Healthy Together Taskforce Meeting 2
Meeting 2 | April 13th, 2022 10 am to noon

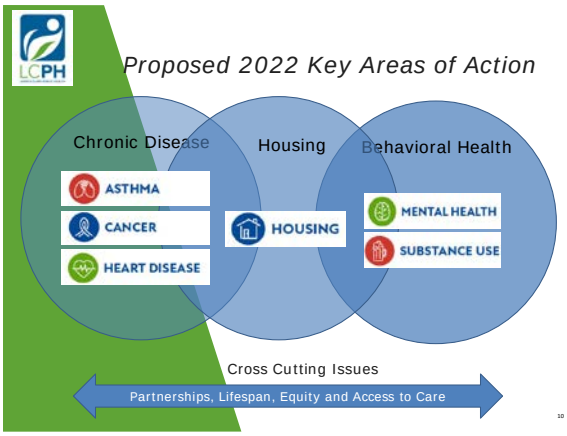
In attendance:

- Jake Henderson, AWARE
- Ben McGaugh - Project Manager; PureView Health Center - Helena, MT
- Sarah Sandau, Prevention Programs Supervisor at Lewis and Clark Public Health(LCPH)
- Mary Sparks Home Visiting Supervisor, LCPH
- Jill Steeley, Executive Director, PureView Health Center
- Kim Lloyd, Harvest of the Month Community Coordinator, St. Peter's Health
- Sandy Bauman, Dean/CEO, Helena College
- Jess Hegstrom, suicide prevention coordinator, LCPH
- Brandi Thomas- Child Care Connections- Provider Services Supervisor
- Kayla Morris, Supervisor of Community Based Services- St. Peter's Health
- Julie Bir, CONNECT Coordinator, Lewis and Clark Public Health
- Jolene Jennings, Behavioral Health Systems Improvement Specialist, LCPH
- Kathy Marks, Operations Director, Rocky Mountain Development Council, Inc.
- Dawn Sullivan, Public Health, Admin Asst II
- Gina Boesdorfer, Executive Director, The Friendship Center.
- Patty Kosednar, Account Manager, Mountain Pacific Quality Health
- Jeff Buscher - Community Impact Coordinator, UWLCA
- Kathy Moore, LCPH ? of position
- Mindy Diehl, Rocky Senior Nutrition and Transportation Program Director
- Brett Lloyd, PHEP Coordinator, LCPH
- Rebecca Hargis, Chair, Elevate Montana Helena Affiliate
- A.C. Rothenbuecher, Community Health Promotion Division Administrator, LCPH
- Damian Boudreau, Communications Manager, LCPH
- Lisa Lee, Director, Montana No Kid Hungry & Lead of the Kids Nutrition Coalition
- Drenda Niemann, Officer, LCPH
- Chloe Lundquist, SNAP-Ed Instructor, MSU Extension
- Kim Dale Program Operations Director, Helena Food Share (
- Kellie McBride, Director, CJS

(Can you note who attended groups with key ie; B-BH, H-Housing, C-Chronic Health) We had 6-8 people in BH group, and wanted to make sure all listed – Kellie was in BH and not on list.hoping you tracked☺

10 am – Welcome and introduction of group leads and framework

Katie reviewed work in Meeting 1 and reminded the group about why the three areas were selected and introduce the frameworks for each topic
Allowed group members to self-select into one of three breakout rooms



