SHA/SHIP Coalition Minutes
December 13, 2017
1:30-3:00pm
Webinar: hhsmt.webex.com/

SHA/SHIP Coalition Attendees:

- **Kristi Aklestad** (Toole County Health Department—Small County Member)
- **Natalie Claiborne** (Montana State University Office of Rural Health)
- **Bill Gallea** (Montana Medical Association)
- **Hillary Hanson** (Flathead City-County Health Department—AMPHO)
- **Todd Harwell** (DPHHS, PHSD Administrator)-Co-Chair
- **Katie Hawkins** (Health Resources Division, DPHHS)
- **Eric Higginbotham** (Developmental Services Division, Children's Mental Health Bureau, DPHHS)
- **Greg Holzman** (State Medical Officer, DPHHS)
- **Jack King** (Montana Hospital Association)
- **Janet Runnion** (Rocky Boy's Health Board—Tribal Health Department Member)
- **Kari Smith** (Department of Environmental Quality)
- **Helen Tesfai** (Rocky Mountain Tribal Epidemiology Center)
- **Tony Ward** (School of Public and Community Health Sciences)
- **Aaron Wernham** (Montana Healthcare Foundation)
- **Lora Wier** (MPHA)-Co-Chair
- **Todd Wilson** (Helena Indian Alliance)

Other Attendees:

- **Jeremy Brokaw** (Injury Prevention Coordinator, PHSD)
- **Stacy Campbell** (Chronic Disease Bureau, PHSD)
- **Joan Miles** (SHA/SHIP Facilitator)
- **Jessica Miller** (System Improvement Office, PHSD, Coordinator)
- **Kerry Pride** (System Improvement Office, PHSD)
- **Terry Ray** (System Improvement Office, PHSD)
- **Kristen Rogers** (Family and Community Health Bureau, PHSD)
- **Jane Smilie** (Population Health Partners, LLC, Facilitator)

Excused SHA/SHIP Members:

- **Mike Andreini** (Rocky Mountain Tribal Epidemiology Center)
- **Karin Olsen Billings** (Office of Public Instruction)
- **Autumn Cummings** (Health Resources Division, DPHHS)
- **Kim Cuppy** (Fallon County Public Health Department—Frontier County Member)
- **Jean Curtiss** (Montana Association of Counties)
- **Kristin Juliar** (Montana State University Office of Rural Health)
- **Rosemary Cree Medicine** (Blackfeet Tribal Health Department—Tribal Health Department Member)
- **Kathy Moore** (Lewis and Clark City-County Public Health Department—MEHA)
- **Bobbi Perkins** (Addictive and Mental Disorders Division, DPHHS)

- **Melanie Reynolds** (Lewis and Clark City-County Public Health Department—Large County Member)
- **Medium County Member**--Vacant

Welcome and Introductions

Todd Harwell reviewed the agenda and objectives for the webinar and Jessica Miller took roll. The objectives for the webinar were to review the final draft versions of the SHIP priority health templates and to confirm that they identify clear, measurable goals and strategies that are consistent with the SHA/SHIP Coalition's vision, mission, and guiding principles.

Jessica Miller gave an update on the activities and tasks the SHA/SHIP Coalition has completed and future tasks for the Coalition. Twelve SHA/SHIP presentations have been completed in total from May-November. These presentations were conducted to provide awareness of the document and gather feedback for the SHIP priorities. As a result of the feedback received from the SHA/SHIP presentations, we revised the priority areas to include Injury Prevention. We have now finalized the SHIP priority areas as well as the mission, vision, and guiding principles. The draft SHA will be sent out to stakeholders and public early January 2018 along with a survey for feedback.

Goals, Objectives, and Strategies' Survey Feedback

Jane Smilie reviewed the survey feedback and provided a review of the changes made to each priority health template.

Aaron Wernham commented that there may be several ways in which illicit drug use can be measured and that they are worth exploring due to the recent rise in methamphetamines. Todd Harwell replied that PHSD will look into possibly including substance use treatment and law enforcement data as possible illicit drug use measurements. Aaron Wernham added that we also want to make sure that we are emphasizing rural, frontier, and American Indians as groups to focus on improving behavioral health disparities. Jane Smilie commented that the templates have been revised to state "Expand culturally relevant behavioral health services for diverse and health disparate populations (American Indian, LGBTQ, veterans, low income, rural, and frontier)".

Bill Gallea stated that he strongly endorsed the clinical strategy for Unintentional Injuries' Motor Vehicle Crashes document. As a result of this strategy, he stated he would add the DPHHS EMS and Trauma Systems Group as a Key Partner. He also stated that there should be a focus on injury in the workplace. Todd Harwell commented that he agrees and we will look into adding those items. Aaron Wernham emphasized that it might be good to look into impaired vs. unimpaired injury. If impaired injury was the priority, you could measure progress on MVIs, falls, and suicides all under one heading and one set of strategies.

Todd Harwell commented that the last four policy strategies in the Unintentional Injury document were added recently. We will still need to check with the Department of Transportation to ensure that they approve of us pursuing these strategies. These are evidence-based strategies, however, they might be difficult to accomplish.

Thank you and next steps

Jessica Miller discussed the next steps for the Coalition. The draft SHA will go out to stakeholders in late January 2018 along with a survey for feedback. We are requesting for everyone to reach out to their stakeholders and make them aware of what the SHA and SHIP are and ask them to join the listserv to receive these draft documents. Todd Harwell thanked the group and reminded everyone that the next meeting will be a webinar on February 28th from 1:00 to 2:30pm.

Montana SHA/SHIP Coalition

Agenda

Wednesday December 13, 1:30-3:00pm
Montana DPHHS, Public Health and Safety Division, Room C209
Cogswell Building - 1400 Broadway, Helena MT
Webinar: Join WebEx meeting (https://hhsmt.webex.com)

Meeting Purpose

- Final review of templates for State Health Improvement Plan
- Confirm that templates identify clear, measurable goals and strategies that are consistent with SHA/SHIP Coalition's vision, mission and guiding principles

Agenda

Welcome, Introductions (5 minutes)

- Todd Harwell - Review goals for the meeting
  - Short update on SHIP timeline and process

Review of templates

- Review final drafts of ***Chronic Disease and Unintended Pregnancy*** templates
  - Any additional comments from Coalition members?

