders to create a trauma-informed Lewis and Clark County to reduce toxic stress in communities |
| Shared measurement | Goals:  
  - Increase the number of large employers mandating ACE training for new hires. Measurement-2/year  
  - Create a 5-10 year community strategic plan to create a trauma-informed community  
    - Snapshot  
    - Inventory of plan  
    - Designate roles  
    - Measurement 1) ACE report created, Strategic Plan created  
  - Use a collective Impact model to do the work  
    - Work groups identified including data and executive  
  - Increase awareness of trauma informed  
    - Measurement: # of trainings, # of people trained, # of employees w/ embedded trainer  
  - Get funded staff for collaborative stuff  
    - Staff efforts to a trauma-informed community |
# Behavioral Health: Stigma Reduction and Prevention

## Attributes of the Current System
- Lewis and Clark Suicide Prevention Council is the multi-sector convener
  - Vista: awareness and communication with the community
- Non-existent; difficulty finding help
- Lack of access
- Stigma prevented by stigma
- Middle-aged men at highest risk for suicide
- 20 suicides last year, 19 prior year
- Man Therapy, Mayor’s Challenge (Veterans’/Military)
- Mobile crisis units, ER/jails
- Certified mental health professionals; determine if need higher level of care
- Have CRT, paramedic, peer supports
- Difficult to find placement, centralized placement
- Current legislative request for funding (L&C, Silver Bow Counties) - not in place at this point
- Lethal means; 63% of suicides are lethal means (firearms)
- Need for education, gun locks/safe storage
- Limit access to means of suicide
- Not everyone aware of services that exist in our community
- How does a person ask someone if suicidal; dispel “plant a seed” myth
- More and more science, connection of environmental factors to mental health
- Chronic pain impact
- Loneliness, isolation
- Suicide prevention training; how to get to a saturation level
- Individuals who are exposed to suicide are more likely to commit suicide
- Employment education, embracing information
- Violence prevention
- Murder/suicide; unhealthy relationships
- Air quality, Vitamin D levels
- Location, living in MT effects on health
- Rural state
- Rx pads for providers to prescribe website to patients
- Opioid addiction
- Licensed addiction counselors
- Self-medicate, substance use

## Envisioning the Ideal System
- Increased education/saturation for community
- Increased access to services
- Training opportunities for veterans, Mental Health First Aide, QPR, ASSIST, PAL
- Increased awareness
- Increased number of providers in the community; being able to refer an individual to services that exist; LAC, therapists, MAT
| Critical Shifts Needed to Move from Current to Ideal System | Support families (family to family)  
- Increased resources and funding  
- Trained peer support  
- Education/training  
  - ASK Campaign: best ways to approach with children, teens, and adults  
  - Identifying the signs; concerns, conditions  
- De-stigmatized, treat mental health issues/diagnoses like we treat medical conditions/diagnoses  
- Change perception of how to ask questions, help each other  
- Talk about it, normalize conversations  
- Movement across community  
- Tree City>>>Suicide Safer Community then spread to other communities-PREVENTION  
- Schools-curriculum; Youth Awareness of Mental Health  
- Change Agent>>>>Train agency staff and individuals>>>>Train more people  
- Ask the question initiative |

| Draft “Shared Vision for Change”/Common Agenda | Our vision for Lewis and Clark County is to educate all citizens on suicide awareness and “normalize” the conversation around mental health, increasing access to care and building peer supports in the community. |

| Current multi-sector/lead facilitator group development stage | Backbone: Lewis and Clark Suicide Prevention Coalition-Coordinator=Jess |

| Action steps on group development | Through coalition |

| Current communication |  
- Improve internal/external communication; include non-suicide specific coalition  
- Expand external communication with public and other agencies  
- Tree model; mutually reinforcing common message  
- Need communication plan: media, CONNECT; Gayle  
- Expansion of communications and a shared vision  
- Use coalition to amplify message |
| Current and proposed mutually reinforcing activities | • Education and training of all Lewis and Clark County residents by  
  o Identify orgs willing to listen/be educated; get buy-in (who is committed to plan)  
  o Engage orgs in ongoing communication  
• Build capacity of Lewis and Clark Suicide Prevention Coalition to manage and support partnerships and training  
  o Develop communication plan  
  o Train trainers (do we need more)  
  o Identify funding and staffing needs  
• Expand existing LCSPC campaigns further into broader community  
  o Using/communicating through partner orgs, like tree branches |

| Shared measurement |  |

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### Behavioral Health: Screening and Access to Care

#### Attributes of the Current System
- Collaboration between agencies that provide services
- Screening happening at primary care, pediatrics, public health and appropriate follow-up
- Psych rotation during nursing school
- Integrated behavioral health and warm hand-offs to BH team member
- CONNECT: Consented referral system
- Mandated screenings for depression for primary care patients at St. Peter’s Medical Group & ER Patients
- Integrated behavioral health at Helena OB/Gyn in partnership w/ St. Peter’s Health
- Housing is Healthcare