10:15 am – Small group work

Chronic Disease

Framework

Lewis and Clark County Chronic Disease Continuum

Data and Surveillance	Environmental Approaches	Community programs linked to clinical services	Healthcare System Interventions
Community Health Assessment; LCPH epidemiologist; Healthy People 2030; State Health Improvement Plan; Sources: BRFSS, YRBS, Insurance Data, EHR, Vital stats; State epidemiologists	Active living Wayfinding Plan; Complete Streets; Tobacco free policies (CIAA, parts, point of sale); WIC Farmer's Market; Community gardens; Harvest of the month: Schools and Community; Double snap dollars for produce; Senior food vouchers at farmers market/senior commodities; Helena Food Program; School Meal Program	Diabetes prevention program and self management education; Worksite wellness programs; react Tobacco prevention in schools; Tobacco cessation courses; SPH- Food Rx, Food is Care, Food Farmacy; SNAP Ed Nutrition Classes; Peer breast feeding supports; Chronic disease self management courses; Helena schools District wellness committee	SPH Dieticians; Arthritis movement classes; Culinary Medicine SPH
Asthma: Today's Air DEQ	Air quality monitoring; Asthma monitoring in schools	Asthma home visiting	
Cancer: Montana tumor registry			SPH Cancer Navigators; Breast and Cervical Health Program
Heart Disease		Health Coaches for Hypertension	

Cross Cutting and Lifespan Services

Coalitions and Partnerships	Early Childhood and Families	Youth	Older Adults	Equity	Access to care and services
• Healthy communities coalition • NMTAC • Harvest of the month	• Early childhood coalition • Kids Nutrition Coalition • Elevate MT-Helena Affiliate	• District wellness committee-Helena School District • Youth CONNECTIONS	• Aging well workgroup		• Health Improvement Coalition

Our Vision for the Future

- Policies, systems, and environments are all in place to make the healthy choice the easy choice
- Normalizing health
- Culture of health
- Evidence based intervention
- Equity
- Cross-connecting to programs

How do we get there?
What do we need to strengthen and grow?

- Access to the programs we offer (transportation, availability (schedule, time), etc.)
- Improving school meals-What does Sodexo need?, Long term: commercial kitchen
- Food Access and Education
  ~Healthy Food affordable and accessible
  ~School Meals
  ~Families
  ~Seniors
- Incorporating more sustainability in education efforts- environmental options
- Aero food mapping
- Harvest of the month
- Clean room campaign
- more coordinated and collaborative physical activity initiatives
- Communicating amongst workgroups/avoiding duplication
- Build on trails, sidewalks (active transportation)
- How to access programs (mapping, connecting the dots, etc.)
- How do we build on where people already go for information
- Re-start (and find a lead) for the Breastfeeding Collaborative
- Healthy Living DPHHS Map- updating and including
- Culturally competent strategies and campaigns
  ~Having the groups be part of the solutions
- Look at data for specific groups in these areas

Where are the gaps? What would need to shift or be developed to achieve our vision?

- Word
- Audit, educate, and train healthcare providers for needs of specific populations
  ~LGBT