- Review ***Unintentional Injury*** template
  - Review feedback received via the survey
  - Any additional comments from Coalition members?
  - Template will be finalized following this meeting

- Review ***Behavioral Health*** template
  - Review feedback received via the survey
  - Any additional comments from Coalition members?
  - Template will be finalized following this meeting

- Brief review of ***ACE's*** components

Wrap-up (10 minutes)

- Taken collectively, do the templates identify clear, measurable goals and strategies for the Coalition's priority areas?
- Will this yield a State Health Improvement Plan consistent with the group's vision, mission and guiding principles?
- Next steps

SHA/SHIP Coalition

Webinar

DECEMBER 13, 2017

Agenda

Welcome, Introductions – Todd Harwell

- Review meeting objectives
- Update on SHIP timeline and process – Jessica Miller

Review Coalition feedback and opportunity for additional input – Jane Smilie

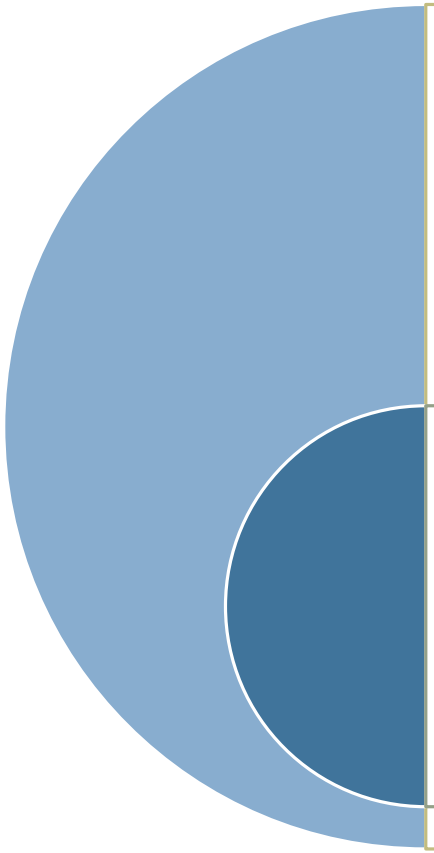
Wrap-up on feedback

Next Steps

Meeting Objectives

- Final review of templates for State Health Improvement Plan (SHIP)
- Confirm that templates identify clear, measurable goals and strategies that are consistent with SHA/SHIP Coalition's vision, mission, and guiding principles

Updated SHA/SHIP Timeline—Activities/Tasks



Completed

- Feedback and discussion sessions for SHA/SHIP
- Finalized Mission, Vision, and Guiding Principles & priority areas
- Draft SHA (feedback from public early January 2018)

Future Tasks

- Finalize Objectives, Strategies, and Metrics
- Priority Workgroups
- Publish documents (SHA & SHIP) March 2018

Chronic Disease Prevention (pg.2)

All respondents said the content is consistent with the Coalition's mission, vision, guiding principles

Additional comments:

- More emphasis on breastfeeding strategies and WIC. We have added WIC to the 1st prevention strategy and 3rd clinical strategy. The plan includes continued implementation of the Baby Friendly Breast Feeding Initiative.
- Inclusion of Alzheimer's disease. This was not ranked highly or prioritized by the Coalition.

Unintended Pregnancy

All respondents said the content is consistent with the Coalition's mission, vision, guiding principles

Additional comments:

- Appreciate emphasis on access to services in rural and frontier areas
- What is moderately effective birth control? Language now refers to "effective" contraception.

Further discussion on these two sections?

Behavioral Health

7/8 respondents said the goals convey what we are trying to accomplish

Suggested changes to goals:

- Reduce the prevalence and adverse consequences of SUD. This change has been made. (pg. 1)
- Be explicit about reducing health disparities in rural and frontier communities and among American Indians. Modified the 2nd clinical and 1st health equity strategy.(pg. 3 and 4)

Behavioral Health

8/9 respondents recommended leaving the indicators as presented

Changes suggested to indicators:

- Indicator 4 not Montana-specific data. This is a national data set, however, the data presented is Montana-specific. (pg. 2)
- Establish measure of illicit drug use, methamphetamine in particular, possibly use BRFSS. DPHHS will consider developing some measures. Use of BRFSS is not recommended by CDC and for reasons including fear of disclosure and under-reporting. Potential data sources include substance use treatment and law enforcement data.

Behavioral Health

6/9 respondents recommended leaving the strategies as presented

Suggested strategies to add:

- Increase access in rural/frontier areas. Added to the 3rd clinical strategy. (pg. 3)
- Name SBIRT. Audit is the screening tool used in SBIRT. This now reads AUDIT/SBIRT. (pg. 3)
- Increase collaboration and coordination among behavioral health, criminal justice and corrections systems… This was added. (pg. 4)
- Increase the use of peer recovery supports... Reworded 3rd policy strategy. (pg. 4)
- Gun lock strategies: Promote safe storage of firearms through the Departments suicide prevention plan.

Behavioral Health

Suggested strategies to delete:

- Caution regarding media campaigns. We agree and assume this will be well-planned and very targeted. (pg. 2)

Additional comments:

- NAMI Montana is now included as a partner. (pg.5)

Further discussion on this section?

Unintentional Injury (pg. 3)

8/9 respondents said the goals convey what we are trying to accomplish

All respondents recommended leaving the health indicators as presented

Suggested changes to goals:

- Be explicit about reducing health disparities including in rural and frontier communities, and among American Indians. We have revised the 3rd health equity strategy.

Unintentional Injury (pg. 3)

8/9 respondents recommended leaving the strategies as presented

Suggested strategies to add:

- Strengthen the health equity section. As we described above, we made changes to the 3rd health equity strategy.
- Strengthen policy section. Four policy strategies have been added.

Unintentional Injury

Why motor vehicle injury (MVI) rather than all causes or falls?

This was the focus we heard from the community/partner groups to whom we presented and asked for feedback. MVI also represents the largest burden of injury and the area to make the most gains to reduce years of potential life lost.

Why distinguish between unintentional and intentional injury?

This is the language being used by most national and state organizations working on surveillance and programming. While the point is well-taken that the causes and interventions are often the same, we feel it would be confusing not to use this convention.

Further discussion on this section?

General question

How did you arrive at the target percentages for indicators?

We followed the Healthy People 2020 targets, which are generally a 10% change in a positive direction over 10 years. Thus, we set goals for a 5% change in a positive direction over 5 years.

