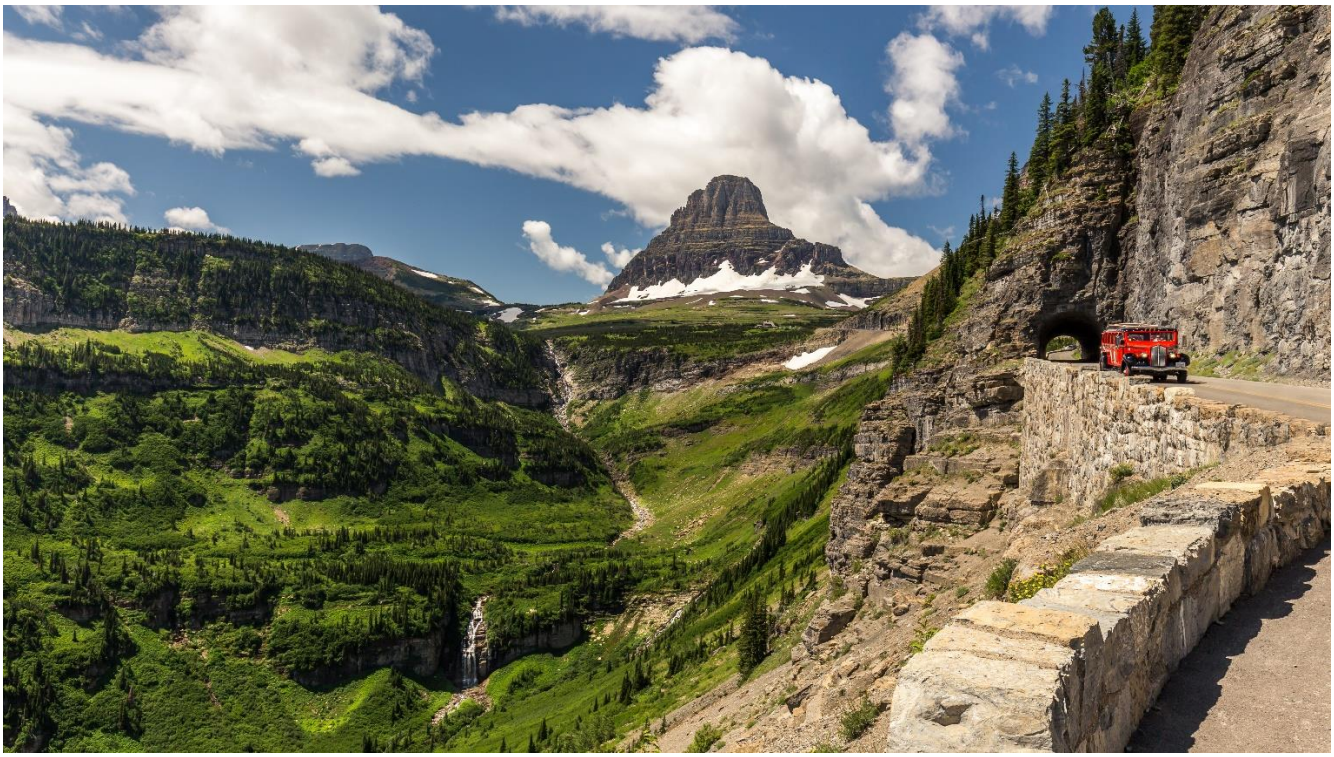
Flathead County Community Health Improvement Plan



2020-2022

NORTH VALLEY HOSPITAL

Flathead City-County Health Department

Flathead Community Health Center

KALISPELL REGIONAL HEALTHCARE

Acknowledgement

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

Flathead City-County Health Department

Flathead Community Health Center

Kalispell Regional Healthcare

North Valley Hospital

Western Montana Mental Health Center

Kalispell Veteran's Coalition

Nate Chute Foundation

Sunburst Foundation

Kalispell Police Department

ImagineIF Library

Montana SOARS Kalispell

ASSIST Flathead

Columbia Falls School District

Kalispell Job Service Center

Flathead Best Beginnings Council

Flathead County Board of Health

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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 2019 as part of a collaborative effort between Flathead City-County Health Department, Flathead Community Health Center, Kalispell Regional Healthcare, and North Valley Hospital. 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 http://flatheadhealth.org/wp-content/uploads/2019/05/CHNA-2018-to-2019.pdf.