~AI
~Low income
~People with disabilities

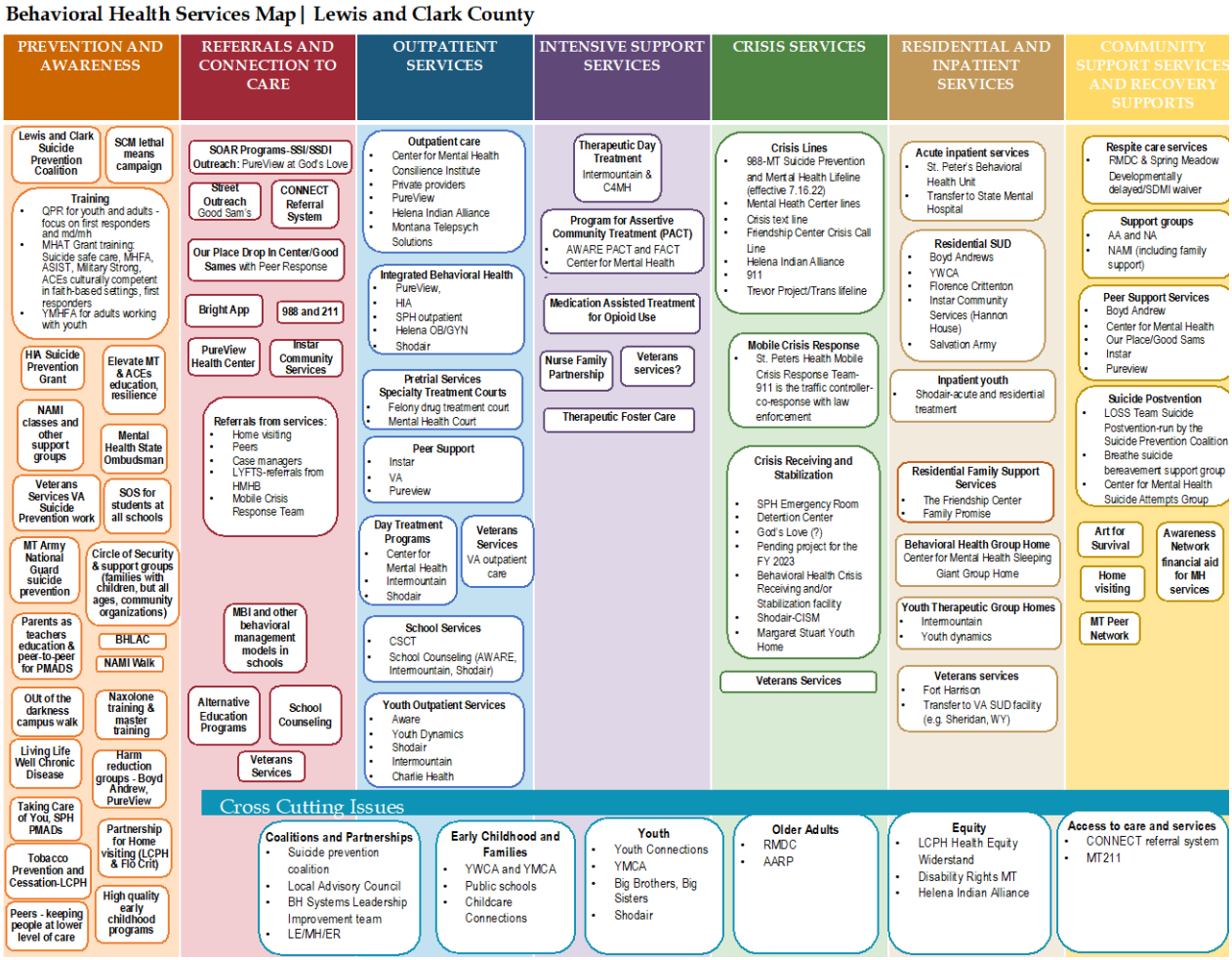
- Awareness: why are these a big issue? Priority? Preventative messages, talk to experts, look at best practices
- Adjustable bites of date
- Fund development to move these programs along
- Right partners at the table (and new partners and voices)
    - Lived experts
    - Businesses
    - Educational institutions
- Next thing: what are the specific groups for each of the groups

Priority areas of action for the CHIP

Key Area for Action	Related Strategies	Who will lead?	How will we measure success?
Engaging new partners (increase cultural competency and power analysis)			
Healthy food and physical activity access			
Education and awareness			
Infrastructure Supports: funding, mapping, data			
Coordination of Chronic Disease and upstream efforts			

Behavioral Health

Framework



Our Vision for the Future

- Anyone who needs care gets appropriate, high quality and timely care
- Zero suicide
- Upstream
- If have condition (conditions or crisis?) receive treatment in community at appropriate levels
- Complete crisis system – 988 Crisis Call Lifeline, Mobile Crisis Response Team (MCRT), and a Crisis Receiving and Stabilization Facility
- Community integration - patients can live and work in community while receiving care
- Strong healthy community - & strong quality of life
- "A state of complete physical, mental and social. well-being and not merely the absence of. disease or infirmity"

How do we get there?
What do we need to strengthen and grow?

- Services available for youth to easily access
- Availability of prevention programs Prenatal - whole life span
- Assessments for BH throughout the system
- Adoption of zero suicide/safe care tools
- Well paid work force
- Incentives to keep providers
- Fair market rates for providers
- Expansion of peer support
- Primary care, pediatricians for screening and referrals
- Access to more quality Early childhood programs that are free to clients
- BH stigma reduction among parents
- Sustainable funding for programs and services

Where are the gaps? What would need to shift or be developed to achieve our vision?