Cross-cutting Issue: ACEs

- Summarizes the evidence base and emerging strategies to address trauma/ACEs
- Handled as a separate “cross-cutting” issue to address redundancy but emphasize implications across priority areas
- Offers guidance to communities, organizations, providers in various disciplines, and state-level strategies
- Includes prevention and treatment approaches

Feedback?

Wrap-up

- Taken collectively, do the priority sections of the plan identify clear goals, measurable indicators and solid strategies to address the Coalition's priority areas?
- Will what has been drafted yield a SHIP that is consistent with the group's vision, mission and guiding principles?

Next Steps

- ❑ Coalition members reach out to their stakeholders for awareness of SHIP and the 2018 health priorities
  - Listserv to receive draft documents http://ahealthiermontana.mt.gov/shaship
  - Draft SHA will be sent out early January 2018 along with a survey to receive feedback
- ❑ Identify priority area workgroups and workgroup leaders
- ❑ Draft SHIP
- ❑ February 28th (next SHA/SHIP Coalition meeting)
  - Webinar from 1pm-2:30pm

Environmental Approaches to Chronic Disease Prevention and Self-Management:

Much of the chronic disease burden is attributable to a short list of key risk factors, including tobacco use, obesity, physical inactivity, and poor nutrition.[1] Tobacco use remains the leading cause of preventable death, with **1,600** tobacco-related deaths occurring in Montana each year.[2] **One quarter** of Montana adults and **one third** of Montana youth currently use some type of tobacco product.[3] Obesity results from a combination of poor dietary patterns and physical inactivity. More than **1 in 10** Montana youth and **1 in 4** Montana adults are currently obese.[4] **75%** of Montana adults and **72%** of Montana youth do not meet physical activity recommendations.[5]

Environmental approaches refer to changes in policies and physical surroundings to make the healthy choice the easy choice. Approaches that change the environment reach more people, are more cost efficient, and are more likely to have a lasting effect on population health. Environmental approaches include policies that change the context and make healthy lifestyles easier (such as comprehensive smoke-free air laws and bans on flavored tobacco products) and they include changes to social and physical environments that make healthy choices easier, safer, and more convenient (such as community designs that encourage walking and biking).

People who are OBESE increase their risk for:	People who use TOBACCO increase their risk for:
▪ Heart disease ▪ Stroke ▪ Some cancers ▪ Diabetes ▪ Arthritis ▪ High blood pressure ▪ High cholesterol ▪ Gallbladder disease ▪ Mental illness ▪ Asthma Exacerbations	▪ Heart disease ▪ Stroke ▪ Cancers (numerous) ▪ Diabetes ▪ Rheumatoid arthritis ▪ Preterm births ▪ Low birth weight babies ▪ Reduced fertility ▪ Asthma Exacerbations

GOALS

1. Prevent tobacco use among youth and adults;
2. Make active living and healthy eating easy, safe, and accessible everywhere Montanans live, work, learn, and play;
3. Increase awareness of modifiable risk factors for chronic disease.

HEALTH INDICATORS by 2022	HP 2020
1. Decrease the percent of Montana adults who currently use tobacco from 26.0 to 23.5 (Baseline: Montana BRFSS, 2016)	√
2. Decrease the percent of Montana youth who currently use tobacco from 32.7 to 29.7 (Baseline: Montana YRBS, 2017)	√
3. Decrease the percent of Montana adults who are currently obese from 25.5 to 22.5 (Baseline: Montana BRFSS, 2016)	√
4. Decrease the percent of Montana youth who are currently obese from 11.7 to 8.5 (Baseline: Montana YRBS, 2017)	√

Action Area	Strategy
Prevention and Health Promotion	• Implement evidence-based programs that facilitate chronic disease prevention and chronic disease self-management (e.g. Walk with Ease [WWE], Worksite Wellness Programs, Rx Trails, Diabetes Prevention Program [DPP], Diabetes Self-Management Education and Support [DSMES] programs, Baby-Friendly Hospital Initiative, Women, Infants and Children (WIC) Breastfeeding Peer Counselor Program, Montana Tobacco Quit Line) and increase referrals to those programs. • Implement public education campaigns to increase awareness of behaviors that address chronic disease prevention and self-management.
Clinical	• Increase referrals to evidence based chronic disease prevention and management programs (e.g. Montana Tobacco Quit Line, DPP, DSMES, WWE, and Chronic Disease Self-Management Programs). • Provide ongoing resources and support to birth facilities/staff to become certified by the Baby-Friendly Hospital Initiative. • Refer every WIC participant who is overweight/obese

	to a registered dietician for nutrition education.
Policy	• Promote improvement and implementation of school wellness policies, including smoke-free and tobacco-free environments, access to nutritious food, active transportation, physical education, recreation facilities open to the community, and reduced screen time use. • Promote and support the implementation of local community Active Transportation policies. • Support worksite creation of policies promoting healthy work environments such as increasing opportunities for employees to engage in physical activity and improving access to healthy food. • Support partners to implement tobacco 21, include e-cigarettes in local Clean Indoor Air Act protocols, and increase the tobacco tax on all tobacco products.
Health Equity	• Develop and disseminate culturally appropriate chronic disease prevention and control materials and public education for target populations. • Increase access to evidence-based programs for chronic disease prevention and control (including telehealth to rural and frontier areas, accessibility adaptations for people with disabilities, locations on American Indian reservations, and support for low-income populations.

Key Partnerships

- Stroke Workgroup
- Million Hearts Workgroup
- The American Cancer Society
- American Heart Association
- Alliance for Healthy Montana
- Montana Office of Public Instruction
- Montana Tobacco Prevention Specialists
- NASPA (Student Affairs Administrators in Higher Education)
- Bike Walk Montana

- Montana State University Office of Rural Health
- Western Transportation Institute
- The Sonoran Institute
- Montana Primary Care Association
- Mountain Pacific Quality Health Foundation
- Montana Medicaid
- State of Montana Health Care & Benefits Division
- Billings Area Indian Health Service
- University of Montana Rural Institute Disability & Health Program
- Montana Diabetes Advisory Coalition
- Montana Diabetes Educators Network
- American Association of Diabetes Educators
- American Diabetes Association
- Local and Tribal Health Departments