After developing a draft of the CHNA, stakeholders including healthcare providers, mental health providers, social service providers, and community members were invited to review the draft, provide feedback, select priority goal areas and develop objectives and strategies to address each of the priority goal areas. Approximately 41 people participated in these stakeholder meetings.

Meeting participants were given a copy of the draft CHNA and were provided with an explanation of the results. Participants were asked to identify theme and brainstorm strategies to address priority goal areas.

Background and Process

Upon completion of the CHNA, the convening group determined the most important health needs by reviewing primary and secondary data, community demographics, and feedback from representatives who provided input on broad community interested. The following priority health issues are listed here:

Priority #1: Comprehensive Care

a. Mental Health and Substance Use
    i. Carryover from the current CHIP's Behavioral Health priority
    ii. Includes Alcohol and Tobacco
    iii. Opioid Use including Medication Assisted Therapy
    iv. Suicide Prevention
b. Access to Care
    i. Sufficient medical providers including primary and specialty care
    ii. Health insurance & affordable care
    iii. Oral health services
    iv. ER usage
c. Chronic Disease Management & Prevention
    i. Respiratory Diseases
    ii. Cancer
    iii. Heart Disease
    iv. Diabetes

Priority #2: Social Determinants of Health

d. Environmental Determinants of Health
    i. Poverty
    ii. Housing
    iii. Transportation
    iv. Food insecurity
    v. Built environment: sidewalks, trails
e. Community Resilience
    i. Trauma informed care
    ii. Access to support services

A third priority area was added for the CHIP: **partnerships and capacity building**. During project brainstorming, we identified that improving our ability to communicate and collaborate was integral to success across all CHIP priorities.

Project Selection

The CHIP does not contain a summary of all the prior and ongoing work which supports the priorities of Comprehensive Care and the Social Determinants of Health. It highlights new, innovative, and collaborative projects aimed at improving the health of Flathead County.

To reach the included project list, we started broadly and ultimately narrowed based on feasibility, span of coverage, efficacy, and the degree to which the project addressed the community identified need. Our process was as follows:

1) October 2017: CHNA process kicked off
2) November 2018: CHNA process complete
3) December 2018: Community prioritization meeting
4) March-April 2019: Community work groups held on each priority area
5) April-July 2019: Interviews with organizations working in each area
6) August 2019: Projects submitted reviewed based on established criteria (above)

Implementation and Tracking

Future CHNA and CHIP will be completed every three years. During the three-year cycle the CHIP will be reviewed to assess progress towards improvement in each of the priority areas. Annual reports will outline specific progress, appropriative or necessary changes and any other pertinent information. The Flathead Community Health Improvement Plan will go into effect January 1st 2020 with the goal to complete all strategies by December 31st 2022.

Priority Area: Mental Health and Substance Use

Behavioral Health is the top priority in Montana's State Health Improvement Plan and consistently the highest priority in Flathead County across multiple surveys and focus groups. It includes the following topics: mental health, substance use disorders, unintentional poisonings, opioid misuse, and suicide prevention

Mental Health and Substance Use: Objective 1	Create a crisis diversion partnership to ensure people in with chronic mental health to access the lowest needed level of stabilization services, when in crisis.
Project Summary	Mobile crisis response: law enforcement and community mental health partnership. Multi-component system to support law enforcement, the community, and provide tiered services. - Utilize the crisis house at WMMHC over mid-level crisis facilities like Pathways or high-level crisis facilities like Montana State Hospital - Coordinate community services and supports including substance use treatment as needed - Proactively support individuals returned to the community from the Montana State Hospital within 48 hours of discharge for case management and medication management - Support law enforcement and community professionals by increasing the services and supports through the warm line. This includes connections to the 24-hour crisis house. - Pilot co-responder model as we investigate feasibility. Law enforcement would call mental health professionals to the field in a crisis.
Project Lead	Abby Harnett, Western Montana Mental Health Center
Collaborating Organizations	- Western Montana Mental Health Center - Kalispell Police Department - Flathead County Sherriff's Department - Whitefish Police Department - North Valley Hospital - Kalispell Regional Healthcare - Flathead City-County Health Department - AlpineGlow Clinic - Oxytocin - Flathead Community Health Center - Sunburst Community Foundation
Timeline	The Crisis diversion work group will apply both for matching funds and for a mobile crisis unit. The tentative project start in January 2020. We aim to implement by April 2020 and run for two years.
Measuring Success	- Setting roll out date - Number of people receiving services through the crisis house - Number of people receiving services through the warm line - Number of ER admissions avoided - Number of jail intakes avoided - Number of MSH intakes avoided
Baseline Data	Not yet available