#### Envisioning the Ideal System
- All healthcare providers screening for depression and social determinants of health
- Broadening the screenings that are done e.g. mania, MOAS, GAD7
- Walk-in appointments at all behavioral health providers
- All children screened at school and daycare; appropriate referrals made
- Behavioral health services in schools, enough school nurses and mental health professionals
- Training for school nurses
- Use Front Door Model for Behavioral Health Services and make a lot of agencies a Front Door
- Integrated behavioral health in in-patient setting at St. Peter’s Health
- Housing inventory is adequate for families/individuals
- More psych providers
- More telemedicine services
- Easier scheduling with mental health providers; more that bill Medicaid
- Retain Medicaid expansion
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<tr>
<th>Critical Shifts Needed to Move from Current to Ideal System</th>
<th>Draft “Shared Vision for Change”/Common Agenda</th>
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<tbody>
<tr>
<td>Adequate funding at schools for screening, referral and services</td>
<td>Integrated system that universally uses standardized screenings across all ages for behavioral health disorders and provides warm hand-offs to adequate and effective services.</td>
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<tr>
<td>Coherent, collaborative plan with the right distribution of resources (don’t unnecessarily duplicate services)</td>
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<td>Train all healthcare providers on screenings, referrals on services available</td>
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<td>Eliminating steps for patients, getting them access to the right people, when they need it (hiring enough people)</td>
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<td>Team-based care, hiring enough people for wrap-around care (primary care, nursing, mental health professionals, case manager)</td>
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<td>Adequate crisis response system</td>
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<td>Health information exchange; including scheduling with therapists</td>
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<td>All agencies using CONNECT Referral System</td>
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<td>MAT being offered at more agencies</td>
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<td>Easier and more efficient licensing for mental health pros (legislation)</td>
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<thead>
<tr>
<th>Current multi-sector/lead facilitator group development stage</th>
<th>Partners:</th>
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<tr>
<td>Local Advisory Council (LAC)</td>
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<tr>
<td>MMA (Montana Medical Association)</td>
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<tr>
<td>MPCA (Montana Primary Care Association)</td>
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<tr>
<td>Colleges &amp; residency programs</td>
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<tr>
<th>Action steps on group development</th>
<th>Current communication</th>
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<tr>
<td>Identify project lead and/or physician champion</td>
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<tr>
<td>Clearly define an action plan</td>
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<thead>
<tr>
<th>Action steps for developing continuous communication</th>
<th>Current and proposed mutually reinforcing activities</th>
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<tr>
<td>Convene healthcare providers and agree on standardized screenings</td>
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<tr>
<td>Determine the process for universal screenings &amp; referrals: who, when, how, where</td>
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<tr>
<td>Determine how to track referrals and outcomes; get them all using CONNECT</td>
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<tr>
<td>Educate all providers on behavioral health resources</td>
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## Cross-cutting Issue: Systems Access and Referral

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<tr>
<th>Attributes of the Current System</th>
<th>ENVISIONING THE IDEAL SYSTEM</th>
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<tbody>
<tr>
<td>• CONNECT Online System</td>
<td>• Family first and person-centered</td>
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<tr>
<td>• Challenge: providers working w/ same client may not be in communication</td>
<td>• Agencies are connected, referrals are smooth; from hiding the chaos to eliminating the chaos and being more transparent to client</td>
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<tr>
<td>• Challenge: not all providers and agencies are on CONNECT</td>
<td>• Individuals/families feel supported</td>
</tr>
<tr>
<td>• Challenge: every agency has its own way of making referrals</td>
<td>• Prioritization of client needs</td>
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<tr>
<td>• Question of cost for referral system, now and future</td>
<td>• Coordination of many agencies for various needs of client</td>
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### Critical Shifts Needed to Move from Current to Ideal System

- Get all agencies using CONNECT as a community; we need to commit
- Interagency coalition and communication
- Dignity and respect for people seeking services, akin to business customer service model
- Individual facing-all
- Agency provider facing-CONNECT
- Respect and dignity
- No wrong door for individuals/families and agencies in accessing services
- Community (agencies) commit to joining CONNECT and using it as the primary source of referral, which allows other agencies to trust and utilize the system so information and resource navigation is available
- Ask and listen to those we serve; how to improve what we’re doing; be willing to be changed by that person when you’re listening

### Draft “Shared Vision for Change”/Common Agenda

- All of the above will allow us to more clearly see and address gaps in our community
- Take St. Pete’s list of physical needs to the community level
- Integration of EMRs and CONNECT; medical community buy-in
| Current multi-sector/lead facilitator group development stage | • Need buy-in from leadership level across sectors, plus bottom-up approach with agencies  
• Agency/coalition building board; agencies want it, but someone needs to fund/own it. Slack? Facebook? Need platform and owner |
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<tbody>
<tr>
<td>Action steps on group development</td>
<td>• Research platform and who owns it</td>
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</table>
| Current communication | • Staff need to communicate back to agencies about coalition meetings  
• Where does broader conversation live? A team? Does it start higher up?  
• CONNECT system has auto-emails, emails from CONNECT coordinator, user surveys |
| Action steps for developing continuous communication | • Identify champions within each agency  
• Identify communication champion  
• Clarify confidentiality safeguards  
• Use of ROI for actual communication  
• CONNECT: who’s not on it? Who needs to be  
• Who is on it who needs support?  
• CONNECT-agencies build in CONNECT into onboarding and existing w/ support of CONNECT coordinator  
• Coalesce coalitions-brain trust of coalitions-LOTR council  
• Improve care coordination; specifics TBD; Kelli McBride’s BH coordinator is doing this well |
| Shared measurement | |

**Wrap up and Conclusion**