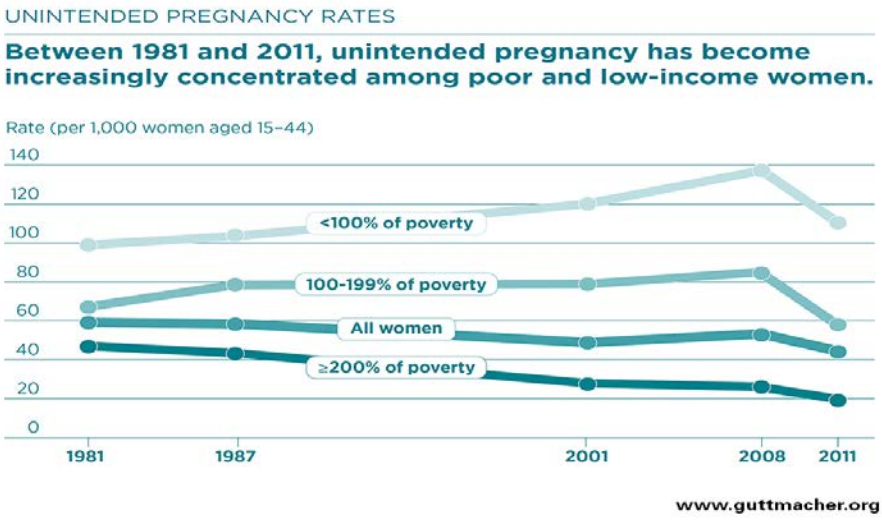
[1] CDC, https://www.cdc.gov/chronicdisease/about/index.htm
[2] CDC, https://www.cdc.gov/tobacco/about/osh/program-funding/pdfs/montana-508.pdf
[3] BRFSS, 2016 and YRBS, 2017
[4] YRBS, 2017 and BRFSS, 2016
[5] BRFSS, 2015 and YRBS, 2017

UNINTENDED PREGNANCY

Unintended pregnancy is defined as a pregnancy that is either unwanted or mistimed. In 2015, 31.8% of Montana births were unintended (Health Survey of Montana's Mothers and Babies, 2015). Of these births, 6.7% were the result of an unwanted pregnancy, with the mother not wanting to become pregnant at that point in time or at any time in the future. A total of 25.1% of Montana births in 2015 were mistimed, with mothers not wanting to be pregnant at that point in time, but still wanting to be pregnant at some point in the future.

Unintended pregnancy is a public health concern because it can result in adverse maternal and child health outcomes, such as delayed and inadequate prenatal care, premature birth, low birthweight, and poor mental and physical health outcomes for mothers and babies[1,2,3,4,5]. Women with unintended pregnancies are more likely to engage in risk behaviors during pregnancy, such as smoking or drinking, and are less likely to use folic acid during pregnancy or breastfeed postpartum[6,7]. In addition, unintended pregnancy contributes to the incidence of abortion, with 42% of unintended pregnancies ending in abortion[8].

National rates of unintended pregnancy are highest among low-income women, women without a high school degree, women aged 15-24, and women of color[8,9]. Since 1981, rates of unintended pregnancy have decreased, with women living at or above 200% of the federal poverty line seeing the sharpest decrease[10].



GOALS

1. Decrease unintended pregnancies by increasing the use of effective methods of contraception.

2. Reduce the rate of teen pregnancy by expanding the implementation of evidence-based teen pregnancy prevention programs.
3. Reduce the rate of births with an 18 month or less interbirth interval by providing reproductive life planning counseling during prenatal and postnatal care.

HEALTH INDICATORS by 2022	**HP 2020**
1. Decrease the proportion of pregnancies that are unintended from 31.8 percent to 26.8 percent (Baseline: Health Survey of Montana Mothers and Babies, 2015).	√
2. Reduce the proportion of pregnancies conceived within 18 months of a previous birth from 33.2 percent to 30.0 percent (Baseline: Montana Department of Public Health and Human Services, Office of Vital Statistics, 2016).	√
3. Reduce pregnancies among adolescent females aged 15 to 17 from 12.5 per 1,000 to 9.5 per 1,000 (Baseline: Montana Department of Public Health and Human Services, Office of Vital Statistics, 2016).	√
4. Increase the proportion of sexually active youth grades 9 - 12 who used a highly or moderately effective method of contraception before their last sexual intercourse from 40.6 percent to 46.0 percent (Baseline: Montana Youth Risk Behavior Survey, 2017).	√
5. Increase the percentage of women aged 18 to 49 years that adopt or continue use of the most effective or moderately effective methods of contraception from XX percent to XX percent (Baseline: Montana Behavioral Risk Factor Surveillance System, 2018). A baseline will be established in 2018.	√

Action Area	**Strategy**
Prevention and Health Promotion	• Promote the use of effective methods of birth control, targeting youth, low-income women, and native women. • Promote reproductive life planning during well-woman, prenatal, and postpartum visits.

	• Educate youth on healthy relationships and multiple methods of family planning (i.e. contraception, abstinence).
Clinical	• Increase the percentage of Title X Family Planning clients using effective methods of birth control. • Increase access to family planning services in rural and frontier areas though telehealth services.
Policy	• Implement evidence-based teen pregnancy prevention (i.e. sex education) programming in Montana public schools.
Health Equity	• Develop culturally competent materials that target American Indian communities. • Target youth with the use of social media campaigns. • Secure funding public health programs that serve low-income populations, such as Medicaid's Plan First and State-Funded Family Planning.

Key Partnerships

- Indian Health Services (IHS)
- Montana Behavioral Risk Factor Surveillance System (BRFSS)
- Montana Health Care Foundation (MHCF)
- Montana Medicaid
- Montana Medical Association (MMA)
- Montana Office of Public Instruction (OPI)
- Montana Office of Vital Statistics
- Montana Personal Responsibility and Education Program (PREP)
- Montana Primary Care Association (MPCA)
- Montana Title X Family Planning Program
- Montana Youth Risk Behavior Survey (YRBS)
- National Campaign to Prevent Teen and Unintended Pregnancy
- Office of Population Affairs (OPA)
- Local and Tribal Health Departments
- Urban Indian Health Centers