Mental Health and Substance Use: Objective 2	Create community wide systems for Screening, Brief Intervention, and Referral to Treatment (SBIRT) for depression and substance use.
Project Summary	SBIRT is an evidence based program to identify concerns, provide immediate assistance, and coordinate further care as needed. This project will focus on primary care patients in three health systems and provide universal screening. Patients who screen positive, will receive a brief intervention from staff trained in motivational interviewing. The referral and follow up process will be mapped and tracked for efficacy.
Project Lead	Leslie Nyman, KRH and Holly Jordt, Flathead City-County Health Department
Collaborating Organizations	- Kalispell Regional Healthcare - Flathead City-County Health Department - Flathead Community Health Center - North Valley Hospital
Timeline	Primary care universal screening for depression will be in place by January 1, 2020 at KRH and NVH. The Flathead Community Health Center will finalize their depression screen process in early 2020. The second half of 2020 will be dedicated to referral mapping and training for depression SBIRT. Substance use SBIRT work will kick off in summer 2020 with a target implementation date of June 1, 2021.
Measuring Success	- Number of primary care patients screens - Number of positive screens receiving a brief intervention - Number of patients with a positive screen receiving being correctly referred to services - Number of patients referred who connect to services within 5 business days
Baseline data	Not yet available.

Mental Health and Substance Use: Objective 3	Build a referral guide and improved process for Maternal Mental Health
Project Summary	The Maternal Mental Health Coalition has identified barriers to seeking care for perinatal mood disorders. We lack comprehensive resources specifically targeted at the perinatal period.
Project Lead	Holly Jordt, Flathead City-County Health Department
Collaborating Organizations	- Best Beginnings Community Council - Flathead City-County Health Department - Kalispell Regional Medical Center - North Valley Hospital
Timeline	The Maternal Mental Health Coalition in Flathead County formed in 2018 and began focusing on the need to improved systems to connect people to perinatal mental health resources in spring 2018. A referral guide project is set to be completed in early 2019 to be followed by a referral process mapping project.
Measuring Success	- Number of women using the referral guide - Number of women who report being successfully connected with services
Baseline data	Not yet available.

Mental Health and Substance Use: Objective 4	Suicide Prevention with a focus on veterans and men in the middle years.
Project Summary	Suicide is a major health issue in Montana where rates far exceed the national average. In Flathead County, a significant boost in suicide prevention capacity for school age children occurred in 2014 with a SOARS grant. FCCHD examined the data and found that our highest suicide rates were among men ages 35 to 60 years old- a population not being targeted. Project components include: - QPR train the trainer completed, moving on to community outreach - Marketing and outreach to men in the middle years - Community trainings on trauma informed care and suicide prevention
Project Lead	Nan Wise, Veteran's Coalition and Malia Morris, Flathead City-County Health Department
Collaborating Organizations	- Flathead Veteran's Coalition - Flathead City-County Health Department - Flathead Vet Center - Flathead County Roads Department
Timeline	QPR train the trainers through the Veteran's coalition were identified in 2019. The Flathead City-County Health Department began Adult Mental Health First Aid training in 2018 and trained all internal staff and two outside organizations in 2019. Coordination between suicide prevention and response activities are set to ramp up in early 2020.
Measuring Success	- Number of community members trained in QPR each year - Number of community members trained in Mental Health First Aid
Baseline data	Train the trainers have been identified. Data to be collected.