- Detox services
- $$$
- Workforce
- Community champions
- policy change - county, state, federal, organizational
- Change community perception
- Identify common goals, ground, and language
- Siloed agencies
- All aspects of health care are accessible, equitable
- Change decision/policy makers perception
- Technology and Data Systems throughout BH Programming: Note from Jolene-Important link to LCC BH Crisis System Analysis, 2021 as needed and something we are working towards in BH Local Advisory Council Workgroup.

Priority areas of action for the CHIP

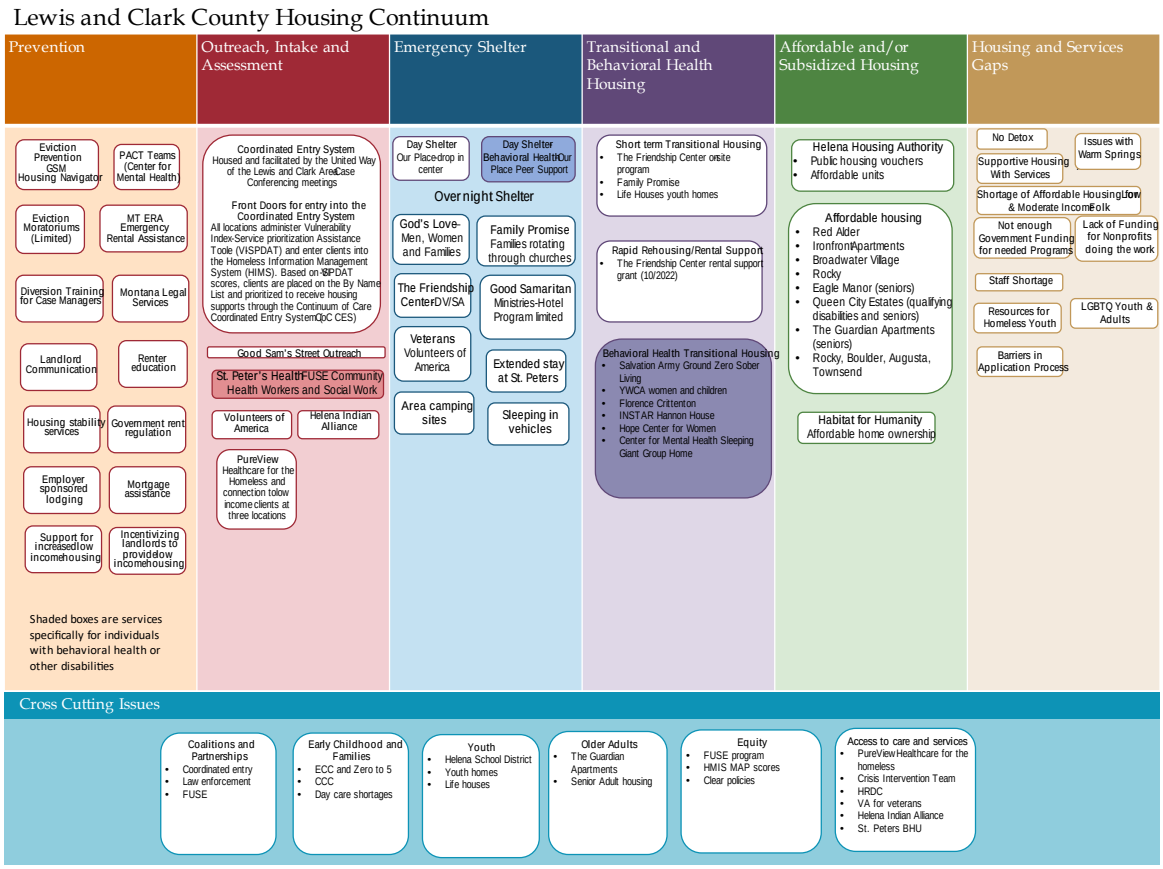
Key Area for Action	Related Strategies	Who will lead?	How will we measure success?
State & federal-level advocacy around funding & streamlining services	• Health insurance coverage, increase professional license options for billing		