[1] Sonfield A et al., The Social and Economic Benefits of Women's Ability To Determine Whether and When to Have Children, New York: Guttmacher Institute, 2013.
[2] Lawrence III HC, Testimony Before the Institute of Medicine Committee on Preventative Services for Women, Washington, DC: American Congress of Obstetricians and Gynecologists, 2011.
[3] Herd P et al., The implications of unintended pregnancies for mental health in later life, American Journal of Public Health, 2016, 106(3):421–429.
[4] Wendt A et al., Impact of increasing inter-pregnancy interval on maternal and infant health, Paediatric and Perinatal Epidemiology, 2012, 26(Suppl. 1):239–258.
[5] Kavanaugh ML and Anderson R, Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers, New York: Guttmacher Institute, 2013.Finer LB, Unintended pregnancy among U.S. adolescents: accounting for sexual activity, *Journal of Adolescent Health*, 2010, 47(3):312–314.
[6] Rosenberg, Kenneth D., Jill M. Gelow, Alfredo P. Sandoval. Pregnancy Intendedness and the Use of Periconceptional Folic Acid, *Pediatrics*, 2003, 111(1): 1142-1145.Finer LB, Unintended pregnancy among U.S. adolescents: accounting for sexual activity, *Journal of Adolescent Health*, 2010, 47(3):312–314.
[7] Cheng, D., EB Schwarz, E. Douglasb, and I. Horon, Unintended pregnancy and associated maternal preconception, prenatal and postpartum behaviors, *Contraception*, 2009, 79(3): 194-198.
[8] Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011, N*ew England Journal of Medicine*, 2016, 374(9):843–852).
[9] Finer LB, Unintended pregnancy among U.S. adolescents: accounting for sexual activity, *Journal of Adolescent Health*, 2010, 47(3):312–314.
[10] Guttmacher Institute. Unintended Pregnancy in the United States, September 2016. https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states.

Behavioral Health: Prevention, Treatment, and Recovery Support

Problem 1: Mental Health and Substance Use Disorder

Poor mental well-being affects thousands of Montanans. One in ten Montana adults (nearly 84,000) report frequent mental distress with 14 or more days of poor mental or emotional health in the past month (MT BRFSS, 2016). Further, 41,000 Montana adults have serious mental illness (NSDUH, 2014-2015). Mental health crisis continues to affect every Montana community with suicide. Suicide deaths in Montana are two times higher than the U.S.; there were 240 suicide deaths each year, on average, in Montana from 2011 to 2015 (MT death records, 2011-2015).

Many Montanans struggle with substance use disorder (SUD). Alcohol is the most commonly abused substance in Montana; nearly 59,000 adults in Montana have a SUD (NSDUH, 2014-2015). Illicit drug use, such as marijuana, cocaine, or heroin, in Montana follows similar trends as the United States. Methamphetamines continue to be of concern in Montana; however, data regarding usage are limited, particularly among Montana's adult population. Among Montana youth, 2.2% of high school students reported having used methamphetamines during their lifetime (YRBS, 2017). Opioid use is the primary driver of drug overdose deaths in the state of Montana. Forty-four percent of all drug overdose deaths are attributable to opioids. Montana has made progress in recent years addressing prescription opioid misuse and abuse and reducing overdose deaths, though much more can be done to ensure that opioids are prescribed, taken and disposed of safely and that patients being transitioned off high dose prescription opiates do not transition to illicit narcotics such as heroin.

Access to treatment for SUD and mental health is limited. Between 2012 and 2015, an estimated 60,000 adult residents in Montana needed but did not receive treatment for a SUD (SAMS, 2012-2015). From 2010 to 2014, approximately 39% of adolescents aged 12 to 17 years with a Major Depressive Episode (MDE) received treatment within the last year (NSDUH, 2015).

GOALS

1. Improved access to timely and effective behavioral health services;
2. Prevent and treat depression, anxiety and other mental health conditions;
3. Reduce the prevalence and adverse consequences of SUD; and
4. Prevent suicides

HEALTH INDICATORS by 2022	HP 2020
1. Reduce the proportion of adults with frequent mental distress (≥14 days in past month with poor mental health status) from 10.4% to 9.9% (Baseline: MT. BRFSS, 2016)	**Y**
2. Decrease percentage of high school students who report binge drinking in the past month from 17.6% to 16.7% (Baseline: MT. YRBS, 2017).	**Y**
3. Reduce the proportion of high school students who attempted suicide in the past year from 9.5% to 9.0% (Baseline: MT. YRBS, 2017)	**Y**
4. Decrease past month alcohol use from 9.9% to 9.4% and illicit drug use from 10.0% to 9.5% among adolescents aged 12 to 17 years. (Baseline: Montana National Survey on Drug Use and Health (NSDUH),2014-2015 and 2013-2014)	**Y**
5. Decrease the proportion of adults who report binge drinking in past 30 days from 18.9% to 17.8% (Baseline: MT. BRFSS, 2016)	**Y**

Action Area	Strategy
Prevention and Health Promotion	• Implement evidence-based strategies in the Montana suicide prevention plan. • Increase the number of communities implementing Communities That Care model to prevent underage substance use. • Implement public education / media campaign to reduce behavioral health stigma, awareness that recovery is possible, awareness of risks and protective factors to reduce adolescent substance use, binge drinking, prescription drug misuse, etc.) • Promote tobacco-free behavioral health programs.

Clinical	• Promote routine screening for mental illness, anxiety, depression, SUD, and suicidal ideation in primary care and other medical settings using evidence-based screening tools (i.e. SBIRT/Audit, Craft, Patient Health Questionnaire (PHQ)-9, PHQ-A, Generalized Anxiety Disorder (GAD)-7). • When screenings are positive, promote primary care-based interventions and, when appropriate, referrals and engagement in specialty services. • Increase access to integrated behavioral health services and medical care, including telehealth and increased workforce, particularly in rural and frontier communities. • Increase use of medication assisted SUD treatment services. • Increase access to SUD services for pregnant women with SUDs. • Promote tobacco screening and cessation services and products in behavioral health, primary care, and other health settings. • Increase training in Adverse Childhood Experiences (ACEs)/trauma-informed care among medical and behavioral health professionals. • Increase the use of peer recovery supporters as a cost-effective way to improve the timeliness of entry to care and engagement in care throughout the treatment course, and to reduce recidivism after discharge from inpatient or residential treatment and incarceration.
Policy	• Develop strategies to work across Montana's behavioral health system (mental health and SUD) to align payment reform, address workforce shortages, monitor to identify access barriers, ensure rapid and effective crisis response, and provide treatment in the least restrictive environment. • Increase collaboration and successful warm handoff for individuals admitted to and discharged from state operated facilities, hospitals, residential behavioral

	health/psychiatric facilities and community-based healthcare providers to lower annual readmission rate and to serve individuals in their own communities whenever possible. • Increase the use of certified behavioral health peer specialists in recovery support and to improve timeliness of entry to care, engagement in treatment and to reduce repeat hospitalizations and incarcerations. • Increase direct collaboration and coordination of services between the SUD and mental health care system and the criminal justice and corrections system.
Health Equity	• Expand culturally relevant behavioral health services for diverse and health disparate populations (American Indian, LGBTQ, veterans, low income, rural, and frontier). • Increase wrap around support services to individuals receiving or needing behavioral health services (crisis stabilization, care coordination, recovery support).