Mental Health and Substance Use: Objective 5	Decrease Tobacco use among teens and increase access to cessation services.
Project Summary	Tobacco use is the single most preventable causes of death and disease in the United States. Tobacco use causes cancer, heart disease, lung disease (including emphysema, bronchitis, and chronic airway obstruction) and premature birth low birth weight, stillbirth and infant death. Although cigarettes and smokeless tobacco continue to be issue, the increase of youth using electronic vapor products has dramatically increased. FCCHD is working to combat increased use of e-cigarettes in youth by increasing outreach and educational opportunities to Flathead County schools. NVH is developing a care pathway for education and support of patients who use tobacco. FCCHD is also working to partner is KRH owned clinics to implement an e-referral system to the Montana Quitline.
Project Lead	Malia Morris, Flathead City-County Health Department
Collaborating Organizations	- Kalispell Regional Health Care - North Valley Hospital - Flathead County Schools - Flathead City-County Health Department - Montana Department of Public Health and Human Services

Timeline	DPHHS and KRH are finalizing the details Fall 2019 Project start in January 2020 and aim to implement by June 2020
Measuring Success	- Number of Quit line referrals made by healthcare providers in Flathead County. - Number of Flathead County students informed about tobacco and teen cessation resources
Baseline data	The 2017 Youth Risk Behavior Survey (YBRS) Data for Middle School Students (students in 7th & 8th grade) in Flathead County reported that 19.06% of students have tried an electronic vapor product (e-cigarette). Over the past 30 days, 9.7% of student reported that they have used an electronic vapor product at least one day. For high school students: 43.8% of students have tried an electronic vapor product and over the past 30 days, 20.5% of students reported using an electronic vapor product at least one day. The 2019 YBRS Data for Middle School Students (students in 7th & 8th grade) in Flathead County: 24.4% have tried an electronic vapor product. Over the past 30 days, 12.77% of student have used an electronic vapor product at least one day. For high school students: 51.43% have tried an electronic vapor product and over the past 30 days, 35.43% of students have used a vapor product at least one day.

Priority Area: Access to Care

Improving access to care is not a specific Montana SHIP priority. However, other health priorities such as behavioral health and chronic disease management in the SHIP call out the interconnection between poor health outcomes and inability access essential services.

Access to Care: Objective 1	Build referral pathways and expand CONNECT, a coordinated electronic referral system.
Project Summary	The CONNECT system is a statewide, electronic referral system first launched by the Kalispell School District in 2014 as part of the SOARS grant and piloted by the Flathead City- County Health Department. FCCHD took on management of the system in July, 2019 and major systems updates occurred in September of 2019. Pairing CONNECT with a project to reduce the duplication of referral guides for health and social services will increase consistency and decrease training time for new social workers. ASSIST also maintains a training to increase awareness of community resources. By aligning training materials and the referral information, we will decrease barriers to connecting people to needed services. We will also reduce the staff time required to make referrals and gather high quality data on the success of referrals.
Project Lead	CONNECT Coordinator, Flathead City-County Health Department
Collaborating Organizations	- Flathead City-County Health Department - Kalispell SD #5 - KRH/ASSIST - The Nate Chute Foundation
Timeline	The system updates in September 2019 are a way to reengage agencies.
Measuring Success	- Number of agencies using CONNECT - % of CONNECT referrals that are successful
Baseline Data	- 39 agencies enrolled in July 2019.

Access to Care: Objective 2	Community Health Workers providing in-Home Supports
Project Summary	Community Resource Partners (AKA as Community Health Workers) will visit people in their homes to connect them to community resources to help them regain their health and independence. Examples: Medicaid, Food Stamps, Disability and Veteran benefits. Activities include investigating feasibility of partnerships with MT DPHHS and local EMS to apply for grant funding pilot or support growth of EMS as Community Health Workers.
Project Lead	Katie Larsen, Kalispell Regional Health Care
Collaborating Organizations	- Kalispell Regional Healthcare local EMS services -Community Leaders -ASSIST -NVH
Timeline	Planning to begin in spring 2020. A pilot project is set to start by October 1, 2020.
Measuring Success	- Number of patients seen - Number of referrals made
Baseline data	Not yet available

Priority Area: Chronic Disease Prevention and Management

Chronic Disease Prevention and Self-Management is a priority identified in the Montana State Health Implementation Plan. The SHIP takes a more broad approach in focusing on obesity, though cancer screening is also mentioned.