	Medicaid/Medicare ie; LAC , LCPC. • Community Letter of Support for Bill on Licensure Required • Detention Center (DC) ability to bill for Medicaid needed- Education to Law Makers		
Service-wide mental health and substance use assessments	• Develop support from Primary Care Adult and Peds to apply assessments. • Suicide safe care training to apply assessments		
Fulfill and build three pillars of a crisis system (emphasis on crisis facility)	• Identify Provider to operate Crisis Receiving and Stabilization Facility • Define funding with DPHHS • Advocate to Private insurers in state for BH services reimbursement • 988-Awareness /marketing/ continue to collaborate with first responders, broaden COC outreach and monitor Crisis Pillar interaction.		
Housing for frequent users of services	• Engage in FUSE Housing Coalition Social Determinants of Health- standardize		
Health Insurance coverage	Engage with advocacy group for BH Crisis and		

	COC services reimbursement from private sector such as BCBS of MT		
Access to services in a timely manner	Advocate to DPHHS for both Receiving and Stabilization Crisis Facility to allow access to a full range of acuity levels for timely response.		
Building Workforce	Bring awareness to BH education and training opportunities at Helena College and MSU Extension. Collaborate with workforce development organizations. Identify funding and scholarship for workforce development.		

Housing

Framework



Our Vision for the Future

- Additional emergency shelter
- Temporary outdoor shelter/camp similar to Missoula
- Diverse housing options-rental/Co-Ops/Homes
- Engage developers
- Increased funding for affordable housing-HUD, Housing tax credits
- True housing prioritization for those with highest need
- Affordable student housing-aging out
- Reduce regulations and red tape
- Education
- Training for homelessness avoidance
- Landlords that communicate eviction risk to a case worker to interventions can be done
- Training for local religious groups re: options for housing
- Clear path for clients
- Single location for all information

- One quick application to get on all the lists

How do we get there?

What do we need to strengthen and grow?

- Additional emergency shelter
  - Collate existing data
  - Find physical location
  - Find sponsor/s partners
- Engage developers
  - Engage with Invest in Helena Builders etc
- Education
  - Training for Diversion Case managers
  - Tenant and Landlord
  - Community education about housing concerns
  - How homelessness and SUD/MH intersect-where does this type of education come from
- Clear path for clients
  - System collaboration
  - One stop shopping (Big billboard)
- More affordable housing for all
  - Increase supply
  - Create a Housing Solutions coalition

Where are the gaps? What would need to shift or be developed to achieve our vision?

- Additional emergency shelter
  - $$$$
  - Legislation
- Engaging developers-how to make this profitable?
- Education
  - Who or where is the subject matter expert?
  - Tap into existing resources-CSH
- Clear path for clients
  - Find models of this option-college application example
- More affordable housing for all
  - More houses
  - Legislation to remove barriers

Priority areas of action for the CHIP

Key Area for Action	Related Strategies	Who will lead?	How will we measure success?
Housing solutions coalition	Engage service providers, nonprofits, developers, gov, officials, school etc	United Way	Organize and meet
Additional emergency shelter	Pool current efforts	City/Co	Specific plans to open a shelter or a shelter opening
Public education	Community level education, education for landlords, education for case managers. Tap into existing resources experts-CSH	Non profits-Helena Housing Authority	De-stigmatize homeless and low income housing
System collaboration	Investigate existing models-one application for low income housing. Data sharing, client conferencing to continue after individual is house.	Non profits (?)-HHA	Increased ease of housing navigation and success-collaboration at all levels
More affordable housing for ALL	See coalition (above). Project dedicated to new developments	Community coalition	Increasing % of housing per population. Decreased "involuntary" homelessness

Next meeting: Wednesday May 11th from 10 am to noon