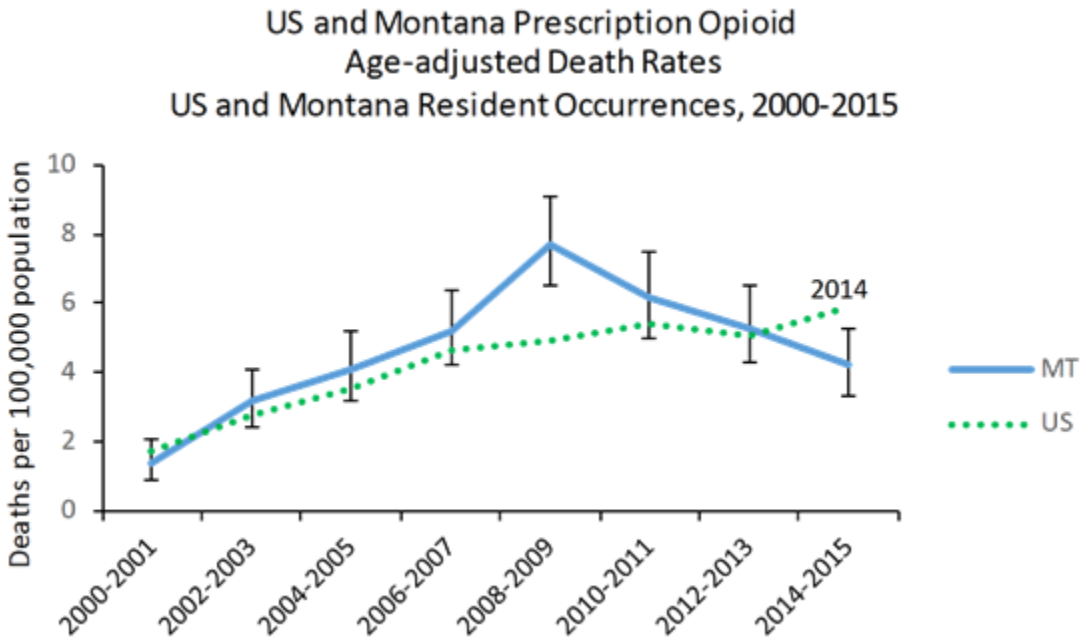
Key Partnerships

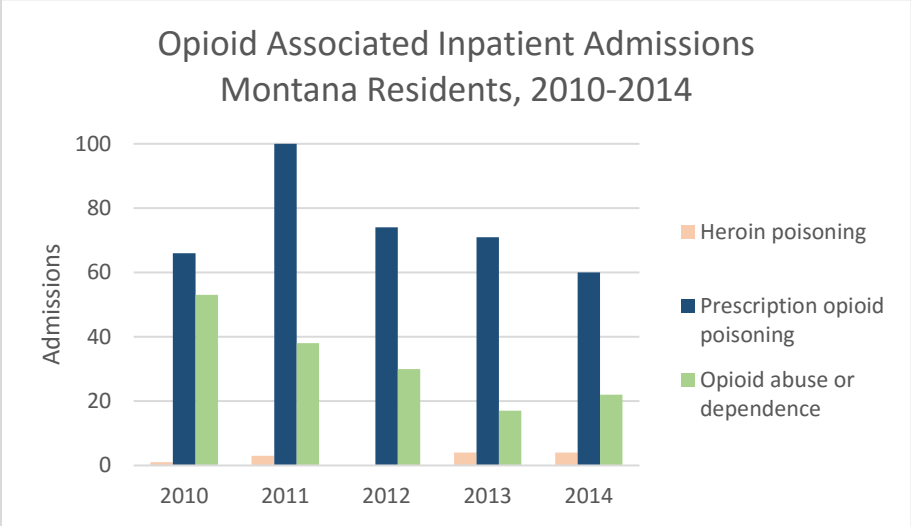
- Hospitals
- Psychiatric Residential Treatment Facilities
- Federal Qualified Health Centers
- Rural Health Clinics
- Tribal Health Clinics
- State Approved SUD Treatment Providers
- Licensed Mental Health Centers
- Indian Health Services
- MT WY Tribal Leaders Council
- Peer Network
- Mental Health America
- MT Primary Care Association

- MT Medical Association
- Montana State Hospital
- Montana Behavioral Health Association
- Montana Chemical Dependency Center
- MT Nursing Care Center
- National Alliance on Mental Illness Montana (NAMI)
- Schools
- Community prevention partner
- DUI Task Forces
- Policy leaders
- Business leaders
- Local advisory councils
- Local and Tribal Health Departments
- Department of Transportation
- Corrections
- Department of Revenue
- Department of Justice
- Board of Pharmacy
- Board of Behavioral Health
- Board of Medicine
- Recovery support groups
- Opioid Treatment Programs

Problem 2: Unintentional Poisonings, Opioids

Opioid use is the primary driver of drug overdose deaths in the state of Montana. Forty-four percent of all drug overdose deaths are attributable to opioids. Montana has made progress in recent years addressing prescription opioid misuse and abuse and reducing overdose deaths, though much more can be done to ensure that opioids are prescribed, taken and disposed of safely and that patients being transitioned off high dose prescription opiates do not transition to illicit narcotics such as heroin.





GOAL

1. The goal is to decrease overdoses and deaths associated with drug overdoses due to opioids through coordination of prevention, monitoring, enforcement, treatment and recovery services.