Chronic Disease: Objective 1	Increase coordinated cancer prevention and screening.
Project Summary	In the State of Montana, cancer is the second leading cause of death, second only to heart disease. Breast cancer is the leading diagnosis for women in Flathead County. FCCHD, FCHC, NVH, and KRH all deal with cancer in their day-to-day work. Whether that is encouraging or conducting screening, helping women pay for screening or diagnosis of cancer and treatment in the valley. These four organizations will be working to increase coordination of cancer services to reduce cancer prevalence and death in our community. Some of the activities for this objective will include increasing breast and cervical screening by 8% in the next three years, developing care pathways for newly diagnosed patients and working to provide support for patients and families with a cancer diagnosis.
Project Lead	Molly Neu, Flathead City-County Health Department
Collaborating Organizations	- Flathead City-County Health Department - Kalispell Regional Healthcare - North Valley Hospital - Flathead Community Health Center - Cancer Support and Survivorship - Save a Sister
Timeline	FCCHD and FCHC partnered together January 2019 to complete UDS data cleanup for cervical screening
Measuring Success	- Number of clients served by KRH's Cancer Support and Survivorship - % of women who have completed breast and cervical cancer screenings - Number of women screened by the Montana Cancer Screening Program - Number of women screened by Save a Sister
Baseline information	From the 2019 CHNA: 70.9% of women 50-74 have had a mammogram within the past 2 years and 73.1% of women ages 21-65 have had a pap test in the past 3 years. From 2017 Montana State Health Assessment (SHA): About 47,000 Montana women aged 50 to 74 years need breast cancer screening and 58,000 women aged 21 to 64 years need cervical cancer screening.

Chronic Disease: Objective 2	Improve education and services for patients with asthma while improving community knowledge on air quality.
Project Summary	In Montana about 17,000 children (9.7%) are estimated to live with asthma and 1 in 3 of those children are estimated to have uncontrolled asthma. Uncontrolled asthma leads to an increase in missed days of the child from school or daycare, increase of hospitalizations, Emergency Room or Urgent Care visits, and an increase in parents missed days from work due to their child's asthma. The prevalence of asthma has increase since the 1980s. However, deaths from asthma have decreased since the 1990s. The causes for asthma are an active area of research and involve both genetic and environmental factors. FCCHD, KRH and NVH are all working to provide education and services to patients with asthma in Flathead County. Some of projects include expanding the Asthma Education Program to outpatient clinics, expanding Montana Asthma Program services to adults, and measuring indoor air quality as a pediatric population data project to improve recommendations for families, especially during wildfire smoke events.
Project Lead	Julia Meyer, Flathead City-County Health Department
Collaborating Organizations	- Flathead City-County Health Department - Kalispell Regional Healthcare - North Valley Hospital
Timeline	Adult enrollment in the Montana Asthma program will begin in September 2019. The indoor air quality data project will have its first round of data collection complete by January 1, 2020.
Measuring Success	- Number of adult patients receiving services - Number of pediatric patients receiving services - Indoor air quality data project completion.
Baseline Data	- 21 pediatric MAP clients in FY 18 - 8 Purple air monitors collecting baseline data for indoor air quality from August 1st to Dec 31st 2019 - CHNA 2018: 5% of Flathead County adults currently suffer from asthma

Priority Area: 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 (HP2020). Examples of SDOHs include adequate housing, educational attainment, neighborhood safety, and a clean environment. While SDOH is not called out as a Montana State Health priority, we are excited to include them for the first time in our Flathead CHIP. These needs 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.

SDOH: Objective 1	Map the housing system in Flathead County and create systems for addressing housing insecurity among high risk patients.
Project Summary	Housing is consistently called out as a barrier to other health improvement projects. During a community planning session on Mental Health and Substance Use, housing was identified as the second most pressing need to address. Without adequate housing, people struggle to focus on treatment or stabilize enough to work with existing resources. FCCHD began a housing data project in April 2019 to begin mapping housing needs in Flathead County. Building on this data, a community based project will map housing resources and prioritize next steps in January of 2020.
Project Lead	Holly Jordt, Flathead City-County Health Department
Collaborating Organizations	- Flathead City-County Health Department - Community Action Partnership of Northwest Montana - Public Defender's Office, Kalispell MT - Abbie Shelter - Kalispell Regional Healthcare - Samaritan House - Sunburst - Flathead Community Health Center - Gateway - Youth Dynamics - Western Montana Mental Health Center
Timeline	The planning group for this mapping project will start meeting in September 2019. A community housing map and priority selection will be held with Katie Loveland in January 2020.
Measuring Success	- Number of community organizations participating in the mapping process - Completion of a housing systems map and identification of housing priorities - Community collaboration process for taking a system approach to housing in the Flathead. - Future outcomes dependent on the priorities selected.
Baseline Data	Not yet available

SDOH: Objective 2	Integrating access to employment support services in community locations.
Project Summary	The job service in Kalispell can be a daunting place for community members. The public library in Kalispell has a high number of patrons on a daily basis, many of whom are in need of social services. By providing job services in the library, this project can decrease stigma and increase service utilization. In a related project, the job service has identified child care as a major barrier to employment. Job seekers are not aware of the resources and scholarships for finding and affording childcare. By co-locating the applications, we aim to decrease barriers for job seekers.
Project Lead	ImagineIf Library
Collaborating Organizations	- ImagineIf Library - Kalispell Job Service - Best Beginnings
Timeline	Pilot project began in September 2019. Project expansion expected in early 2020.
Measuring Success	- Number of queries to job service from the library - Number of childcare assistance applications filed from the library.
Baseline data	Not yet available

SDOH: Objective 3	Investigate opportunities to incorporate UberHealth or alternative transportation routes into existing medical systems to improve access to health services in Flathead County (Transportation)
Project Summary	Uber Health/ Lyft Health KRH is looking for new ways to provide transportation to their clients. Project activities include assessing feasibility of UberHealth adoption or similar programs, supporting ASSIST program in coordinating specific clinic days with KRH clinics to maximize ride shares, exploring opportunities to support "blue line" growth for Eagle Transit. NVH will support and participate in KRH's efforts in developing transportation strategies to improve access to health care
Project Lead	KRH
Collaborating Organizations	- Flathead Community Health Center - Flathead City-County Health Department - North Valley Hospital - -Eagle Transit - ASSIST
Timeline	Ongoing
Measuring Success	-Number of patients utilizing ASSIST services -Number of patients utilizing UberHealth services -Number of requests for medical transportation services in Flathead County
Baseline data	-Number of riders utilizing Eagle Transit and Dial-a-Ride (need from Eagle Transit) -Number of patients utilizing ASSIST services (need from ASSIST)

Priority Area: Resilience

The Montana SHIP selected Adverse Childhood Experiences (ACEs) as a priority. While this is not an exact overlay, ACEs are the foundation behind our understanding of cumulative stressors in childhood which lead to lifelong risks for poor health outcomes. Addressing ACEs and addressing resilience will lead to the same goal: a stronger, healthier, and more connected community.

Access to Care: Objective 1	Creating a "Community Conversations Salon" to build social connectedness across the lifespan.
Project Summary	Social isolation is a growing concern, especially among seniors. ImagineIF Libraries and the Flathead City-County Health Department will design and implement a program tailored to the growing population of older adults in Flathead County. Social isolation is a risk factor for poor health outcomes. This project will formally kick off in September 2019 with a presentation by Lisa Daron Grossman of the Connection Cure. The Connection Cure is a national project that challenges people to engage with themselves, others, and the world through meaningful conversation and connection. The pilot intervention will last for six months in the shape of a salon with a local expert and will include topics of interest in the Flathead Valley that are timely, relevant, and multifaceted. Library and Health Department staff will co-facilitate the discussion between community members to encourage input from all attendees and help seniors feel less lonely. Attendees will leave with a better understanding of the various viewpoints surrounding an issue as well as a feeling of community connection. The result is a more compassionate, engaged and resilient community.
Project Lead	Megan Glidden, ImagineIf Library
Collaborating Organizations	- ImagineIf Library - Flathead City-County Health Department - Flathead Agency on Aging
Timeline	Six month pilot program at the Library to kick off in January 2020.