HEALTH INDICATORS by 2022	HP 2020
1. Decrease opioid overdose death rate from 4.2 per 100,000 to 3.8 per 100,000 (Centers for Disease Control and Prevention. Multiple Cause of Death 1999-2014 on CDC WONDER Online Database; 2015 [cited Jul 2016]. Available from http://wonder.cdc.gov/mcd-icd10.html.)	
2. Decrease the number of adults reporting non-medical use of pain relievers in the last year to 22,500 (Baseline: 25,000 in 2014; National Survey of Drug Use and Health. 2010-2014)	
3. Decrease the rate of ED visits relating to drug overdose to 24,100 in the years 2015-2019 (Baseline: 26,800 from 2010-2014; Hospital Discharge Data System, 2010-2014)	
4. Decrease number of unintentional analgesic medication exposures among children from 404 a year to 360 (Baseline: Montana Poison Center 2016 Annual Report)	

Action Area	Strategy
Prevention and Health Promotion	• Implement a statewide public education campaign that includes harm reduction, storage, and disposal messaging of opioids, targeting at-risk populations • Increase awareness of and support for prescription drop boxes and disposal bags statewide • Support prevention specialists in Montana communities to implement evidence-based Opioid Use Disorder/Substance Use Disorder (SUD) prevention activities
Clinical	• Train and increase number of Licensed Addiction Counsellors (LACs) and dually licensed mental health and substance use providers and peer supporters
Policy	• Support administrative and legislative policies to increase prescribing according to the CDC guidelines • Support policies requiring pharmacists to check identification before dispensing narcotics • Better utilize the Montana Prescription Drug Monitoring System to prevent over prescribing of opioids or unintended drug-drug interactions
Health Equity	• Increase number of state approved SUD providers who can access Medicaid reimbursement, including supporting tribally operated clinics and Urban Health Clinics to become state approved • Foster collaboration, particularly between frontier and rural areas and larger urban centers, to improve continuum of care in communities

Key Partnerships

- DPHHS Public Health and Safety Division
- DPHHS Addictive and Mental Disorders Division
- DPHHS Prevention Resource Center
- Montana Medicaid

- DOJ Division of Criminal Investigations
- Montana Medical Association
- Montana Hospital Association
- Montana Pharmacy Association
- Montana Healthcare Foundation
- Board of Pharmacies
- Board of Medical Examiners
- Public Health Prevention Specialists
- Law Enforcement Agencies
- Open Aid Alliance
- Montana Peer Support Network
- Indian Health Services
- Veterans Affairs
- Substance Use Disorder Strategic Planning Taskforce
- Local and Tribal Health Departments

Unintentional Injury: Motor Vehicle Crashes

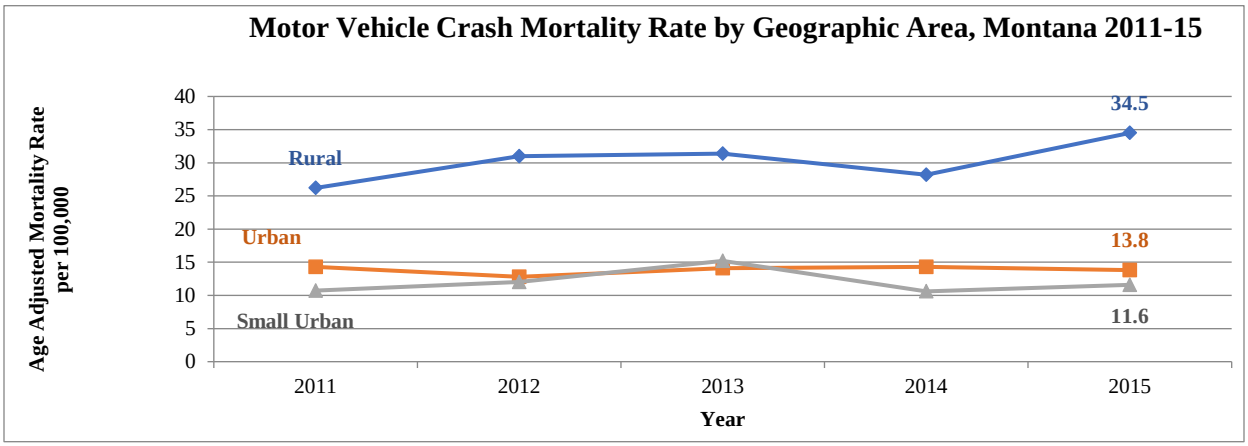
THE PROBLEM

Motor vehicle crashes (MVCs) are one of the most common causes of both fatal and non-fatal injuries in Montana. MVCs result in huge medical and work loss costs, especially since younger people are disproportionately affected. High risk driving behaviors such as not using a seatbelt consistently, speeding, impaired driving, and distracted driving are highly prevalent in Montana.

From 2011 – 2016, 55% of all MVC related fatalities involved a driver impaired by alcohol or drugs, and among fatalities to occupants of vehicles with seatbelts available, nearly 70% were unrestrained. Distracted driving is also on the rise.

In 2015 Montana had a motor vehicle fatality rate of 21.40/ 100,000 people compared to the national motor vehicle fatality rate of 11.83/100,000.

Rural Montana residents have more than double the age-adjusted mortality rate due to MVCs compared with residents of urban or small urban areas.



GOAL

1. To prevent deaths and serious traumatic injuries due to motor vehicle crashes by mitigating pre-crash, during crash, and post-crash factors

HEALTH INDICATORS by 2022	HP 2020
1. Decrease age-adjusted mortality rate due to motor vehicle crashes from 20.94 deaths per 100,000 to 12.4 deaths per 100,000 *(Baseline: 2015 WISQARS)*	√
2. Decrease the proportion of unrestrained MVC fatalities to occupants of vehicles with seatbelts from 50% to 40% *(Baseline: 2016 FARS)*	
3. Increase the proportion of adult motor vehicle occupants that report always wearing seatbelts from 73% to 83% *(Baseline: 2016 Montana BRFSS)*	√
4. Increase the proportion of youth less than 18 years of age that report always wearing seatbelts while riding in a car driven by someone else from 51.5% to 83% *(Baseline: 2017 Montana YRBS)*	√
5. Decrease the proportion of MVC fatalities that involve impaired drivers from 62% (118/190) to 52% *(Baseline: 2016 FARS)*	
6. Decrease proportion of high school students who report texting or emailing while driving from 54.2% to 44.2% *(Baseline: 2017 MT YRBS)*	

Action Area	Strategy
Prevention and Health Promotion	• Promote Montana Department of Transportation's Vision Zero- to move toward zero deaths and injuries on Montana roadways • Increase awareness of high risk driving behaviors • Improve surveillance of MVCs through data linkages
Clinical	• Support further development of the trauma system (both EMS and trauma facilities) to reduce severity of injury outcomes
Policy	• Primary seatbelt law • Statewide cell phone ban • Encourage community design and policies that keep all road users safe • Increase age requirements on child passenger restraints from aged 5 years to aged 8 years. • Increase age requirements for Graduated Licensing learners permits from aged 14 years to aged 16 years • Increase age requirements for Graduated Licensing unrestricted license from aged 16 years and 6 months to aged 18 years old • Encourage the use of ignition interlocks for DUI offenders
Health Equity	• Utilize data to identify high risk groups • Develop and implement culturally competent materials and programs to address disparities (American Indian, rural, and frontier) in MVC fatalities and high risk driving behaviors