Measuring Success	- Number of places advertised compared to how attendees learned of program
	- Number of attendees (total per session and repeat)
	- Qualitative feedback from participants on likes and dislikes of program and outcomes
	  ○ Project Outcome Survey after each event
	  ○ Informal interviews after each event

Baseline data	Not yet available

Access to Care: Objective 2	Creating spaces for peer support for families of young children
Project Summary	The Best Beginnings Community Council identified family engagement as a priority. Child focused playgroups have provided opportunities for parent connection and education. With the support of the Zero to Five Initiative, two new groups will be piloted with staff taking a secondary role. The focus will be creating fun, engaging spaces to bring out the best parent-child and parent to parent relationships.
Project Lead	Mary Buenz, Best Beginnings Community Council & Kayme Backstrom, Flathead City-County Health Department
Collaborating Organizations	- Flathead City-County Health Department - The United Way - The Nurturing Center
Timeline	Biweekly family group to begin in January 2020. A second location in Flathead County will be piloted starting in February 2020.
Measuring Success	- Number of places advertised compared to how attendees learned of program - Number of attendees (total per session and repeat) - Qualitative feedback from participants on likes and dislikes of program and outcomes o Project Outcome Survey after each event Informal interviews after each event
Baseline data	Not yet available

Partnership and Capacity Building

During the process of prioritizing needs from the 2018/2019 Community Health Needs Assessment, we identified another category of need not captured above. All of these priorities are possible because of the strong relationships formed between different organizations. For our CHIP work to continue to be successful, we need to foster these partnerships and continue to build our capacity to work collaboratively.

Partnerships and Capacity Building: Objective 1	Building a Summit of Coalitions to improve communication and support collaborative projects.
Project Summary	
Project Lead(s)	Planning committee: - Hillary Hanson, Flathead City-County Health Department - Connie Behe, ImagineIF Library - Lisa Sheppherd, Agency on Aging - Ned Cooney, Best Beginnings Community Council
Collaborating Organizations	- Flathead City-County Health Department - The Nurturing Center - ImagineIF
Timeline	The Summit of Coalitions kicked off in 2019. Still need to establish goals?
Measuring Success	- Number of organizations represented either 2019 Summit of Coalitions meetings
Baseline data	- Number of organizations represented either 2019 Summit of Coalitions meetings: x

Partnerships and Capacity Building: Objective 2	Promote Flathead Forward as a communication and project planning tool for collaborative projects.
Project Summary	Flathead Forward is a planning tool for and of the community. The tool is designed to connect individuals and groups so we can all work better together to impact our neighborhoods and communities. Flathead County's Community Planning Tool can be found at www.flatheadforward.com
Project Lead(s)	Molly Neu and Heather Murray
Collaborating Organizations	- Flathead City-County Health Department - ImagineIF Library
Timeline	-FlatheadForward Advisory Group will begin meeting in Fall 2019 -5 year plan for FlatheadForward will be completed by June 2020
Measuring Success	- Number of organizations represented on FlatheadForward - Number of organizations with raw data in groups - Number of new community members on FlatheadForward
Baseline data	- Number of organizations represented on FlatheadForward: 16 - Number of community members on FlatheadForward: 142

How to Get Involved in Community Health Improvement Plan

Over the next three years, our county will begin their work in address these priority areas. In order to make these community changes happen, we will need your help!

Ways to Get Involved

- Join a project: Reach out to the Project Leads on one of the strategies in the CHIP. We can always use your help!
- Use data that has already been collected: Formalize yourself with the data that has already been collected for Flathead County: Visit Flathead Forward's Data Warehouse http://www.flatheadforward.com/datawarehouse/
- Join FlatheadForward as a registered member: See the planning happening in real time by joining groups, seeing events or progress updates when they come out. http://www.flatheadforward.com/register/
- Read annual CHIP reports to track our progress: Annual CHIP reports can be found at http://www.flatheadforward.com/community-plans/ .
- Contact us with strategies you're currently working on or ideas for future CHIP projects! Email us at FFContactUs@flathead.mt.gov.