Key Partnerships

- MT Department of Transportation
- Comprehensive Highway Safety Plan partners (including Department of Corrections, Department of Justice, Department of Revenue, MT Judicial Branch, Office of Public Instruction, local and tribal health departments)
- Local and Tribal Health Departments

Cross-cutting Issue: Adverse Childhood Experiences

The harmful effects of adverse childhood experiences (ACEs) on health status throughout the lifespan have been well documented. ACEs are traumatic events and include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence, substance misuse within the household, household mental illness, parental separation or divorce and having an incarcerated household member.[i]

Studies have shown an association between ACEs and chronic diseases, behavioral health issues and initiation of risky health behaviors. Studies have also documented a dose-response relationship between ACEs and adverse health and behavioral health outcomes, meaning that persons with more ACEs (a higher ACE score) are likely to have more adverse health outcomes.[ii]

A recent systematic review and meta-analysis of the published literature on ACEs indicated that persons with four or more ACEs, were at increased risk for all negative health outcomes examined in the study. The strongest associations were found with problematic drug use, interpersonal and self-directed violence, sexual risk taking, poor mental health and problematic alcohol use, followed by moderate associations with smoking, heavy alcohol use, poor self-rated health, cancer, heart disease and respiratory disease. While considered weak or modest, associations were nonetheless documented with physical inactivity, overweight or obesity and diabetes.[iii]

Since multiple ACEs can be considered a major risk factor for many health conditions, a public health approach to ACEs and childhood trauma is warranted. While clinical treatment of psychological trauma is well-established, population-based strategies for prevention are still emerging.[iv]

Recognizing that ACEs/trauma informed strategies need to be applied across the health priorities addressed in this plan, it was determined that this special section of the plan should describe key cross-cutting strategies. Every effort should be made to support populations that are potentially disproportionately affected by this issue including populations with low incomes and American Indians.

- Implement community-based strategies recommended by the Centers for Disease Control and Prevention to prevent ACEs and trauma, and increase resiliency, including: providing quality and affordable child care and education early in life; strengthening economic supports for families; changing social norms to support parents and positive parenting; enhancing parenting skills to promote positive child development; and intervening to lessen harms and prevent future risk to children.[v]

- Integrate knowledge about the wide-spread effects of ACEs and trauma into policies, procedures, practices and environments of health, human service, education and other organizations serving children, with the goals of providing trauma-informed approaches and reducing re-traumatization. SAMSHA provides direction in implementing trauma-informed approaches across 10 organizational domains in its publication, “Concept of Trauma and Guidance for a Trauma-Informed Approach.” Those domains are: governance and leadership; policy; physical environment; engagement and involvement; cross sector collaboration; screening, assessment and treatment services; training and workforce development; progress monitoring and quality assurance; financing; and evaluation.[vi]

- Implement resiliency-building and trauma informed educational and behavioral approaches in schools and early childhood settings (e.g., Montana Behavioral Initiative, social-emotional learning practices, restorative rather than punitive disciplinary practices).

- Promote the use of early childhood home visitation programs as recommended by the Community Preventive Services Task Force based on strong evidence of effectiveness in reducing child maltreatment among high-risk families. Home visitation to prevent violence includes programs in which parents and children are visited in their home by nurses, social workers, paraprofessional and community peers. Visits must occur during the child's first two years of life, but they may be initiated during pregnancy and may continue after the child's second birthday.[vii]

- Increase awareness of and referrals to evidence-based early childhood home visitation programs among healthcare, human service and other professionals.

- Develop and maintain a state-level resource to share information about ACEs/Trauma informed approaches (e.g., resources for various fields of practice; training and education opportunities; support for organization moving toward trauma-informed approaches; and resources for individuals, families and communities).

- Continue to support training and train-the-trainer initiatives addressing ACEs and trauma-informed approaches for health and human service providers, educators, early childhood service providers, schools, communities and other organizations, including those provided by the DPHHS, ChildWise Institute and Elevate Montana, National Native Children's Trauma Center.

- Screen for ACEs and trauma among high risk parents and children using age-appropriate and setting-specific screening tools as recommended in professional guidelines for various disciplines. When results are positive, assure appropriate referrals and follow-up services.

- Promote the use of group and individual cognitive-behavioral therapy for symptomatic youth who have been exposed to traumatic events as recommended by the Community Preventive Services Task Force based on strong evidence of effectiveness in reducing psychological harm.[viii]

- Promote the use of evidence-based clinical interventions included in the Substance Abuse and Mental Health Services Administration (SAMSHA) National Registry for Evidence-Based Programs. This registry includes 14 evidence-based interventions that are targeted to specific populations and/or settings.[ix]

- Implement strategies described in this plan to mitigate the health consequences of ACEs/trauma which include increased prevalence of chronic disease; increased risk for depression, mental illness, substance use disorders and suicide attempts; early initiation and continued misuse into adulthood of alcohol, tobacco and other drugs; and increased prevalence of high risk sexual behaviors.

- Continue to collect and analyze data to monitor the burden of ACEs and trauma in Montana, and progress toward reducing it (e.g., data regarding the prevalence of ACEs, the extent to

which training and education regarding ACEs is being provided, implementation of trauma informed approaches, provision of home visitation services).

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[i] samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences Accessed November 29, 2017.

[ii] Gilbert LK et al. Childhood adversity and adult chronic disease: An update from ten states and the District of Columbia, 2010. *American Journal of Preventive Medicine*. 2015; 48(3):345-9

[iii] Hughes K et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet.* 2017; 2:e356-66 [iv] Montana Healthcare Foundation and Loveland, K. Trauma-Informed Approaches: Opportunities and Challenges in Montana. 2017.

[v] https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html Accessed December 8, 2017.

[vi] https://store.samhsa.gov/ Accessed November 30, 2017.

[vii] https://www.thecommunityguide.org/search/trauma#page=2 Accessed November 29, 2017.

[viii] https://www.thecommunityguide.org/search/trauma#page=1 Accessed November 29, 2017.

[ix] https://www.samhsa.gov/ebp-resource-center Accessed November 29, 2017.